SPSO decision report

Case: **201406403, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment of his mother (Mrs A), who was admitted to Perth Royal Infirmary following some falls, and then transferred to Murray Royal Hospital for assessment. Mrs A remained in Murray Royal Hospital for about three months, although she was transferred back to Perth Royal Infirmary on several occasions.

During Mrs A's time at Murray Royal Hospital, Mr C made allegations of abuse by nursing staff, and he complained that the board did not investigate this properly. Mr C also raised concerns about Mrs A's nursing and medical care at Murray Royal Hospital. These included concerns about her falls and physical safety, the numerous transfers between hospitals, the delay in replacing Mrs A's dentures, Mrs A's medications, and the decisions to detain Mrs A under the Mental Health Act and to use covert medication. Mr C also said the board failed to reimburse him for items lost during Mrs A's admission.

The board apologised to Mr C for the time taken to replace Mrs A's dentures and for the lost items. They arranged several reviews of Mrs A's care in response to Mr C's complaint, but found her care was satisfactory.

After taking independent advice from a mental health adviser and an adviser who is a consultant in general medicine, we upheld two of Mr C's complaints. We found there had been some failings in nursing care, including inadequate care planning (particularly in relation to falls risk) and inadequate nutrition monitoring. We also found the board failed to agree a clear communication plan with Mr C. However, we found that Mrs A's medical care was reasonable, and the decisions to detain Mrs A and use covert medication were made appropriately and in line with relevant guidance. We also found that, although the board had not yet reimbursed Mr C for all the missing items, they had handled his claim reasonably.

Recommendations

We recommended that the board:

- apologise to Mr C for the overall failings our investigation found;
- feed back the findings of our investigation regarding falls prevention, care planning and nutrition monitoring to the staff involved for reflection and learning;
- take steps to ensure individualised care planning is used to proactively identify and address patients' comprehensive care needs;
- review the use of communication plans for relatives and carers at Murray Royal Hospital; and
- review staff training needs in relation to falls prevention planning and responding to a fall (particularly where there is a suspected fracture).