SPSO decision report

Case: **201809208, Lothian NHS Board - Acute Division**
Sector: Health
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

C complained on behalf of their late parent (A) regarding nursing and medical care and treatment provided to A during an admission to the Western General Hospital.

We took independent advice from a nurse and from a consultant in general medicine and care of the elderly.

With regard to the concerns about nursing care, we found that there were failures in relation to:

risk assessment completion and accuracy

personal care

pressure sore prevention and management

wound care

continence management

encouraging mobilisation

person-centred care planning

We upheld this aspect of C's complaint.

With regard to medical treatment, we found that there was an unreasonable delay in providing antibiotics for A's urinary tract infection. However, we noted that the board had acknowledged and apologised for this failing previously. We also found that A was kept on the medical assessment unit for the entire admission of over a week, despite this unit being for maximum stays of 48 hours. Given these failings, we upheld this aspect of C's complaint.

C further complained that A had a dental appointment at another hospital in the area whilst they were an in-patient, and no arrangements were made to assist A to attend this or to arrange for them to be seen by their dentist at the Western General Hospital. The board had previously acknowledged that they should have arranged for transport and for a member of staff to attend the appointment with A, apologised, and offered to compensate C for the cost of transport. We upheld this aspect of C's complaint.

Finally, C complained that the board failed to identify that they were making a formal complaint. We found that C's complaints were not appropriately identified and responded to in line with the Model Complaint Handling Procedure and the board had accepted this. We therefore upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to provide reasonable nursing care and medical treatment to A, and for the failure to handle C's complaint in a reasonable manner. 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:

- Appropriate care rounding should be carried out in a patient at risk of pressure damage.
- Every patient should have a person-centred care plan, and this should include consideration of how to manage any continence issues and mobility issues.
- Patients should be encouraged to get out of bed and get dressed appropriate to their condition.
- Patients should be transferred from the medical assessment unit to a ward, or be discharged, within a reasonable timescale. If a patient is on the medical assessment unit for more than the board's maximum period of stay (48 hours), the reasons for this, and any attempts to find a more suitable ward or a single room should be documented.
- Pressure sore prevention and management should be carried out in line with Healthcare Improvement Scotland Pressure Ulcer Prevention Standards.
- The Waterlow Pressure Area Risk Assessment Chart should be accurately completed on admission.
- Where appropriate, antibiotics should be provided in a timely manner when lab results become available.
- Wounds should be assessed and managed in line with Healthcare Improvement Scotland Scottish Wound Assessment and Action Guide, and relevant wound formularies.

In relation to complaints handling, we recommended:

- Complaints should be accurately identified and logged. If it is not clear whether the issues are a complaint or a concern, this should be clarified.

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.