SPSO decision report

Case: **201701429, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained on behalf of her late mother (Mrs A) who was admitted to Aberdeen Royal Infirmary after complaining of severe back pain. On admission to hospital, Mrs A was also suffering from vomiting, constipation and had an infection. Ms C considered Mrs A did not receive reasonable care and treatment during her admission. In particular, that the board should have performed an MRI scan on Mrs A's back as she had previously had surgery for a spinal fracture.

We took independent advice from a consultant in geriatric medicine (specialist in care of the elderly) and a nurse. We found that the actions of staff following Mrs A's admission to treat the cause of her dehydration and to determine why she was unwell and in pain were reasonable. We considered that all the relevant tests had been carried out and action taken by medical staff was reasonable. We also considered that the pain relief medication prescribed for Mrs A during her admission was appropriate. However, we noted that on one occasion Mrs A did not receive a dose of paracetamol when she should have and it was possible she may have suffered an increase in her pain as a result. The adviser noted that Mrs A's pain relief medication was an important part of her treatment. This incident was referred to by the board as an adverse event and was recorded on their Datix system (a system for tracking and reporting incidents). It was also noted that Ms C had not been made aware of this incident at the time. Therefore, we upheld Ms C's complaint.

Ms C also complained that the board did not respond reasonably to her complaint. The board acknowledged that there were factual errors in their complaint correspondence and we considered that they had appropriately apologised to Ms C for this. We found, however, that there was an unreasonable delay by the board in informing Ms C that an adverse event had been recorded and this was compounded by their failure to tell Ms C the specific details of this event, despite her asking for them. We considered that the board had not provided Ms C with a full and reasoned response to her complaint and, therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to provide Mrs A with reasonable care. Also apologise for the unreasonable delay in informing Ms C that an adverse event had been recorded on the Datix system, and for not providing her with an appropriate explanation of the adverse event and what, if any, harm had been caused to Mrs A. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

In relation to complaints handling, we recommended:

- Identify any training needs to ensure staff fully and appropriately respond to complaints.

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.