SPSO decision report

Case: **201605046, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained that staff at Glenrothes Hospital failed to provide her father (Mr A) with appropriate medical care and treatment, particularly regarding dehydration, confusion and breathlessness. She also complained that there were unreasonable failures to provide adequate nursing care, and that staff failed to communicate appropriately with her and her family. She said that their concerns were ignored. The family had concerns about Mr A returning home. Mrs C said that Mr A had been given inadequate physiotherapy and that, despite his poor condition, staff insisted upon completing an assessment at home. Mrs C said that after she complained about these matters she did not receive a response until three months later and she was not kept informed about what was happening.

In replying to the complaint, the board agreed that there had been some delay for which they apologised. In relation to the family's concerns about Mr A's confusion, the board said that medical staff could have treated Mr A's dehydration more aggressively by giving him intravenous fluids but that although the family had concerns, they did not consider there to have been a problem. Similarly, they considered that after Mr A reached his physiotherapy goals there was no need for further input. The board did not consider that they had undertaken an inappropriate home assessment, nor did they think that they had failed to discuss matters reasonably with the family during Mr A's admission to the hospital.

We took independent advice from a nurse, a GP and a mental health nurse. We found that Mr A's dehydration could have been treated earlier, perhaps by earlier admission to another hospital for intravenous fluids, but that this would not necessarily have prevented the deterioration in his overall health. We upheld this aspect of the complaint.

We also found that not all the records had been completed fully regarding Mr A's nursing care, particularly those concerning his fluid balances. We found that Mr A had had a surprising result during cognition tests and that this had not been monitored. We upheld this aspect of the complaint.

We found that the family were kept appropriately up-to-date regarding Mr A's condition and that where the family had concerns, these were noted and taken into account as far as was possible. We did not uphold the aspect of the complaint regarding communication.

We found no evidence that Mr A had been given insufficient physiotherapy as he had achieved the goals that had been set for him and we did not uphold this part of the complaint.

We did not find evidence that a home assessment had been carried out unreasonably, or that the decision to return Mr A home was unreasonable. While the family were not in agreement, this had been what Mr A wanted. As such, we did not uphold this part of the complaint.

Finally, we found that the board had not responded to the complaint in a timely manner, nevertheless, the family

had been kept updated about the delay. On balance, we upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to monitor Mr A's fluids and cognition properly. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Nursing staff should complete all care rounding charts as required to ensure that the fluid levels of patients is properly recorded.
- When there has been a surprisingly low cognition score, cognitive functioning should be kept under review.

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.