SPSO decision report

Case: **201301558, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained to us about the care and treatment of her late mother (Mrs A) while she was in the care of St Michael's Hospital. She raised concerns about her mother's oral health care, and her enteral tube feeding (she was fed by a percutaneous endoscopic gastrostomy (PEG) tube into her stomach, also known as 'enteral tube feeding').

We took independent advice from one of our advisers, who is an experienced nurse. We found that Mrs A was an in-patient for 13 months. A care plan was put in place when she was admitted, which identified her oral health care needs, and we found that this was followed. However, it was not reviewed and updated on a monthly basis, and did not take into account Mrs A's increased risk of mouth problems due to the enteral tube feeding. Mrs A was also given a mouth wash on an ongoing basis, as she had a painful mouth due to gum disease. Our adviser pointed out that the guidelines for the use of the mouthwash indicate that it should only be used for seven days, after which its use should be reviewed. This did not happen.

In relation to Mrs A's enteral tube feeding, Mrs C raised concerns that the care and management of her mother's tube was insufficient, and that on occasion she was fed while lying flat. This then led to her aspirating (breathing in foreign material) her food, and contracting aspirational pneumonia (inflammation of the lungs and airways from breathing in foreign material). Mrs A died of aspirational pneumonia. Our investigation found that Mrs A's enteral tube feeding was in line with her care plan. However, the documentation of this care was on an 'exceptional' basis, in that staff only recorded events that were outside the normal care provision. The evidence indicated that Mrs A had not been laid flat to feed, and that when she was found flat, appropriate action was taken to remedy the situation. We found that the board's actions in relation to Mrs A's tube feeding were reasonable, but that their care in relation to her oral health was inappropriate.

Recommendations

We recommended that the board:

- ensure that staff are aware of the need for monthly reviews of oral care plans and the level of detail that should be recorded; and
- provide a written apology for the failure to provide appropriate oral health care for Mrs A.