SPSO decision report

Case: **202005809, Edinburgh Health and Social Care Partnership**
Sector: Health and Social Care
Subject: Clinical treatment / Diagnosis
Decision: upheld, recommendations

Summary

C complained about various aspects of the care and treatment their spouse (A) received from the partnership.

A was an in-patient at a community hospital. Over the course of a few days, A was repeatedly admitted to a larger, specialist hospital for treatment before being transferred back to the community hospital.

C complained to the partnership about the care and treatment A received in both hospitals. The partnership apologised for any distress caused to A or C but did not identify any failings in A's care. C remained unhappy and brought their complaint to us. C complained that there had been a failure to adequately monitor, manage, and treat A in both hospitals, which had led to a serious deterioration in their condition.

We took independent advice from a consultant in care of the elderly and general medicine. We found that there had been a failure to medically review A. We also found that there had been a failure to obtain a urine sample during A's first admission to the specialist hospital and that this had resulted in a failure to detect a serious infection. Therefore, we upheld C's complaint.

We also found that the partnership's response to the complaint failed to fully reflect the information they obtained during the investigation and failed to adequately detail the learning taken from A's experience.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C 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:

- When there is an acute deterioration in the condition of a patient at the community hospital, a prompt medical review of the patient should be carried out. Nursing staff at the hospital should be appropriately trained to ensure they are empowered to request a prompt medical review of a patient from the out-of-hours teams when there is no medical cover on site. At the second hospital, appropriate systems should be in place to ensure that when a urine sample is requested, it is actioned and the result fed back to the appropriate clinical 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.