SPSO decision report

Case: **202304835, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their client (B) about the care and treatment given to B's late parent (A) while in hospital. A fell on the ward, suffered a cerebral haemorrhage and died several days later. C complained there had been a lack of basic nursing care, a failure to carry out and record nursing risk assessments and routine observations and a failure to maintain documentation to a reasonable standard. C also complained that the level of communication and information sharing with A's family was unreasonable.

In response to the complaint the board acknowledged there had been failings and explained that action had been taken in response.

We took independent advice from a senior nurse adviser. We found that there were significant and serious failings in A's care in relation to a failure to consider delirium, the absence and recording of regular vital signs monitoring and observations, a failure in fluid balance management, poor record keeping, a failure to move A in the ward offering more visibility, a lack of a pharmacology review and a failure to have in place an escalation process for staff concerns.

Therefore, we upheld the complaint. However, we recognise the learning already implemented by the board which has led to significant improvements to patient care and addressed the failings identified in this case.

We also provided feedback on the score given on the Serious Adverse Event Review (SAER) report, which was not reflective of the failures identified in this case. SAERs should be reviewed in a timely manner in partnership with the patient and/or their family/carers.

Recommendations

In relation to complaints handling, we recommended:

- Complainants should be kept updated on their complaints in line with the Model Complaints 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 ComplaintsInvestigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.

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.

Note - 22 May 2025

When this complaint was first published on 21 May 2025 it read "B fell on the ward, suffered a cerebral haemorrhage and died several days later." This was in error and should have read A.