SPSO decision report

Case: **201806699, Highland NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C and their spouse (B) complained about events during two periods of hospital treatment for their child (A). A has complex medical needs. They are cared for by C and B at home, however they have required multiple and prolonged spells in hospital. C and B complained about the care and treatment A received, communication by the board, communication within the board and how their complaint was handled.

In response to C and B's complaints, the board acknowledged a number of failings in A's care and treatment and the way in which they had communicated with C and B. They also said that consideration should have been given to earlier involvement of social work and the community children's nurse.

We took independent advice from a consultant paediatrician and a social work adviser. We found that the care and treatment A received on their first admission were unreasonable. We considered that there was inadequate dietetic support, an unreasonable reliance on C and B's assessment as to whether intake was sufficient, and a lack of information and help for the family when A required emergency care after a gastro-jejunal tube (G-J tube, a tube used to vent the stomach and small intestine) procedure. We upheld this aspect of the complaint.

In relation to A's second hospital treatment, we considered the care and treatment to be reasonable. We did not uphold this aspect of the complaint.

We also found a lack of reasonable communication with C and B about A's care and treatment and a lack of reasonable communication between the board's staff during A's second admission. We upheld these aspects of the complaint.

Finally, we found that the board failed to handle C and B's complaint reasonably. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and B for the lack of information on what to do if they had concerns following the procedure, for wrongly informing them that the child concern form (CCF) would be removed from A's medical records (and explain the reasons why this cannot be done) and for the failings identified in complaint handling. 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:

- All relevant staff should be aware of the local guidance for the management of fabricated or induced illness (FII) for multi-agency use, of the guidance for the completion of CCFs, of their roles and

responsibilities in such cases; and of the GMC guidance: Protecting children and young people 2012 (in particular Sections 56 and 57).

- Children with feeding tubes should have a de-escalation plan individualised for each child advising of the feeding regimen if the tube dislodges. This should be shared with parents, tertiary and local centres. There should be clear documentation of advice regarding fasting for procedures and a checklist to identify those who may be at risk of fasting. Consideration should be given to carrying out such procedures on an in-patient basis if the patient is considered at increased risk.

In relation to complaints handling, we recommended:

- Complaint investigations and responses, including acknowledgement of receipt, should be in accordance with the board's Complaints Handling Procedure. The board should keep a complainant regularly updated about their complaint including 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.