SPSO decision report

Case: **201001288, Grampian NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: upheld, recommendations

Summary

Mr A was an elderly man with a history of hypertension, aortic aneurism, and chronic kidney disease. Mr A fell while crossing the road and was taken by ambulance to hospital, where he stayed for several days. He was discharged but remained unwell and was admitted again a few days later. He was discharged after several days. Mr A remained unwell and was admitted to another hospital about three weeks later, where he died after three days. His daughter (Mrs C) complained that the care and treatment her father received during and between his second and third admissions was inadequate, that her concerns and information she provided were not recorded or reasonably acted upon during his second and third admissions, and that the board's complaint handling was poor.

Having looked at the clinical records and taken advice from two of our medical advisers we found that Mr A's care and treatment appeared, overall, to have been reasonable. However, we upheld Mrs C's complaints. We identified a number of failings in relation to obtaining Mr A's first admission records, prescribing antihypertensive medication, communication about drug treatment and discharge planning. We also found that the board had acknowledged that information provided by Mrs C was not always recorded.

In addition, our advisers found only limited evidence of communication being recorded, which was below a standard that could reasonably be expected. We also found that, although it was reasonable for the board to have asked different clinicians for their views of Mr A's treatment, more could have been done to integrate their views into a coherent response to Mrs C's complaints. The board should have explained in advance of a meeting with Mrs C why staff responsible for the administration of records were not included, despite Mrs C having asked for them to be present. The note of the meeting should have been checked more carefully to ensure that the correct names were used, as Mr A's name was wrong in two places. In the board's response to Mrs C's final

complaint, they should have provided more information about what was done to address the issues raised about Mr A's third admission, and they should have openly acknowledged their failings in handling Mrs C's complaint.

Recommendations

We recommended that the board:

- review their procedure for urgently obtaining clinical notes of patients re-admitted, to reduce the opportunities for the procedure to fail;
- review this case to improve practice on prescribing antihypertensive medication in such circumstances;
- review this case to improve practice on communicating between community and hospital care about drug treatment, and recording such communication in the clinical record;
- review their discharge policy, to ensure it complies with national guidance and that staff act in line with it;
- apologise to Mrs C for staff failing to communicate with her to a reasonable standard about Mr A and for failing to deal with her complaint appropriately; and
- review how they draft responses to complaints, to ensure these are coherent and transparent.