SPSO decision report

Case: **201803946, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, a support and advocacy worker, complained about the standard of medical and nursing care and treatment provided to their client (A) during A's hospital admissions at Victoria Hospital and Cameron Hospital over 11 months. The concerns raised cover numerous aspects of the care and treatment provided by clinicians at A&E and the intensive care unit at Victoria Hospital, and clinical staff at Cameron Hospital. These include unreasonable failures in relation to the response to A's deterioration, medication including dosage, communication, bedsores, rehabilitation, and discharge. C also said that the board failed to handle A's complaint in a reasonable way. C told us that as a result of the failings, A developed complications which have had a profound impact on them and their spouse's life.

We took independent advice from four advisers: consultants in emergency medicine, psychiatry and anaesthesia, and a nurse specialist in tissue viability. We found that A had not been regularly reassessed as they should have been in A&E for a number of hours during which time their condition deteriorated and their transfer to the intensive care unit was delayed, and that staff in A&E failed to communicate with A's spouse in a reasonable way. We found that clinicians failed to take reasonable action to prevent hospital-acquired pressure damage to A and then failed to investigate and treat A's pressure ulcers, which led to severe and extensive pressure damage to a degree rarely seen in today's healthcare setting. We noted that this was avoidable and that the board's failure to identify these failings in their subsequent review was very concerning. We also found that the board's response to the complaint about A's condition and its cause did not reflect the evidence from the clinical records and advice obtained from specialists. We upheld five of C's complaints.

We did not find failings in relation to medications, communication from clinical staff in intensive care, transfer, handling of A by nursing staff at Cameron Hospital, rehabilitation care and treatment and discharge. We did not uphold eight of C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this investigation. The apology should meet the standards set out in the SPSO guidelines onapology available at www.spso.org.uk/information-leaflets.

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

- Ensure communication by healthcare professionals is of a reasonable standard.
- Ensure patients are regularly assessed so that any deterioration is noted and respond to appropriately and within a reasonable time.
- Review the clinical failings to ascertain: how and why the failings occurred; any training needs; and what actions will be taken (or since then have been taken) to prevent a future recurrence. Before doing so, the board should consider why their previous review failed to identify the failings and ensure that the

methodology of this review is robust and that whoever undertakes it is appropriately qualified, objective and impartial.

In relation to complaints handling, we recommended:

- Ensure all complaint responses are accurate and reflect the available evidence and information.

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.