SPSO decision report

Case: **201604406, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, who is an advocacy and support worker, complained on behalf of her client (Mrs B) about the care and treatment provided to Mrs B's son (Mr A) at the Royal Edinburgh Hospital. Mr A had a range of complex psychiatric and physical health conditions and spent long periods of time in hospital. Mr A's health deteriorated while he was in the hospital and he was transferred to another hospital for treatment and died the following day. Ms C complained that the board failed to provide Mr A with appropriate treatment for both his mental health and his physical health. She also complained that the board failed to respond appropriately to Mr A's deteriorating physical health in the two weeks leading up to his death.

We took independent medical advice from a psychiatrist, a mental health nurse, and a consultant in general medicine. We found that Mr A received appropriate mental health treatment and that the board had followed the relevant guidelines. We did not uphold this part of the complaint.

In terms of Mr A's physical health conditions, the psychiatric adviser said that a more systematic approach to assessing/managing Mr A's risk of infection should have been taken. We also found failings in Mr A's nursing care, including a failure to adequately complete charts to monitor his weight, food and fluid intake. We upheld this part of the complaint.

On the events leading up to Mr A's death, we found that his deteriorating physical condition was not responded to adequately, on occasion, by nursing staff and that there was a delay in requesting a medical review. Based on the evidence provided, we upheld the complaint. However, the advisers said that the remedial action taken by the board in relation to this part of the complaint was reasonable and we therefore had no further recommendation to make regarding this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs B and her family for the failings in care and treatment that Mr A received in hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Charts used by nursing staff to monitor patients weight, nutritional screening and food and fluid intake should be completed in full and in line with organisational expectations.
- Nursing care should be effectively and transparently planned and evaluated.

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.