SPSO decision report

Case: **201900799, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment a family member (A) received in Monklands Hospital prior to their death. C raised particular concerns that nursing care was not delivered proactively and that the family had to continually ask for care to be provided, including catheter care, oral care, nutrition and pain management. A suffered a fall while in hospital and C also raised concerns about the adequacy of the medical assessment which was carried out following this.

We took independent advice from a nursing adviser. We found that the nursing care was reasonable overall, with appropriate care rounding evidenced in the records. This covered catheter care, pain management and general care. However, we identified an unreasonable two-hour delay in commencing appropriate medication for pain and agitation due to medical staff being unavailable to prescribe. We also identified that prescribed oral care was not administered as prescribed, and that person-centred care planning did not reflect A's needs with regards to oral hygiene and end of life needs. We considered that this contributed to A's noted discomfort in the final days of their life and, on balance, we upheld this complaint.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly) regarding the medical assessment which followed A's fall. We noted that a thorough and well-documented assessment was carried out which concluded that A had sustained minor injuries only and that no scans or further investigations were required. We did not consider there was a clear connection between the fall and its follow-up and A's subsequent deterioration. We did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the delay in commencing appropriate medication for A's pain and agitation; the failure to administer oral care as prescribed; and for the failure to update the person-centred care plan to reflect A's needs. 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:

- Person-centred care plans should be updated at every shift change to capture person-centred needs. The board should carry out a review of person-centred care planning in the relevant ward.
- The board should investigate why medical staff were unavailable to prescribe timely medication for pain and agitation. Measures should be put in place to prevent this happening again; and the board should demonstrate compliance with the Scottish Palliative Care Guidelines 2013.
- Treatment should be administered as prescribed, or a code entered in the medicine kardex to indicate why this has not been administered. Ward staff should be reminded, in a supportive manner, of their responsibilities and the policy for the administration of prescribed medication.

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.