

## SPSO decision report



**Case:** 202301101, Dumfries and Galloway NHS Board  
**Sector:** Health  
**Subject:** Nurses / nursing care  
**Decision:** upheld, recommendations

### Summary

C complained about the medical and nursing care and treatment provided to their late parent (A). A was admitted to hospital after repeated falls at home. A's behaviour changed significantly during their admission which suggested that their mental state was deteriorating. C said that they were not directly informed of this, and that A was not referred to the mental health team. A had also been refusing to eat and began to vomit blood. C was not contacted at this point, and was not informed of A's deterioration until later that day.

We took independent advice from a registered nurse and a consultant geriatrician (specialist in medicine of the elderly). We found that A had been prescribed medication, which combined with existing health conditions, should have required additional medication to protect their stomach. This was exacerbated by A's refusal to eat. We found that nursing records of A's nutritional intake were not completed. Additionally, A's mental state was not properly assessed. We also found that the board had told C that they would make a change to improve the electronic prescription system. However, this change was not possible and the board had not informed C of this. We considered that A's nursing and medical care fell below a reasonable standard and upheld these parts of C's complaints.

C also complained about the board's complaint handling. We found that the board's response to C was inaccurate. Therefore, we upheld this part of C's complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure in medical and nursing care, as well as the complaint handling failures identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/information-leaflets](http://www.spsso.org.uk/information-leaflets).

What we said should change to put things right in future:

- Patients should receive the relevant assessments and care planning that reflects their needs. All relevant patient documentation should be completed and recorded in the nursing records in accordance with the NMC Code.
- Patients receiving corticosteroid medication at risk of gastritis or other gastric injury, should receive proton-pump inhibitor (PPI) medication as well.
- Patients should be appropriately assessed when there are changes in their behaviour.
- Person centred care plans should be followed for each patient and weight loss should be recognised and responded to.
- Staff are aware of the importance of prescribing and monitoring a patient's medication appropriately.
- The board should develop clear guidance to ensure patients with mental health issues can have timely access to nursing staff trained in mental health care.

In relation to complaints handling, we recommended:

- Complaints should be investigated in line with the Model Complaints Handling Procedure. Actions and improvements should only be included in complaint responses when the board is able to carry them out.

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.