SPSO decision report

Case: **201910278, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their late parent (A) received from board. A was admitted to A&E at Victoria Hospital following a fall at home. A was found to have fractured their femur and was subsequently transferred to a ward. A died shortly after transferring to the ward. No post-mortem was required by the Procurator Fiscal and a heart attack was recorded as the likely cause of death.

C said that they were told by the board's staff that tests carried out in the A&E did not indicate any problems with A's heart. As such, no additional monitoring was required when A transferred to the ward.

C complained that the board's staff failed to note and act upon a number of “red flag” symptoms that should have highlighted that A was at increased risk of a heart attack. C noted that A had been given a high dose of morphine by the ambulance crew. C complained that the board's staff failed to adequately monitor A's general condition or their reaction to the morphine.

We found that A's general condition was reasonably assessed in the A&E. An echocardiogram (a heart scan that uses sound waves to create images) was carried out and did not raise any concerns about A's heart. Whilst A displayed a number of symptoms that could have been linked to a heart problem, the tests carried out by hospital staff were thorough and gave no indication that there was a need for any specific additional heart monitoring when A transferred to the ward.

A was given a high dosage of morphine by the ambulance crew. We accepted medical advice that the hospital staff should have been aware of this and that they should have monitored A's response to this medication. We found no record of the morphine dosage having been recorded upon A's admission to hospital, or of specific monitoring taking place to check for any adverse reactions to the medication. A displayed symptoms that could have been caused by morphine. It was not possible to determine whether A's death was caused by a problem with their heart, or a reaction to the morphine. However, we were critical of the board's failure to record the morphine dosage and monitor A's reaction to it throughout their admission. We upheld the complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the failures identified. The apology should meet the standards set out in the SPSO guidelines on apology available atwww.spso.org.uk/information-leaflets.

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

- That the board confirms to this office whether they assess patient care against the Scottish Standards for the Care of Hip Fracture patients and provides details of any learning and improvements resulting from C's complaint.

- That the board share a copy of this decision with the departments involved in A's care with a view to preventing similar issues in the future.

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.