SPSO decision report

Case: **201501341, Fife NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Miss C complained on behalf of her late mother (Mrs A). Miss C complained that Mrs A's dressings were not changed regularly enough, that the board failed to communicate with her regarding how ill her mother was and, in particular, that Mrs A had signed a do not attempt cardiopulmonary resuscitation (DNACPR) order. Miss C also complained that after her mother's death, she had asked nursing staff to re-dress her mother and this request had not been carried out. Miss C said the board took an unreasonable amount of time to respond to her complaint.

We took independent advice from one of our nursing advisers. The adviser said Mrs A's dressings should have been more closely monitored, so we upheld this complaint. However, as the board had already acknowledged this and taken appropriate action, we did not make a recommendation.

Our adviser noted that Mrs A was competent and able to make decisions about her own care. The DNACPR order had been properly communicated and administered by staff. It was for Mrs A to decide if she wanted to discuss this with anyone else. We did not uphold this complaint.

Regarding Miss C's request for her mother to be re-dressed, we noted that the nurse Miss C spoke to had assured her this would be done by mortuary staff. When the mortuary were contacted, however, they did not believe it would be appropriate for them to carry out this request and passed it on to the undertaker. We were critical that the board had assured Miss C that this request would be carried out. However, the adviser's view was that the decision taken by the mortuary staff was reasonable and was taken to ensure Mrs A's dignity. We did not uphold this complaint.

The board had explained that the reason for the delay in responding to Miss C was caused when staff continued to request information from a doctor who no longer worked for the board. For that reason, we upheld the complaint and made one recommendation.

Recommendations

We recommended that the board:

- reflect on why staff were not alerted to the fact that the doctor had left the board, and how this might be avoided in future.