SPSO decision report

Case: **201104206, Lothian NHS Board - Acute Division**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Mr and Mrs C's son (Master A) has numerous complex medical conditions and needs constant care. They complained about a number of issues, including the care and treatment provided to their son during a series of admissions to hospital. Their concerns included that their son was not observed frequently enough, signs of deterioration were not detected, medication was not given at the right time, he developed infections and there was a general failure to assess his cognitive ability or communicate with him.

Having taken independent advice from our nursing and medical advisers we found that, generally, the medical and nursing care provided to Master A was appropriate and demonstrated effective management of his symptoms and conditions. We did not find evidence of many of the concerns raised by Mr and Mrs C. However, we upheld the complaint on the basis that there was evidence that Master A had been left unattended in a cubicle and, as a child with a tracheostomy (an artificial airway), this was a potentially unsafe practice.

Mr and Mrs C also complained that the board failed to provide appropriate home nursing care for their son. However, we did not uphold that complaint as we found that the care package provided was in line with national guidelines for children with exceptional healthcare needs. We also found no evidence to reconcile a difference in opinion between the board and Mr and Mrs C about the number of nursing shifts that had not been covered.

Finally, Mr and Mrs C had complained that they were not involved in discussions and decisions about their son's care, and that staff at the board had victimised and bullied them. Again, we could not find evidence of this. We did find evidence of good levels of communication from the clinical and nursing staff involved in Master A's care - in terms of updating Mr and Mrs C, taking into account their views, and discussing care and treatment. Although we did not uphold these complaints, we pointed out to the board that some of the steps they had taken during the latter stages of their contact with Mrs C demonstrated potentially unreasonable restrictions.

Recommendations

We recommended that the board:

- apologise to Mr and Mrs C and Master A for failing to ensure Master A was supervised at all times; and
- remind staff who may be caring for children with tracheostomy of the need to ensure constant supervision of these children, with reference to the guidelines provided by Great Ormond Street Hospital.