SPSO decision report

Case: **201104809, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C was admitted to hospital, suffering from increased confusion and needing more and more pain relief. She was also on a high dose of steroids for giant cell arteritis (GCA - inflammation of the blood vessels, usually in the head, which can cause blindness). She was transferred to another hospital nearly four weeks later, then back to the first hospital around three months after that. Mrs C's husband (Mr C) complained that she fell while in both hospitals and was concerned that these events had not been properly investigated. He also said that his wife's medication was not properly monitored, that the nursing care in relation to her deteriorating condition and pressure ulcer was inadequate and that his complaints were inadequately handled.

As part of our investigation we took independent advice from a medical adviser. They said that Mrs C had a complicated medical history, but that she had an unacceptable number of falls in the first hospital, and that the assessment of her being at risk of falling was inadequate. In line with national guidance, staff should have done more to prevent Mrs C from falling, and so we upheld the complaint that she was not properly monitored or assessed for this. However, we did not uphold Mr C's other complaints about his wife's care. Our investigation found that after each of the falls both hospitals treated Mrs C's symptoms appropriately. We also found evidence showing that Mrs C was appropriately monitored and assessed for the medications she was prescribed. She received good personal care from nursing staff, and an appropriate care plan was implemented for a pressure ulcer that developed on her heel. This was dressed regularly but we noted that there was no wound chart for it - to have one would have demonstrated good practice in wound care management.

We also upheld Mr C's complaint about complaints handling. Our investigation found that, although the board's responses to the complaints addressed the issues concerned and explained the reasoning behind treatment decisions, they should have tried to address the underlying issues when responding to Mr C. In addition, the length of time it took the board to respond to the complaint was unreasonable, only occurring after we had started to investigate the complaint, some nine months later.

Recommendations

We recommended that the board:

- provide Mr and Mrs C with a full apology for the failings identified;
- ensure all relevant staff at the first hospital are aware of and implement appropriate falls prevention measures, including when to seek the advice of a falls specialist, in line with national guidance;
- remind relevant staff that when prescribing off-label (prescribing drugs in unusual circumstances or doses) the relevant protocol should be followed to ensure there is a proper record and the patient or, where appropriate, their family, is fully informed;
- take steps to acknowledge and address any clear underlying issue causing distress to the complainant as far as possible in complaint responses; and
- ensure that responses to complaints are sent out in a timely manner within the appropriate NHS complaints timescale.