SPSO decision report

Case: **202109772, Grampian NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the nursing care that their parent (A) received. A had dementia and was admitted following a fall in their care home, remaining in hospital until their death some weeks later. C complained that during A's admission, A was not treated with dignity, that they were left without food or water, and that they were allowed to aspirate on pureed food because they were not safely positioned in bed.

The board maintained that overall the nursing care was of a reasonable standard, but they accepted that documentation had been poor. They provided us with a detailed action plan which they were implementing in response to the failings that they had identified.

We took independent nursing advice. We found gaps in record-keeping in relation to food and fluid intake. We found that the board had failed to evidence that A was cared for in a dignified and respectful manner. Comfort rounding was not provided as frequently as it should have been, taking into account A's frailty and general condition. A had pressure ulcers and we found that the board had failed to demonstrate sufficiently frequent skin checks and repositioning. The board also failed to maintain wound charts, recording wound sizes and grade. There was no evidence of oral care having been provided.

We did not find evidence to support the account that A was left to choke on pureed food on the day before they died. The records indicated that A was being checked on regularly that morning, and that A was asleep much of the time and noted to be 'too drowsy for oral intake'. A was being treated for secretions, which we considered may have accounted for the gurgling sound reported. Although it was not possible to establish precisely what had happened on this date, it was regrettable that this incident caused so much distress to the family, and we noted that the board had apologised for the distress caused.

Taking all of the above into account, we upheld the complaint. We found that the board's action plan did not adequately address the failings in this case and we therefore made our own recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and C's family for the failings our investigation has found. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients should receive appropriate pressure ulcer care, prevention and grading in line with relevant guidance.
- Records should document what is required to capture that person-centred care has been assessed, planned and the outcome of the plan evaluated.

- Patients should have wound charts completed as appropriate and in line with relevant guidance.
- There should be a discussion with family/carers as appropriate when a patient moves onto a palliative care treatment plan to facilitate understanding and an awareness of what to expect particularly in relation to fluid and nutrition in line with relevant guidance.

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.