SPSO decision report

Case: **201507568, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C raised a number a number of concerns about the care and treatment given to her late mother (Mrs A) during an admission to Ninewells Hospital. Mrs C had complained to the board about the general clinical and nursing care that her mother had received. She had complained about the standard of communication and the delay in diagnosing and treating her mother, and she said that her mother had suffered unnecessary pain due to the non administration of medication. Mrs C was also unhappy with the board's handling of her complaint.

During our investigation, we took independent advice from a consultant geriatrician and a nursing adviser.

When responding to Mrs C's complaints the board accepted that there had been a number of failings and had taken action to address these. This included putting in place an improvement plan. However, notwithstanding the failings identified by the board, the advice we received and accepted from the geriatrician adviser was that there were failings in relation to the clinical treatment provided to Mrs A. These related to failings in communication within and between departments. We also found that the consent process for a procedure to fit a stent had not followed the relevant guidance.

While the board had already accepted failings in relation to the nursing care provided to Mrs A, the advice we received from the nursing adviser was that there had been other failings by nursing staff. We found that there were gaps in nursing care, particularly around the use of the malnutrition universal screening tool (MUST - a way to screen patients to identify and treat adults at risk of malnutrition), and checking Mrs A's food, fluid and nutritional care.

In relation to complaints handling, the board accepted that they had failed to deal with Mrs C's complaints in a timely and reasonable manner, so we upheld all aspects of Mrs C's complaint.

Recommendations

We recommended that the board:

- provide an update on the improvement plan put in place as a result of this case;
- investigate further the actions taken in relation to the stent procedure and provide details of the reasons for the delay, including the provision of anaesthetic staff for this process, to ensure lessons are learned;
- bring to the attention of the relevant staff the consultant geriatrician's comments, that a number of doctors were involved in Mrs A's care but there was no clear indication of who was in charge overall;
- bring the geriatrician adviser's comments in relation to the management of Mrs A's medication and an error which occurred in relation to her medication to the attention of relevant staff;
- ensure that relevant staff are able to complete the MUST and carry out actions as appropriate and report back to us on this;
- formally apologise to Mrs C for the additional failings identified by this investigation and for the handling of her complaint; and

- provide an update on the review being carried out on their complaints process.