SPSO decision report

Case: **201508508, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment given to her husband (Mr A), who suffered from dementia and was wheelchair-bound. Mr A was admitted to University Hospital Ayr with a urinary tract infection, was kept in hospital for about a week, then discharged on a Friday. Mrs C required a lot of assistance to manage Mr A over the weekend, and following a GP visit the following Monday, he was readmitted to hospital. It was agreed that Mr A would be transferred to a nursing home for his future care. However, while in hospital he suffered ischaemia (lack of blood supply) to his left leg and died. Mrs C complained about a number of aspects of care, including that nursing staff did not seem to have a good understanding of dementia and did not understand Mr A's needs.

The board met with Mrs C and apologised for some aspects of care. They developed an improvement plan in response to Mrs C's complaint, which included changes to improve continuity of care and staff communication with families. The board also introduced a 'dementia champion' on the ward to raise awareness of dementia. However, they did not tell Mrs C about the action that had been taken in response to her complaint until prompted by this investigation.

After taking independent medical and nursing advice, we upheld Mrs C's complaints about the first discharge and about nursing care. While we found most aspects of nursing care were reasonable, we were critical that the board used a standard chart for monitoring Mr A's pain, whereas they should have used a chart designed for people with cognitive impairment (such as dementia), who are not always able to express their pain verbally. We did not uphold Mrs C's complaint about communication, as we found there was evidence that staff had regular conversations with Mr A's family about his condition. While Mrs C said she always had to initiate conversations, it was not possible to tell this from the clinical records, and we found no evidence that staff did not communicate reasonably. However, we found that some conversations between staff discussing Mr A's care were not recorded, and we made a recommendation regarding this.

Recommendations

We recommended that the board:

- feed back the findings of this investigation relating to Mr C's discharge to the doctor involved for reflection and learning;
- review the discharge planning process on the ward to ensure there is adequate planning, including assessment of ongoing care needs where appropriate;
- remind relevant medical staff of the importance of recording multi-disciplinary team discussions about patients' care (including 'whiteboard meetings');
- introduce a tailored pain assessment tool for use with people with dementia;
- provide us with information on steps taken (or an action plan) to indicate how dementia awareness is being carried out, in line with the national Promoting Excellence framework; and
- apologise to Mrs C for the failings found during this investigation.