SPSO decision report

Case: **201508343, Fife NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment of his late mother (Mrs A). Mrs A had multiple health problems and was admitted to Victoria Hospital with back pain. She was subsequently transferred to Queen Margaret Hospital but became unwell a few weeks later and was transferred back to Victoria Hospital. She deteriorated quickly due to sepsis (an infection of the blood) and died the following morning. Mr C complained about various aspects of the nursing care provided to Mrs A.

We took independent advice from a consultant physician and a nurse. We noted that there was a failure to correctly label a urine sample, resulting in the laboratory being unable to process it and a subsequent delay in obtaining a repeat sample. This resulted in a two-day delay in Mrs A receiving antibiotics. The medical adviser considered that had there been no delay, Mrs A may have had a better chance of survival, although they could not be certain that this would have been the case. We also noted a failure to assess and document Mrs A's leg wound upon admission, leading to a delay in appropriate treatment.

Mr C had alleged that a nurse's physical handling of Mrs A amounted to assault and, although the nursing adviser considered that this complaint was taken seriously and dealt with sensitively, they advised that consideration should have been given to handling this more formally through the relevant incident-reporting system.

Mr C also complained about a delay in responding to the family's request for the toilet to be cleaned and while we could find no evidence of a delay, we noted that the board had not directly addressed this concern. While we noted that the board had already acknowledged many of the identified failings and taken appropriate remedial steps, we upheld this complaint.

Mr C also complained about the communication with his family, in particular a lack of opportunity to speak with medical staff about Mrs A's care. The medical adviser agreed that there was minimal evidence of good communication between medical staff and the family. They considered that an 'Adults with Incapacity' form should have been completed earlier in the admission and discussed with the family.

We found no evidence of inadequacies in relation to the communication surrounding Mrs A's transfer back to Victoria Hospital or when a DNACPR decision was taken (a decision that means a healthcare professional is not required to resuscitate the patient if their heart or breathing stops). In addition, we were also unable to evidence specific occasions where Mr C described inappropriate communication and attitude of particular members of nursing staff. However, we upheld the complaint. We noted that the board had acknowledged and acted upon failings but we made some recommendations for further remedial action.

Finally, Mr C complained about the board's handling of his complaint and in particular the time it took to respond. We noted that his complaint was very detailed and asked a significant number of specific questions. We were satisfied that the board's response was reasonable and proportionate in the circumstances. We were also satisfied that they took appropriate steps to keep Mr C updated regularly throughout their investigation. However,

we considered that the investigation was not concluded in a timely manner and that there was an unreasonable failure to set a revised target response date when it became clear that the response would be delayed beyond the standard time frame. Therefore we upheld the complaint. While the board had already provided an explanation and apology for the delay, we made a further recommendation.

Recommendations

We recommended that the board:

- take steps to ensure that allegations of the nature of those raised by Mr C are handled in line with their formal incident reporting system;
- highlight to relevant staff the family's concerns about the failure to respond to their request for the toilet to be cleaned, and remind them of the importance of responding promptly to such requests;
- review the use of 'Adults with Incapacity' forms in the relevant ward/department to ensure that the appropriate processes are being followed and that the actions being taken are in keeping with Health Improvement Scotland visit standards;
- remind nursing staff of their responsibility to facilitate good communication between families and medical staff; and
- highlight to complaints handling staff the importance of aiming to provide complainants with a revised response timescale when it becomes clear that the 20-working-day target will not be met.