# SPSO decision report

**Case:** **201404376, Fife NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** some upheld, recommendations


## Summary

Ms C complained about the care and treatment her mother-in-law (Mrs A) received while a patient in the Victoria Hospital in the days immediately before her death. Mrs A had a history which included, amongst other things, epilepsy and dementia.

Mrs A was admitted to the hospital after a fall from bed. She then fell a further twice from bed, and shortly after the second time, she sustained a serious injury and subsequently died. Ms C said that the hospital failed to protect her mother-in-law properly, particularly as Mrs A had been assessed as being at high risk from falls. She said Mrs A was not provided with the one-to-one care she should have been given nor was she given appropriate medical care after she fell from bed. Ms C was also concerned at the level of communication with the family because although they were advised of both falls, the second time there was no sense of urgency despite Mrs A's very serious condition.

We took independent advice from a consultant geriatrician and from our nursing adviser. We found that the medical care Mrs A received was reasonable, so did not uphold that aspect of her complaint. However, we found that nursing staff failed to provide Mrs A with adequate nursing care; there was a general lack of detail in some of Mrs A's records; and there was a similar lack of detail given to the family about Mrs A's condition, so we upheld all of Ms C's complaints about these issues.


## Recommendations

We recommended that the board:

- formally apologise to Ms C for their shortcomings in nursing care;
- confirm to us that the recommendations they made, after a significant adverse event review, have been satisfactorily completed;
- ensure that all staff are reminded of their obligations to provide properly detailed notes and demonstrate to us that they have done so;
- apologise for their communication failures; and
- remind staff on the relevant ward of the necessity of good, clear communication with patients' families, particularly in circumstances where the patient is unable to make their own decisions.