SPSO decision report

Case: **201701956, Dumfries and Galloway NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care that her late mother (Mrs A) received at Dumfries and Galloway Royal Infirmary. Mrs A was admitted for emergency treatment of a bowel issue and after some time in the intensive care unit, she was moved to the high dependency unit (HDU). Mrs A's condition deteriorated while she was in the HDU and she later died. Ms C was concerned about the standard of both medical and nursing care that Mrs A received. Ms C also complained about the level of communication with family members and the way that the board dealt with her concerns.

We took independent advice from a critical care consultant and a nursing adviser. We found that the care and treatment provided to Mrs A by both medical and nursing staff was appropriate and reasonable. Therefore, we did not uphold these aspects of Ms C's complaint.

However, we found communication with the family during Mrs A's time in hospital to be unreasonable. The nursing adviser noted that staff will refer to the 'ceiling of care' indicating the level of intervention that is appropriate for that particular patient. We considered that the records made of discussions with Mrs A's family were insufficient as they did not document enough information about ceiling of care and to what extent this was discussed. Therefore, we upheld this aspect of Ms C's complaint. However, we noted that the board had already identified areas for improvement.

In relation to complaints handling, we found that there had been a short delay in issuing a final response to Ms C and that the board had not arranged an extension or apologised for this. Therefore, we upheld this aspect of Ms C's complaint. However, we noted that the board had acknowledged this failing and had made improvements to their approach to complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for the delay in responding to her complaint. 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:

- Communication with patients and their families should be in line with the General Medical Council's Good Medical Practice guidance, particularly sections 33 and 49. Ceilings of care should be discussed, agreed, documented and reviewed with all involved (patient, medical and nursing staff). The board should consider using a separate section within the notes to document discussions with relatives or carers.

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.