SPSO decision report

Case: **201801342, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the medical care and treatment that his wife (Mrs A) received from the board. Mrs A had a diagnosis of cancer and had a number of admissions to Aberdeen Royal Infirmary over a two month period. We took independent advice from a consultant clinical oncologist (a doctor who specialises in the diagnosis and treatment of cancer). We found that:

Mrs A was discharged from hospital before the results of a stool sample were obtained and while she was experiencing diarrhoea

there are no written records of the phone calls that the doctor had with Mrs A or her GP following a positive result for Clostridium difficile (a bacterium that causes diarrhoea and more serious intestinal conditions)

Mrs A was not readmitted to hospital as soon as the Clostridium difficile result became available.

We considered the medical care and treatment to be unreasonable and upheld this aspect of Mr C's complaint.

Mr C also complained about the nursing care and treatment that Mrs A received. We took independent advice from a nursing adviser. We found that:

the board's response in relation to hand gels was inaccurate in that hand gels are ineffective when caring for patients with Clostridium difficile

Mrs A's personal hygiene requirements were not recorded consistently and daily records were not kept to indicate what personal hygiene assistance Mrs A had received or had been offered

nursing staff did not appear to adhere to the Infection Control Policy.

nursing staff did not record how they knew about Mrs A's shingles (a viral infection that causes a painful rash) diagnosis or whether this information had been passed on to the admitting doctor.

We considered the nursing care and treatment to be unreasonable and upheld this aspect of Mr C's complaint.

Mr C also complained that the board did not handle his complaint reasonably. We found that the board failed to keep Mr C updated about the reason for the delay in responding to his complaint and to provide a revised timescale for completion. We also found that the board's complaint response did not address all the points that 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 for the failure to provide Mrs A with reasonable medical and nursing care and treatment and for failing to handle his complaint reasonably. 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:

- Nursing staff should be aware that alcohol based hand rubs or hand gels are ineffective in removing Clostridium difficile spores and that hand-washing is an important aspect of preventing the spread of Clostridium difficile.
- Personal hygiene requirements should be recorded clearly and consistently. There should be daily recordings to indicate what personal hygiene assistance patients have received or have been offered.

In relation to complaints handling, we recommended:

- Complaints should be handled in line with the model complaints handling procedure. The model complaints handling procedure and guidance can be found here: www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs.