SPSO decision report

Case: **201901349, Glasgow City Health and Social Care Partnership**
Sector: Health and Social Care
Subject: other
Decision: some upheld, recommendations

Summary

C complained about a home visit to attend to their late spouse (A) concerning A's PEG (a tube into the stomach to enable non-oral feeding) which was leaking. A family member of C had called the district nurses and was put in touch with an enteral feeding (a method of supplying nutrients directly into the gastrointestinal tract) nurse who agreed to visit the next day. The nurse advised C that the leak appeared to be due to constipation. C complained that the nursing care provided to A was unreasonable. The nurse also filed an Adult Support and Protection Referral (ASPR) with social work due to concerns about A's safety. C complained that the ASPR was not appropriate.

We took independent advice from a community health nurse. We noted that the partnership's pathways and referral process indicated that unscheduled care from the community enteral feeding team should be provided within four hours (or an alternative care plan identified). We found that an urgent response was required in this case as A was bedbound and dependent on the PEG for providing all nutritional needs, including administration of medications essential for managing long-term conditions. Any malfunction of A's feeding and medication regimes would result in detriment to their wellbeing. The visit to A should have been classed as 'unscheduled care' and A should therefore have been seen within a four-hour time period in terms of the process. In relation to the overall nursing care, we were critical that there was no detailed documentation of the assessment and examination during the visit, and no treatment plan recorded (other than advising the family to contact the GP to arrange an x-ray). However, we noted that the nurse followed up with the GP, which was good practice. We also noted that a subsequent hospital scope indicated that the nurse's diagnosis of constipation appeared reasonable. In view of the lack of detailed records or care plan, and the failure to comply with the partnership's own timeframes for reviewing A, we considered that the care and treatment was unreasonable and we upheld this complaint.

In relation to C's complaint that the ASPR was not appropriate, our role is not to decide whether the concerns raised in the ASPR were justified (that is, whether or not A was in fact at risk); rather, we had to consider whether the nurse's decision to make the referral was reasonable, based on their knowledge of the situation and their concerns. We found that the nurses' concerns were appropriate and sufficient reason for making the referral. As such, we did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the poor record-keeping and for failing to meet their timeframes for unscheduled care. 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:

- Unscheduled care should be provided within the timeframes in the partnership's policy, with clear records

of the examination, findings and treatment plan.

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.