SPSO decision report

Case: **201604076, Ayrshire and Arran NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

Ms C complained to the board about the care and treatment provided to her mother (Mrs A) during an admission at University Hospital Ayr. Mrs A was admitted to hospital after her GP noted that she had low sodium levels. During the admission, Mrs A received treatment for heart failure and low sodium. Her condition did not improve and she died a number of days later. Ms C complained to the board about communication with the family, the nursing care provided to Mrs A, the medical treatment provided to Mrs A and the board's failure to respond to a claim for lost property.

In response to Ms C's complaint, the board arranged two meetings with the family to discuss their concerns. The board acknowledged that communication was poor and that nursing care could have been more compassionate, and apologies were offered for these shortcomings. Ms C remained dissatisfied and brought her complaint to us.

In the course of our investigation, we took independent advice from a medical adviser and a nursing adviser. The medical adviser found that Mrs A was very unwell and said that staff should have informed the family of this from the time of Mrs A's admission, not just at the time of her deterioration. The nursing adviser did not find evidence that nursing staff had advised the family of the seriousness of Mrs A's condition, although they could not confirm if nursing staff had recognised this themselves. We noted that the board had identified a number of points of learning and improvement in relation to communication, and we asked the board to provide evidence that appropriate action had been taken. We upheld this complaint and made further recommendations based on the advisers' comments.

We also investigated Ms C's concerns about nursing care. The nursing adviser noted a number of gaps in the fluid balance and clinical risk assessment recording, but otherwise found that the records were generally of an acceptable standard. However, the nursing adviser was critical that nursing staff did not escalate Mrs A's condition to medical staff earlier in the admission, given the family were raising concerns about her condition. The nursing adviser concluded that, on balance, the nursing care fell below a reasonable standard. We upheld the complaint and made a number of recommendations.

Ms C also raised concern about the medical care provided to Mrs A. The adviser noted that Mrs A was very unwell at the time of admission and her condition was complex to treat. The adviser was critical that there was not a proactive plan to manage Mrs A after the day of admission, and noted that the assessments by medical staff were more superficial than they would have expected to see. The medical adviser said that the most important aspect of Mrs A's care was to assess her response to treatment and make sure her sodium level was rising in a safe manner. The adviser noted that this did not happen, and concluded that the care was unreasonable in this case. We upheld this complaint and made a number of recommendations.

Finally, Ms C said that a number of items of Mrs A's jewellery had gone missing on the ward, and complained that the board had failed to respond timeously to a claim for lost property. The board acknowledged that the belongings procedure had not been followed in this case and apologised to Ms C for the delay in responding to

the claim. We upheld the complaint and asked the board to supply us with evidence that their review of the lost property claim results in learning and improvement to ensure that the correct procedure is followed in the future.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C and her family for the specific failings in medical assessment and treatment and the failings in nursing care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Systems should be in place for senior nursing staff to monitor nursing communication sheets on an ongoing basis. Systems should also be in place to monitor feedback received from a range of sources about communication with relatives and significant others.
- Nursing staff should recognise when a patient's condition is deteriorating and take appropriate steps to respond.
- Medical staff should make a detailed plan of treatment for patients with heart failure and low sodium levels. Medical staff should also be proactive in providing treatment and monitoring the response to the treatment.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.