SPSO decision report

Case: **201706740, Borders NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained on behalf of her mother (Mrs A) about the care and treatment provided to Mrs A at Borders General Hospital.

After a fall breaking her hip, Mrs A was admitted to the hospital for an operation. At the time of her admission, Mrs A had hearing only in her right ear and staff were advised of this. Mrs A appeared to be making a reasonable recovery after her operation but, the next day, her condition deteriorated and she developed sepsis (a blood infection). She was given two doses of an antibiotic. Shortly afterwards, she developed a bowel obstruction for which she needed an operation and a few days afterwards, she had a heart attack. Mrs A remained in hospital for nearly six weeks and by then she had lost all her hearing. Mrs C complained about Mrs A's care and treatment and said that the antibiotic she had been given had led to her hearing loss. She also complained about poor communication and, amongst other things, not being told of Mrs A's heart attack.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly) and from a registered nurse. We found that Mrs A's operation had been performed promptly and without any problems but that afterwards, when her temperature and National Early Warning Score (NEWS - an aggregate of a patient's 'vital signs' such as temperature, oxygen level, blood pressure, respiratory rate and heart rate which helps alert clinicians to acute illness and deterioration) began to rise, no specific action was taken as it should have been. In relation to the antibiotics, Mrs A was very unwell and at risk of dying and, therefore, this risk outweighed the potential harm of giving Mrs A the antibiotic (which was associated with hearing loss and balance problems after prolonged use). However, we also found that Mrs A was not given a detailed assessment or screened for sepsis. On balance, we upheld this aspect of Ms C's complaint.

In relation to communication, we found that staff had not told the family about Mrs A's heart attack or made a plan to address or discuss Mrs A's communication needs, with no review of this taking place. We considered that the board's communication was unreasonable and upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise for not fully assessing Mrs A; for failing to follow guidance; and for the communications failures. 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 whose National Early Warning Scores trigger action should be appropriately assessed, including screening for sepsis and delirium.
- Patients and their carers should receive appropriate information about their condition in a way that suits

their needs.