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) that the care and treatment provided to B's relative (A) was unreasonable.

In response to the complaint, the board acknowledged that there had been failings in the delivery of care throughout A's hospital stay and explained that action had been taken in response to these failings.

We took independent advice from a nurse. We found areas of good practice. However, we found significant and serious failings in A's care in relation to delirium, observations and vital monitoring, record-keeping and escalation processes. Therefore, we upheld C's complaint. We recognise the learning implemented by the board which has led to significant learning and improvements to patient care and has addressed the failings identified in this case.

During our investigation, we identified issues with the board's handling of the complaint. We made a recommendation to the board to support improvement of their complaint handling.

We also provided feedback that the board should reflect on the advice we received that the score given on the serious adverse event review (SAER) report was not reflective of the failures identified in this case. We also noted that a SAER should be reviewed in a timely manner in partnership with the patient and/or their family/carers and that in this case, A's family should have received regular updates.

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 Complaints Investigation 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 - 30 May 2025

On 21 May 2025, an earlier version of this summary was published in place of the intended final version due to an administrative error. This has now been corrected. We apologise for any confusion this may have caused.