SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201400557, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C's mother (Mrs A) was admitted to Dumfries and Galloway Royal Infirmary following a fall at home. She had previously been diagnosed with Alzheimer's disease and was noted to be confused upon admission. Staff found no evidence of bone fractures, but kept Mrs A in hospital until her mobility improved. A few days following her admission, Mrs A began vomiting. Medical staff suspected a bleed in her stomach and proposed an endoscopy (a camera inserted into the stomach to find the source of the bleed). Mrs A was fasted for the procedure, but it was delayed on several occasions due to a lack of patient consent.

Mrs C complained that her mother was fasted unnecessarily on a number of occasions in preparation for the procedure. She noted that staff had been informed that she had power of attorney for her mother (a legal document appointing someone to act or make decisions for another person) and complained that she was not asked to provide consent for the procedure. She also complained about Mrs A's hygiene, the monitoring of her fluid intake and poor communication from staff.

We were critical of the board's handling of the consent for Mrs A's procedure. There are clear guidelines for obtaining consent from patients who lack capacity to discuss their own treatment and these were not followed. The record-keeping in Mrs A's case was very poor and suggested a lack of consultant review over a number of days during her admission. We were critical of this, and the lack of discussions with Mrs C regarding Mrs A's treatment plan. We also found the staff's communication to be poor with no proactive plan to discuss Mrs A's care with Mrs C. This led to impromptu discussions in open corridors which we found to be inappropriate.

Recommendations

We recommended that the board:

- conduct an audit of the relevant ward's compliance with malnutrition universal screening tool, falls risk, and adults with incapacity responsibilities;
- review the standard of record-keeping in Mrs A's case and identify any requirements for additional staff training;
- provide us with details of the outcome of the Endoscopy User Group's review and the action taken to prevent further consent issues;
- apologise to Mrs C for the inadequate level of care and treatment Mrs A received during her admission at the hospital; and
- ask senior staff responsible for the relevant ward to review how staff communicate with family members to ensure regular, proactive, communication with particular emphasis on complying with the national standards for care of dementia patients.