SPSO decision report

Case: **202112163, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their parent (A) who was suffering from dementia. A had been found in a neglected state by C's sibling. A had vomited and it appeared that A had been left unattended overnight with no personal care. A's incontinence pad had not been changed for what appeared to have been a significant period and was soaked in urine. C believed this failure in care led to A's resulting aspiration pneumonia (inflammation that's caused by bacteria entering the lungs and causing a severe infection) which was the cause of their death. C also had concerns about other aspects of A's nursing care including the frequency, quality and recording of care, A's skin care and the monitoring and recording of their vital signs. Lastly, C complained that their complaint had initially been designated a "concern" rather than a formal complaint.

We took independent advice from a nurse and a consultant geriatrician (a doctor specialising in medical care for the elderly). We found that there had been a failure to provide reasonable nursing care to A which had been acknowledged by the board. However, we found further issues with respect to ongoing risk assessment, skin care in relation to pressure ulcers, malnutrition screening and the implementation of person centred care planning. It was noted that there were difficulties in definitively assessing the standard of care delivered due to failures to adhere to Nursing and Midwifery Council record keeping standards. Therefore, we upheld this aspect of the complaint. Additionally, we found that unreasonable care had been provided with respect to pain relief. We upheld this aspect of the complaint.

We also found that the complaint had not been handled in line with the board's complaints handling procedure. While there were areas for improvement, on balance, communication with the family had not been unreasonable and we did not uphold this aspect of the complaint. In relation to Cs complaint around the handling of their complaint, we found that the board failed to appropriately handle the complaint in line with their complaints handling procedures. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A's family for the failings in nursing care. 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 and A's family for the failure to increase A's medication. 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 the relevant assessments and care planning that reflects their needs. All relevant patient documentation should be completed and recorded in the nursing records in accordance with the NMC Code.
- Patients should be prescribed and receive appropriate palliative medications at all times.

In relation to complaints handling, we recommended:

- Complaint investigations should be carried out in line with the NHS Model Complaints Handling Procedure.

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.