SPSO decision report

Case: **201805543, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C's adult child (A) had spent time in hospital due to abdominal pain, following which complaints had been raised and promises made that action would be taken to prevent any recurrence. A few years later, A spent time in hospital again as a result of abdominal pain and swelling, bruising to the legs and breathing issues. During the admission, A required cardiopulmonary resuscitation (where the heart and/or breathing is re-started if it stops) and died in hospital. A post-mortem examination established that A had rheumatoid arthritis-related constrictive pericarditis (a condition that causes the flexible sac that surrounds the heart to become stiff, preventing the heart from functioning properly).

C raised a number of concerns regarding the clinical investigations carried out into A's symptoms, the time taken to reach a diagnosis and the quality of clinical nursing care provided. C complained about the standard of communication from the board's staff and expressed their concern that the improvements that had been promised previously had not been implemented by the board.

We took advice from an independent nursing adviser. We found that multiple, relevant, investigations were carried out to establish the cause of A's symptoms, appropriate specialist advice was sought, a reasonable treatment plan was followed and that the true nature of A's heart condition was not detectable, despite the appropriate investigations having been carried out. Given this, we found that the medical care and treatment provided to A had been of a reasonable standard. We did not uphold this aspect of the complaint.

We found that the board's monitoring and management of A's fluid balance and wound care was not of a reasonable standard, and that there were apparent issues in terms of the nursing staff's engagement with A and their family. We found that the board had failed to provide A with a reasonable standard of nursing care. We upheld this aspect of the complaint.

While we found the board's communication with C following A's death was generally reasonable, we found that the board unreasonably failed to apologise to C for not contacting them when A became unresponsive. Given this, and that there were communication failings that the board had accepted, we found that the board had failed to communicate with A's family appropriately during their admission and following their death. We upheld this aspect of the complaint.

We did not find any evidence that the actions and service improvements promised following C's earlier complaint were implemented by the board. We also found that if actions were taken, they were not effective, as the board accepted that similar issues had recurred. We found that the evidence the board provided regarding actions taken as a result of their later commitments were from too small a sample of patients and taken over too short a period to adequately demonstrate that issues identified had been addressed. Given this, we found that the board had failed to implement the actions and service improvements promised following C's earlier complaint. We upheld this aspect of the complaint.

We found that C's complaint was taken seriously and investigated thoroughly. However, there were delays to starting an investigation into the most recent issues raised by C and to arranging a meeting regarding these. We also found that the board's communication with regard to the Chief Executive's attendance at any meeting and how the most recent issues would be taken forward were poor. Given all of the above we found the board failed to handle C's complaint reasonably. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the issues highlighted. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to A's family for failing to contact them when A became unresponsive. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to A's family for failing to effectively implement the actions and service improvements promised following C's original complaint. 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:

- The board should conduct an audit of the relevant ward's current compliance with their obligations to monitor fluid balance and wound condition to ensure that the improvements that have reportedly been made since C's complaint are reflected in the nursing care currently provided on the ward.
- The board should conduct two audits of the general quality of nursing care in the relevant ward to demonstrate an improvement in standards over the next six months.
- The board should effectively implement the actions and service improvements promised following C's original complaint and take action to effectively address issues regarding nursing care, communication, attitude and behaviour.

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.