SPSO decision report



Case: 201902178, Fife NHS Board

Sector: Health

Subject: clinical treatment / diagnosis

Decision: upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her father (Mr A) at Victoria Hospital. Mrs C was also concerned that the investigation of her complaint to the board had been inadequate.

Mr A had been admitted to hospital for treatment of a heart condition. Mrs C believed that his assessment had been inadequate and that he had been prescribed a drug which had caused a severe reaction when combined with the medication Mr A was already taking. Mr A had developed ulcers in his left eye and then contracted cellulitis (an infection of the deeper layers of skin), which had affected both eyes.

Mr A had required surgery to his left eye. Mrs C believed this experience had rapidly increased the onset of Mr A's dementia, leaving him incapable of managing by himself, where as he had previously had a significant degree of independence. Mrs C said that this could have been avoided, had his medication been checked properly before he was prescribed new drugs by the hospital, as ulceration was a known complication.

We took independent advice from an appropriately qualified adviser. We found that Mr A's care and treatment had fallen below a reasonable standard, because his medication had not been properly reconciled prior to the prescription of a new drug. We could not state for certain that Mr A's deterioration was solely attributable to this error, as the side effects he suffered could have been caused by the new drug by itself, rather than in combination with his existing medication. We upheld this aspect of the complaint.

We also found that the board's investigation of the complaint had been inadequate, as it had not identified the failure to reconcile Mr A's medication. Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

Apologise to Mrs C and Mr A for the inadequate standard of care provided by the board and the failure of
the subsequent complaint investigation by the board to identify this. 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:

• Staff need to comply with the board's procedures for medication reconciliation.

In relation to complaints handling, we recommended:

Staff should be able to identify accurately the substantive issues contained within a complaint.

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.