SPSO decision report

Case: **201402576, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C, who is a member of parliament, complained about the care and treatment Mrs A received at Peterhead Hospital. Ms C brought the complaint to us on behalf of two of her constituents, the late Mrs A's daughter (Mrs B) and sister (Mrs D). Mrs A had been admitted to hospital after suffering from sickness and diarrhoea for several days. Ms C said that staff at the hospital failed to provide Mrs A with appropriate clinical treatment and nursing care. Ms C raised a number of concerns, including that there was an overall lack of concern or anxiety about Mrs A's condition shown by nursing staff and the doctor involved, and not enough was done to help her. Mrs A died whilst in hospital.

We obtained independent medical advice about the complaint from a GP and a nurse. Both of our advisers said that Mrs A's SEWS score (Standardised Early Warning System – a system which uses special observation charts completed by nursing staff to recognise deterioration in patients) was such that medical assessment should have occurred, but nursing staff failed to request a review by a doctor.

Our nursing adviser explained that Mrs A's oxygen reading was very concerning and, along with Mrs A being 'clammy' and her 'limbs discoloured', this indicated a very serious deterioration in her condition. She said nursing staff should have been aware of the significance of these signs of shock and should have acted immediately.

Our GP adviser said that when the doctor saw Mrs A, he did not carry out a reasonable assessment, did not record accurate observations and did not take action upon these. She said that the doctor failed to respond appropriately to the abnormal and deteriorating observations recorded on Mrs A's SEWS recording chart and arrange further investigation.

We concluded that there were clear failings in the clinical and nursing treatment provided to Mrs A by the staff at Peterhead Hospital.

Recommendations

We recommended that the board:

- ensure the failings identified by the adviser are addressed with the doctor;
- confirm that the doctor has discussed his full report with the independent GP appraiser and confirm the outcome to us;
- remind nursing staff involved in this case of the importance of SEWS and the reason for using this across Scotland;
- provide us with an update regarding the current use, monitoring and any relevant accuracy of completion of SEWS and response audits;
- provide us with evidence of their on-going assessment and training for medical emergency, including sepsis; and
- provide the family with a written apology for the failings identified.