SPSO decision report

Case: **202005563, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) by Dr Gray's Hospital. C complained that A's colorectal symptoms and weight loss were not properly investigated and that a planned scope investigation wasn't arranged on an urgent basis. C also complained that a head injury A sustained in a fall was not properly investigated and that A was inappropriately discharged when they were unfit to return into C's care. A was re-admitted the following day and died in hospital around two and a half weeks later. C complained about the standard of medical treatment provided during this admission. Furthermore, C complained about the nursing care provided during A's final admission. They complained that visits did not take place in an appropriate location to ensure A's comfort and privacy, and in particular that A was not transferred to a side room in light of their condition. C also considered that A was denied adequate nutrition and hydration. Finally, C complained of difficulties obtaining information from the ward and more generally about communication with the family and the lack of visiting opportunities that they were afforded.

We took independent advice from a consultant geriatrician (a doctor specialising in medical care for the elderly). We found that there was no evidence to indicate the need for urgent investigation. We did not uphold this aspect of the complaint.

We found that A's care surrounding the head injury was reasonable and that they did not meet the criteria for a head scan. However, we noted that there was a lack of care and attention to A's confusion and falls risk and that they should have been kept in hospital. On balance, we upheld this aspect of the complaint.

We noted that A received an appropriate medical review and treatment, apart from a delay in initially being reviewed by a consultant and a lack of attention to A's deterioration prior to their death. We also noted a failure to communicate the DNACPR process to C, but noted that the board had acknowledged this and outlined appropriate steps to address it. Taking communication and the lack of consultation together, in careful and close balance, we upheld these aspects of complaint.

In relation to C's complaint about the nursing care provided during A's final admission, we took independent advise from a nursing adviser. Other than an identified omission where nursing staff failed to sign for prescribed dietary supplements, which the board acknowledged, we found that A received a reasonable standard of nursing care. Therefore, on balance, we did not uphold this aspect of the complaint.

In relation to communication, the board acknowledged that the family weren't afforded the opportunities that they should have been following a change in guidance. We asked the board to provide evidence of the steps that they were taking to ensure staff are kept updated on changes to visiting guidance. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the lack of care and attention to A's level of confusion and the unreasonable decision to discharge them, for the lack of consultant review after A's later admission, for the failure to communicate the DNACPR process to C and for the lack of recognition of A's deterioration and failure to inform C of this. 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:

- The findings of this investigation should be fed back to relevant staff for reflection and learning including, staff reflection on the decision making surrounding A's discharge, the level of consultant input in the days following their readmission and the care and attention given to A's deterioration and lack of communication with C. The consultants concerned should include the findings of this investigation as part of their annual appraisal process.

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.