SPSO decision report

Case: **201306031, Lanarkshire NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Mrs C's late aunt (Miss A) had severe chronic obstructive airways disease (a disease in which airflow to the lungs is restricted). Miss A was admitted to Hairmyres Hospital as an emergency with respiratory failure. A doctor reviewed her the next day, and moved her to the medical high dependency unit (HDU). Medical staff recommended that Miss A should have a CT scan (a scan that uses a computer to produce an image of the body). However, Miss A declined this, as she was anxious about being unable to lie down due to her breathing difficulties. A doctor prescribed anti-anxiety medication, and a consultant respiratory physician discussed options with Miss A for helping her undergo the scan. During Miss A's admission, staff also noticed that she was having difficulty swallowing. Medical staff stopped her non-essential medications, and prescribed a mouth wash and thrush treatment. They were concerned about Miss A's nutrition and fluid intake, and arranged for review by a dietician, but Miss A declined nasogastric feeding (where a narrow plastic tube is placed through the nose, directly into the stomach). Two weeks after admission, Miss A was transferred to a different ward, where she died a few hours later.

Mrs C complained about Miss A's care and treatment. She was concerned that medical staff had mocked Miss A for complaining, and had not taken time to understand her anxiety about the scan. Mrs C was also unhappy with the nursing care. She said Miss A was often left in soiled clothing, was not dressed in her clothes that the family had provided, and was often left without drinking water. She also said that Miss A's cards were repeatedly taken down and returned to the locker drawer after the family had displayed them, soiled bedding was left on her bed, and on one occasion she was left without blankets. Mrs C said that communication was poor, and that nurses thought Miss A was refusing medication when actually she was unable to swallow. Mrs C was concerned that Miss A was moved to a side room on one occasion without the family being informed, and was unfit to be moved to a new ward on the day she died.

After taking independent advice on this complaint from a medical adviser and a nursing adviser, we upheld Mrs C's complaint. There was nothing in the medical records to substantiate some of Mrs C's concerns. There was evidence that Miss A's overall care was of a reasonable standard, and doctors and nurses had spent appropriate time with her, discussing her concerns and encouraging her to accept treatment. However, the advisers said that the level of communication with the family about Miss A's treatment and end of life care fell below the level of care they could reasonably expect. Although we were satisfied that most aspects of Miss A's care were reasonable, we were critical of the failure to communicate appropriately with her family and, on balance, upheld the complaint.

Recommendations

We recommended that the board:

- apologise to Miss A's family for failing to communicate effectively with them about Miss A's health and care; and
- raise the findings in this report with the doctors concerned, for reflection.