SPSO decision report

Case: **202101633, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment their grandparent (A) received when they were admitted to hospital. A was acutely unwell with a poor prognosis and was treated in the COVID-19 ward for a number of days. A's condition improved and they were discharged home. C complained that A did not have capacity to consent to treatment and that treatment to address A's confusion made their symptoms worse. C believed that clinicians failed to clearly communicate the treatment plan for A, that it was unreasonable for clinicians to focus on end of life treatment and that staff failed to meet A's basic needs.

In response to the complaint, the board explained that A was admitted with possible aspiration pneumonia and COVID-19. They said A was treated for COVID-19 and with antibiotics and that the care and treatment in this regard together with the assessment of A's capacity, was appropriate. Nursing staff gave A regular oral hygiene, but due to high flow oxygen therapy this was difficult. Appropriate assessment and treatment was undertaken with respect to A's skin.

We took independent advice from a consultant geriatrician (specialist in care and treatment of the elderly) and a nurse. We found that whilst many aspects of A's care were reasonable and of a standard expected, there was a significant failure with respect to the assessment of A's delirium. We also found that there were significant failures with respect to the level of personal care provided to A. Therefore, we upheld C's complaints relating to medical and nursing care and treatment.

In relation to communication with C and their family, we found that the records documented an appropriate level of communication with respect to decisions made about A's care. Therefore, we did not uphold this part of C's complaint.

C complained that the board failed to handle their complaint reasonably. We found that there was discrepancies and apparent inaccurate information contained in the board's response. Therefore it was reasonable to conclude that the board failed to carry out a reasonable investigation and upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and C for the failure to handle and respond to the complaint reasonably. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C and A for the failures 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:

- Staff to be compliant with HIS (2020) Prevention and Management Standards. All staff assessing pressure ulcer risk fully understand the risks and are able to put in place measures and equipment to minimise risk. Staff completing care rounding able to identify that patients at risk of pressure damage must have their position changed and not nursed in the same position for 24 hours.
- Relevant staff are familiar with the adult with incapacity process and the importance of delirium screening tools with patients where delirium is observed and evident.
- Staff responsible for undertaking oral care are trained and competent in assessing oral hygiene requirements, carrying out oral hygiene and accurately documenting this in the records.
- To ensure a person centred approach to assessment of continence and appropriate prescribing of continence management products.

In relation to complaints handling, we recommended:

- Complaints handling staff to be familiar with the complaints handling procedure. Clinical staff to be aware of the significance and importance of a thorough consideration of clinical records and reflecting on these in an open and transparent manner when offering responses to specific aspects of complaint.

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.