SPSO decision report

Case: **201903611, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their relative (A) during two hospital admissions with the board. C considered that the care that was given to A under the Adults with Incapacity (AWI) Act without consultation with C and their partner was unreasonable, given they were A's guardians. C also complained that the nursing and medical treatments provided to A were unreasonable. C raised concerns about A's arm during their admission and considered that these were not reasonably investigated or responded to.

We took advice from appropriately qualified advisers. We found the board failed to keep reasonable records of the AWI. The board acknowledged that a key piece of paperwork was missing, which suggested that while the assessment had been undertaken, it could not be evidenced. We, therefore, upheld this complaint.

We also found that the board failed to reasonably assess A's capacity. We noted that there were records of some discussion, however there was no evidence that the key paperwork for this was completed. We, therefore, upheld the complaint.

We found that the board provided reasonable treatment to A during their admission. This particularly related to how a cannula (a thin tube inserted into a vein or body cavity to administer medication, drain off fluid, or insert a surgical instrument) was utilised. The adviser considered the use of this was reasonable. It was acknowledged that the cannula shifted, however, this was a known risk and it could not be determined what caused it. Therefore, we did not uphold this complaint.

We found that while there were a number of areas of nursing care which were reasonable, the board failed to provide reasonable nursing care, in particular in relation to the recording and management of A's pressure ulcers. We upheld this complaint.

We found that the board provided a reasonable explanation to C regarding the deterioration of A's arm during their admission. While they could not definitively determine what had occurred, it was reasonable based on the information available. We did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to keep reasonable records regarding the AWI. 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:

- A patient's assessment of capacity should be clearly documented, along with the wishes of any guardian/POA.

- Nurses should follow the tissue viability nurse's documented plan of care.
- Nurses should follow tissue viability advice or escalate the issue to senior management where there is dispute between a family member and a clinical expert.
- Use of the AWI legislation should be appropriately recorded in patient records.
- Wound charts should have tissue type recorded by percentage.

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.