SPSO decision report

Case: **201403495, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C, an advocacy worker, complained on behalf of Mr and Mrs A about the care and treatment their late daughter (Miss A) received during an admission to Dumfries and Galloway Royal Infirmary. Miss A, who was severely disabled, was admitted with breathing and swallowing difficulties, but she became increasingly unwell and died two weeks later. Mr and Mrs A complained about various aspects of her medical and nursing care. They also complained that staff failed to reasonably communicate with them, and they raised concerns about the way in which the board handled their complaint.

We took independent advice from a nursing adviser and one of our medical advisers, who is a consultant physician. We were advised that a reasonable standard of medical care was provided to Miss A and that her death could not have been prevented. We, therefore, did not uphold this aspect of the complaint. However, we noted that one of the recorded causes of death was not appropriate, which the board had already acknowledged, and we asked them to bring this to the attention of the relevant member of staff. We considered that most of the nursing care provided to Miss A was also of a reasonable standard, but we identified a failure in respect of her bowel management. Miss A required her bowels to be manually evacuated and this task unreasonably continued to fall to Mr and Mrs A during her admission. The board's manual evacuation, or digital removal of faeces (DRF), policy was not fit for purpose and staff failed to seek specialist advice to allow them to carry out this task. We upheld this aspect of the complaint.

We also found deficiencies in the recorded level of communication between staff and Mr and Mrs A. In particular, we noted that medical staff did not have a sensitive discussion with them regarding the fact that Miss A was approaching the end of her life. This lack of discussion regarding the severity of the situation left them to attribute the deterioration of her health to a lack of appropriate care and thus added to their distress. We upheld this aspect of the complaint. We also upheld the complaint regarding the way in which the board handled Mr and Mrs A's complaint to them. They unreasonably delayed in responding and, having met with Mr and Mrs A, they failed to follow this up with a full response showing that all the issues raised had been fully investigated.

Recommendations

We recommended that the board:

- bring this decision to the attention of the member of staff who certified Miss A's death in order that they can learn from the identified discrepancy;
- review their policy for manual evacuation/DRF, taking account of any appropriate national guidance in this area;
- bring this case to the attention of relevant staff with a view to improving future communication with patients and their families/carers, particularly around end-of-life care;
- review their handling of this case with a view to making improvements and ensuring compliance with their statutory responsibilities, as set out in the Can I Help You? guidance; and
- apologise to Mr and Mrs A for the failings this investigation has highlighted.