SPSO decision report

Case: **201703836, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained on behalf of his late grandmother (Mrs A) about the care and treatment she received at Aberdeen Royal Infirmary (ARI) and Kincardine Community Hospital (KCH).

Mrs A suffered from severe pain in her back and a suspected chest infection. She was referred by her GP to ARI, discharged on day five and then re-admitted to KCH ten days later. Mrs A was transferred back to ARI over a month later, and then back to KCH, where she later died.

Mr C complained that the board failed to provide a reasonable standard of medical care and treatment, failed to provide a reasonable standard of nursing care and failed to handle his complaint appropriately.

Regarding medical care, Mr C complained about Mrs A's pain management and a lack of communication around her treatment. We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly). We found that Mrs A did not receive sufficient attention for her pain relief requirements. We found that this was an issue that could have been easily avoided, and one that caused Mrs A pain and the need for readmission. We also found that there was a lack of consideration for Mrs A's decision-making capacity regarding an operation that she underwent, and that there was a failure to discuss her care with Mr C and the family at this time. We upheld this aspect of the complaint.

With regards to nursing care, we took independent advice from a nursing adviser. We found that, while the communication did not meet Mr C's family's needs for specific periods of time, there was no evidence in the nursing records to indicate that the overall level of nursing care Mrs A received was unreasonable. We did not uphold this part of the complaint.

Lastly, regarding the board's handling of Mr C's complaint, we found that the board had apologised to Mr C for a delay in handling his complaint. However, we were concerned that, having given Mr C a revised timescale for providing a response, this was not then met and the board were not proactive about keeping him advised about the subsequent process of his complaint. We were also concerned that the complaint response appeared to be incomplete and did not address all of the questions Mr C raised. We upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and his family for the failure to provide Mrs A with sufficient attention for her pain relief and for the failure to adequately communicate with Mr C and his family about Mrs A's pain and its management. 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:

- Patients' pain relief needs should be fully assessed at the time of discharge from hospital. The management of a patient's pain after discharge should be fully discussed with patients and their families.
- Where a patient lacks decision-making capacity, their mental health should be respected and their care discussed with their family.

In relation to complaints handling, we recommended:

- Communication about revised complaint response timescales should be accurate and further contact should be made if it emerges that the revised timescale is not achievable. Responses to complaints should be accurate and address all the issues raised.