SPSO decision report

Case: **202309997, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) during an admission to hospital. C complained that the board had failed to manage placement of a nasogastric tube (NG) correctly and did not act timeously on signs of a complication. C said that the board failed to carry out an adverse event review of this event.

C complained that the board dismissed A's known diagnosis of myasthenia gravis (a rare long-term condition that causes muscle weakness) too quickly and failed to arrange a neurology (speicalism concerned with the diagnosis and treatment of disorders of the nervous system) review. Finally, C said that the board did not maintain A's privacy or dignity when providing end of life care and communication with the family was poor.

The board apologised for failures in A's care in respect of the NG tube insertion and for aspects of their communication. The complication which occurred with the NG tube was a rare but known complication of the procedure. The board said that A's case had been reviewed at a Mortality and Morbidity (M&M) meeting and points of learning had been identified.

We took independent advice from a consultant neurologist (specialist in the diagnosis and treatment of disorders of the nervous system), a consultant gastroenterologist (specialist in the diagnosis and treatment of disorders of the stomach and intestines) and a consultant respiratory physician (specialist in conditions affecting the lungs).

We found that there were aspects of A's care which were reasonably managed including the review by neurology, the decision to site the NG tube, the end of life care provided to A and the review of the admission undertaken by the M&M meeting.

However, we found that the chest x-ray undertaken after insertion of the NG tube was unreasonably delayed. Therefore, we upheld this part of C's complaint. However, we noted that the board had recognised this failure as part of their own review of C's complaint.

C complained that the board failed to handle their complaint reasonably. We found that the board took a significantly long time to respond to C's complaint and failed to provide C with any updates or a revised date of response. 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 failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

In relation to complaints handling, we recommended:

- Complaint investigations should be managed in accordance with the Model Complaint Handling Procedure. They should be managed within timescales or updates should be provided to account for delays and to provide a revised timescale for completion. Complaints should be properly investigated and the complaint response should be accurate.

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.