SPSO decision report

Case: **202303239, Dumfries and Galloway NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the medical care provided to their late parent (A) by the board when they were admitted to hospital. We took independent advice from a consultant in emergency medicine. We found that there should have been better communication between the medical, nursing, and other allied health professional staff in relation to bruising found on A. We found that medical staff failed to take note of the physiotherapy findings of bruising and to document the presence of any significant injury.

We also found that medical staff should have prescribed a second antibiotic at the time of A's admission, that an assessment using arterial blood gas analysis should have been carried out before A's transfer to the critical care unit and that the mental health team failed to assess A's delirium, or prompt medical staff to consider this. Finally, we noted that the cause(s) of A's death should have been recorded in more detail on the death certificate. Therefore, we upheld this part of C's complaint.

C also complained about the nursing care that the board provided to A. We took independent advice from a nurse. We found that nursing records, in particular, risk assessment and care planning documents, were not always completed to the required standard or frequency. We also found that A did not receive a reasonable standard of person centred care in relation to their fluid intake and nutritional support and there was poor and inadequate support provided to assist A with their personal hygiene. Nursing staff should also have identified earlier the bruising on A's body and ensure A had timely access to their medications.Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- A patient's cause of death should be accurately recorded.
- All relevant staff should be aware of the board's responsibilities under the Adults with Incapacity (Scotland) Act 2000.
- All relevant medical staff should have read and understood the contents of the board's doctors handbook.
- Arterial blood gas analysis should be considered for 'any patient with a new oxygen requirement' and 'all critically ill patients'.
- Patients should receive their prescribed medication at the appropriate time.
- Patients should be appropriately examined and assessed and findings from the examination / assessment should be appropriately recorded and communicated.
- Patients should be appropriately examined and assessed. Relevant documentation should meet the

standard required by the NMC The Code. All nursing staff involved in this case should be aware of their requirements to document to the standard required by the board and the NMC to ensure patient safety, person centred care and essential communication.

In relation to complaints handling, we recommended:

- Complaints should be handled in line with the relevant model complaint handling procedure. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.