SPSO decision report

Case: **201805473, Dumfries and Galloway NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the care and treatment the board provided to her late father (Mr A). Her concerns related to the board's out-of-hours service and care provided at Dumfries and Galloway Royal Infirmary.

Mr A had been unwell and the board's out-of-hours service was contacted. Mr A was subsequently admitted to hospital with signs of infection but later discharged himself. He was then readmitted after it had been identified that he had staph aureus bacteraemia (SAB, an infection). Subsequently, Mr A suffered a gastrointestinal bleed (bleeding on the digestive tract, and a symptom of a disorder), and developed kidney failure. Mr A then also developed severe heart failure. He was discharged for palliative care and died shortly thereafter.

We took independent advice from a GP, a consultant in acute medicine and a nurse. In relation to the treatment provided by the board's out-of-hours service, we found that it was reasonable that a GP did not visit Mr A at home, based on the situation and what was known at the time. We did not uphold this complaint.

In relation to Mr A's admissions to Dumfries and Galloway Royal Infirmary, we found that during Mr A's first admission staff had provided reasonable reviews, tests and treatment for Mr A, and the level of clinical care and his treatment was reasonable. However, it had been identified after Mr A left hospital that he had SAB and we found that there was a failure to recognise or act on the seriousness of the SAB result and start proceedings to bring Mr A back to hospital and obtain treatment. In relation to Mr A's second admission, we found that Mr A was given intravenous potassium too quickly and that there was a delay in receiving a transoesophageal echocardiogram (an ultrasound test that uses sound waves to produce moving, real-time pictures of the heart) though it would not have changed his treatment. As such, we found that there were unreasonable failings in the clinical care and treatment provided to Mr A. We upheld this complaint.

In relation to the nursing care provided to Mr A, we found that there was a lack of evidence of day-to-day nursing care, significant failures in record-keeping by nursing staff and a scarcity of relevant nursing records. There were some areas of concern in relation to Mr A's fluid balance and shortcomings in the pressure care provided to Mr A. We also found failings in communication between nursing staff. Therefore, we found that there were unreasonable failings in the nursing care provided to Mr A. We upheld this complaint.

Miss C further complained that the board failed to communicate reasonably with her about Mr A's care and treatment. We found that medical staff had communicated reasonably with Miss C. However, we found there were shortcomings in how nursing staff communicated. In particular, there were limited references to communication, and where they existed, they were prompted by Mr A's family, not by staff. We therefore found there was a failure by nursing staff to communicate reasonably with Mr A's family. As such, we upheld this aspect of Miss C's complaint.

Miss C also complained that the board had failed to respond reasonably to her complaint. We found that there were a number of failures by the board in their handling of Miss C's complaint. We found that there was an

unreasonable delay in acknowledging Miss C's complaint, a repeated failure by the board to meet their own timescales to finalise the complaint response letter or request a further extension and a lack of clear communication with Miss C. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for the failings this investigation has identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- A SAB result should prompt staff to review the patient, repeat blood cultures, give consideration to the investigations needed to find the source, and provide treatment. Relevant staff should be aware of the correct rate for administering intravenous potassium. Where a transoesophageal echocardiogram is planned, this should be carried out as soon as possible.
- The board should have systems in place to ensure the quality of day-to-day nursing care and record-keeping.
- Ward nursing staff should communicate with a patient and their relatives and ensure that any communications are appropriately recorded in the nursing notes.

In relation to complaints handling, we recommended:

- Complaint investigations and responses, including acknowledgement of receipt, should be in accordance with board's complaints handling procedure. The board should, whenever possible, inform a complainant about when they should expect to receive a response to their communication and if there is going to be a delay in providing 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.