SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201703340, Borders NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment that her late husband (Mr A) received when he was admitted to Borders General Hospital and diagnosed with pneumonia (an infection of the lungs). Mr A was discharged from the hospital but later had a CT scan which showed that he had had a stroke. Mr A was readmitted to the hospital but his condition deteriorated and he died several weeks later. Mrs C complained about the medical treatment and nursing care that Mr A received and that the board failed to reasonably monitor his replacement heart valve on a six-monthly basis, as previously agreed.

We took independent advice from a consultant geriatrician (a doctor who specialises in the medicine of the elderly) and a nurse. In relation to Mr A's medical treatment, we found that there had been a lack of continuity during his first admission, which contributed to the fact that the significance of the deterioration in his cognitive function and incontinence was missed, despite the family highlighting this. Whilst much of the communication with his family had been reasonable, there was a failure to listen to the family's concerns at that time. We also found that it was unreasonable that a CT scan was not carried out during this admission, although we could not say whether or not this would have diagnosed Mr A's stroke. Therefore, we upheld this aspect of Mrs C's complaint.

In relation to the nursing care, we found that there had been a failure to meet some of Mr A's basic personal care needs and to assess and manage his ongoing continence problems. Nursing staff also failed to review his cognitive impairment on an ongoing basis and to involve his family in the planning and review of his care. We also found that there was a failure to adequately document his care needs and how they were met on an ongoing basis. We upheld this aspect of Mrs C complaint.

Finally, we found that the board had failed to reasonably monitor Mr A's replacement heart valve on a six-monthly basis, as previously agreed. We considered that it was unreasonable to plan to follow up a patient with a serious chronic condition, but fail to do so, without any clear explanation. Therefore, we upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in relation to Mr A's medical and nursing care and treatment. 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:

- Patients admitted to hospital with cognitive impairment should receive CT scanning in line with the Scottish Stroke Care Standards.
- There should be ongoing structured assessment, management and review of patients with cognitive

impairment and delirium in hospital settings.

- There should be a structured and comprehensive approach to identifying and reviewing care needs and how these needs will be met during a patient's stay in hospital. Where appropriate, this should include involving the patient's family.
- The care needs of patients in relation to continence assessment and management in hospital should be appropriately met.
- The 'Getting to Know Me' document should be completed and used to inform a person-centred care plan.
- Patients with a serious chronic condition should have follow-up care as agreed. Where it is decided to stop the follow-up appointments for a patient, the patient should be informed of this and the reasons for this.

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.