SPSO decision report

Case: **201305032, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr A suffered from advanced cancer, and was admitted to Ninewells Hospital for treatment to control his pain. While there, he fell and a fractured hip was suspected, although it was established this was not the case. He was transferred back to a palliative care centre (a place providing care to prevent or relieve suffering only), but was semi-conscious on arrival, and died shortly afterwards.

Mr A's daughter (Ms C) complained that her father had not received adequate care. She said Mr A's mobility problems had not been properly addressed, which had contributed to his fall. His pain had not been properly controlled and staff had failed to communicate properly with the family. The family felt Mr A was not properly assessed after his fall and should not have been transferred.

The board accepted that there were failings in Mr A's care, and apologised for these, explaining that changes had been made to procedures as a consequence. They said the decision to transfer Mr A was appropriate, although he had deteriorated during the transfer. They also said that he was properly assessed after his fall and his pain had been adequately managed. The board told the family they had an action plan to improve care, and this would be shared with them.

We took advice from a palliative care adviser, a nursing adviser and a geriatric medicine adviser. The palliative care adviser said Mr A had suffered a reaction to his medication. His dosage had been reduced, but it had later been increased again. She was also critical that Mr A was not medically reviewed before transfer. Our nursing adviser criticised the standard of nursing care, but noted that the board had taken action to remedy the majority of the failings. The geriatric medicine adviser agreed that the decision to transfer Mr A was appropriate, but was critical of the failure to review him immediately prior to transfer, or to discuss the decision with the family.

We found the decision to transfer Mr A was reasonable, but that he should have received a medical review immediately before being transferred. The transfer should also have been discussed with the family before it took place. We found serious failings in the nursing care provided to Mr A, noting that the board had addressed these, although they had failed to evidence this to the family. We upheld Ms C's complaints, and made several recommendations.

Recommendations

We recommended that the board:

- apologise for the failings that our investigation identified;
- review their complaints procedure to ensure that where appropriate complainants are provided with copies of action plans drawn up in response to their complaints;
- remind staff of the inappropriateness of the use of the term 'cotsides' when discussing patient care;
- review their procedures for transfer of patients, to ensure that patients are appropriately reviewed by medical staff immediately prior to transfer;

- remind staff of the importance of reviewing a patient's clinical notes prior to prescribing opiates; and
- remind all staff of the importance of providing accurate information to relatives in relation to the medical care being provided.