# SPSO decision report

**Case:** **202110901, Grampian NHS Board**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** some upheld, recommendations

## Summary

C complained that the board failed to provide reasonable care and treatment to their sibling (A) after they were admitted to hospital. A had a cardiorespiratory arrest (the cessation of effective ventilation and circulation) in the hospital and suffered a brain injury as a result of this.

We took independent advice from a consultant in critical care. We found that the board had provided reasonable care and treatment to A and we did not uphold this aspect of the complaint.

C also complained that the adverse event review that the board subsequently carried out was unreasonable. In relation to this complaint, we found that the board had carried out a level 2 review when a level 1 review should have been carried out. The level 2 review had also been allocated to an inexperienced review team, it reviewed only part of A's care journey, and it was short and poorly detailed. We also found that the record-keeping on the ward immediately before and after A's cardiorespiratory arrest was limited and not of the standard expected. Detailed retrospective entries should have been completed shortly after these events occurred, by both medical and nursing staff. We therefore upheld this aspect of the complaint.

We also found that the board's complaint handling of C's complaint was unreasonable.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for causing confusion in their responses which related to the new structure that had been put in place. Apologise that part of the complaint handling process was uncoordinated and delayed and that they added to the stress and anxiety the family were feeling at that time. Finally, apologise that they failed to deal with C's complaints in a timely or satisfactory manner. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C that a level 1 review should have been performed in place of the level 2 review and that the level 2 review that was performed was allocated to an inexperienced review team, it reviewed only part of A's care journey and it was short and poorly detailed. 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:

- For a level 1 review to be carried out.
- Patient records should be accurately completed, signed and dated with the appropriate level of information included, in accordance with the relevant medical and nursing standards.
- Before an adverse event review is carried out, the board should appropriately identify the review level, identify the terms of reference (part of the patient's care journey to be reviewed) and allocate a suitable staff review team.

In relation to complaints handling, we recommended:

- The board should ensure all complaints are handled in line with the guidance set out in the NHS Model Complaint Handling Procedures, in particular, respond in writing and in a timely manner and address all issues raised that the board is responsible for.

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.