SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201104845, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C's father (Mr A) was admitted to hospital via the accident and emergency department after a fall. Mr A had suffered two previous falls and had become increasingly forgetful over a period of seven to ten days. Mr A's level of consciousness was recorded as being normal upon admission, but dropped shortly afterward. A scan showed that he had had a cerebral bleed (bleeding on the brain). Although he made a slight improvement while in hospital, he developed pneumonia and died the next month.

Miss C raised a number of concerns about the treatment that Mr A received from the hospital's staff and the level of attention paid to his needs whilst he was an in-patient. She also complained about the board's communication and handling of her complaint.

We took independent advice from two of our medical advisers, and upheld almost all of Miss C's complaints. We found that the overall level of care and treatment provided to Mr A was reasonable, but there were some specific issues that concerned us and we considered these to be serious failings. Specifically, we found that insufficient nursing care was provided throughout one day, when Mr A was in a single room. A lack of written notes cast doubt as to whether certain tasks had been performed and, in particular, whether a swallow screen test (a test to check the patient’s ability to swallow) was carried out by a suitably qualified member of staff.

We were concerned to note that Mr A's family were not told that a decision had been made not to attempt resuscitation (ie that a doctor was not required to resuscitate Mr A if his heart stopped). We also found that this decision was taken without the input of a senior clinician as is required. Generally, we did not consider that the lead clinician caring for Mr A was sufficiently involved in his care. We were satisfied that the information contained in Mr A's clinical records was reasonable, but were critical of the board for the number of omissions in the records. We made a number of recommendations to address the failings we found.

We did not uphold the complaint about complaints handling, as we found the board's handling of Miss C's complaint to be reasonable.

Recommendations

We recommended that the board:

- draw our adviser's comments on the use of anti-sickness medication in syringe drivers to the attention of clinical staff;
- provide the Ombudsman with details of the outcome of their 'care round' document trial and any changes to their patient monitoring procedures that result from this trial;
- review the level of involvement of senior clinical staff in patients' treatment;
- remind their staff of the need to discuss 'do not resuscitate' decisions with patients and their families;
- remind nursing staff of the need to maintain full and accurate nursing records in line with Nursing and Midwifery Council guidance; and

- apologise to Mr A's family for the issues highlighted in our investigation.