SPSO decision report

Case: **202304367, Lothian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their spouse (A) about the standard of care and treatment received in the months before A died. The board partially upheld the complaint, including failings in communication and a lack of privacy and dignity shown to A.

We took independent advice from a registered nurse. We found that while the board had acknowledged some failings, they had not identified other issues with person-centred care planning, care delivery and documentation. We therefore upheld this part of the complaint.

C complained that the board had failed to communicate with A and their family to a reasonable standard. The board acknowledged that despite C being A's carer, and it having been agreed to utilise email communication, information was not always shared with the wider team, which may have contributed to C's perception that communication was lacking. We found that the board's position that there was no record of any upset between A and individual staff members was factually incorrect. We thereby upheld this part of the complaint.

C complained that there was no record of a care plan, and that the package of care was not adequate for A's needs. The board acknowledged the lack of a suitable care package had an impact on discharge planning, and that they had failed to establish a more detailed person-centred care plan once A was discharged. We found that there was detailed planning and discussion around discharge involving C and A. We did not uphold this element of the complaint because, on balance, while the delivery of care did not match C and A's expectations, this did not make the plan unreasonable in the circumstances.

C also complained that the board's response to their complaint was unreasonable and delayed. We found that C's complaint was complex and multi-faceted accounting to some extent for the delay. However, the response had inaccuracies and failed to identify all the failings in care. For that reason, on balance, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failures in this case. 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:

- The board should ensure that person centred care planning is person specific and staff are knowledgeable on how to create a person-centred care plan; that care rounding is completed appropriately, that pain is assessed to the appropriate level and using the correct tools, that privacy and dignity is maintained by all staff for all patients and that staff are aware of how to promote continence and are competent in the use of

products used to promote continence.
- Communication with patients and families should be person-centred, full, and accurate.

In relation to complaints handling, we recommended:

- Complaint responses should be accurate and identify all failings.

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.