SPSO decision report

Case: **202002896, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their parent (A) received during an admission to a community hospital.

A had a degenerative condition which affected their mobility and was latterly diagnosed with a form of vascular dementia (a common form of dementia, caused by problems in the supply of blood to the brain). A was admitted to hospital following a fall. C told us that A had a number of falls in hospital and suggested that one of these falls led to an injury to A's leg. C raised a number of general concerns regarding the nursing care and implied that A was allowed to become dehydrated, only drinking when assisted by family members or when family members prompted the ward staff.

C also raised concerns about the clinical aspects of A's care. C said that A became lethargic and unresponsive during their admission to hospital. Family members expressed their concern to staff that this may have been the result of sepsis (blood infection) or a urinary tract infection. However, they were reassured that A's symptoms were likely caused by antibiotics.

A suffered a heart attack. Staff performed cardiopulmonary resuscitation (CPR) and revived A. A was then transferred to a general hospital for care where A died five days later. C explained that A was uncomfortable and agitated during their final days. C said that staff there had expressed concern that no Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) had been signed for A. C complained that the additional five days of suffering that A experienced could have been avoided had a DNACPR been discussed with family members.

We found that A's condition and medical history meant that clinical staff should have considered DNACPR each time that they reviewed A. Whilst we were critical of the board for failing to do so in A's case, we acknowledged that they had already taken action to improve their procedures and ensure that the consideration of DNACPR is not left until an emergency situation develops.

We found that A had developed sepsis, likely as a result of the leg injury sustained during their admission. We noted an apparent delay of several days before the cut to A's leg was identified. However, once the nursing staff were aware of this, they appropriately escalated the situation to the clinical team. We found that no clinical review was carried out and that the nursing staff instead consulted NHS24 for advice as to how to treat A's leg. A was treated with oral antibiotics. We found that had A been reviewed in person by a member of the clinical team, the severity of their infection may have been recognised and intravenous (into a vein) antibiotics may have been prescribed. We noted an overall lack of clinical input into A's care during their admission and concluded that this led to a failure to diagnose A's sepsis.

With regard to the nursing care that A received, we found that there was a four day delay to A's falls risk being assessed and mitigated after their transfer to hospital. The number of falls A had and the severity of the harm caused increased during this time and we found that this was a clear failure to adapt to a patient's specific needs.

We were critical of the board for failing to record and monitor A's leg wound in a wound chart.

Whilst we were satisfied that there was evidence of the nursing staff monitoring A's food and fluid intake, we noted that their focus was on the weekly variations in A's weight. This meant that A's significant weight loss over a longer period was not identified. Had it been, staff may have taken proactive steps to increase A's intake and increase their weight. We upheld all aspects of this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the failings 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:

- That the board conduct a review of the nursing care provided on A's ward and take steps to ensure that they are compliant with the relevant standards for falls risk assessment, nutritional assessment and wound care.
- The board conduct a review of the medical provision available to patients on dementia wards at the hospital and take steps to ensure that they meet the standards of inpatient care set out in the guidance from the Royal College of Psychiatrists.
- The board share this decision with the nursing staff.

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.