

SPSO decision report

Case: 202105741, Ayrshire and Arran NHS Board
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A). A had a history of Parkinson's Disease (a condition in which parts of the brain become progressively damaged over many years), dementia and cerebrovascular disease (a range of conditions that affect the flow of blood through the brain). A was admitted to hospital with a suspected urinary tract infection but their condition deteriorated and they died a few months later.

C complained that the board failed to provide A with appropriate nutrition and hydration in the first few weeks following admission, that staff had not treated A with dignity and ascribed A's symptoms to their pre-existing conditions rather than treating individual needs. C also complained about the personal care provided to A, particularly with respect to management of their skin during admission.

The board considered that they provided A with reasonable care and treatment but acknowledged and apologised for a delay in inserting an nasogastric tube (NG tube, a tube that carries food and medicine to the stomach through the nose).

We took independent advice from a consultant geriatrician (specialists in care of the elderly) and a registered nurse with experience in tissue viability care.

We found that the management of A's hydration was reasonable. However, there was a period of up to two weeks where A was Nil by Mouth without any other arrangements in place to ensure their nutritional needs were being met. We also found that staff were aware of A's Parkinson's Disease and it remained a priority during their admission. However, whilst specialist advice was sought, there was only limited input from relevant specialists and we found it unreasonable that there was not more direct involvement from relevant specialities. We also found that there was a failure to document the reasons for the provision of different medication and changes in delivery method. In relation to wound management, we considered that there were gaps between wound assessments and that the documentation was not completed appropriately, resulting in no structured or measurable approach to assessing A's pressure sore. Therefore, we upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the issues highlighted in this decision notice. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Decisions in relation to medication changes should be appropriately documented and, where appropriate, the risks and benefits of a particular medication regime and its delivery fully considered and documented.
- Patients at risk of or with existing pressure sore damage should receive appropriate and timely pressure

sore care in accordance with relevant local and national guidance.

- Patients that have complex care needs should receive appropriate input and care from all the relevant clinical specialities when requested.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.