SPSO decision report

Case: **201605793, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained about the medical treatment and nursing care that her late mother (Mrs A) received at Victoria Hospital. Mrs A had been diagnosed with advanced lung cancer and was admitted to hospital with symptoms of nausea and persistent vomiting. The issues Mrs C raised concern about related to a lack of blood testing to monitor Mrs A's kidney function as she had chronic kidney disease, that no intravenous (IV) fluids were given over two specific days and that fluids were not appropriately monitored, that there was a delay in a urinary catheter being inserted and that communication with the family was poor.

We took independent advice from a consultant in respiratory medicine and from a nurse. We found that there were a number of unreasonable delays in relation to Mrs A's medical care and treatment. We considered that if IV fluids had been administered in a timely manner, this may have delayed or prevented the development of an acute kidney injury (the inability to turn waste material into urine) and may have allowed Mrs A to spend more time with her family. We upheld Mrs C's complaint about medical care and treatment.

In terms of the nursing care, we found that there was a lack of comprehensive monitoring of Mrs A's fluid intake and urine output which the board's complaint investigation did not identify. We considered that such monitoring may have helped assist medical staff identify issues with urinary output sooner. We upheld Mrs C's complaint about nursing care.

We noted that the board had accepted that there were problems with the way in which staff had communicated with Mrs C and the family. Therefore, we have asked the board to provide evidence of the action that they said they would be taking to address this. However, we also recommended that the board take further action to address how they review the care and treatment of patients as their response to the complaint contained inaccurate information.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in Mrs A's medical and nursing care, and for the fact that the board's complaints investigation was not thorough enough.

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

- Review by a senior doctor for patients admitted as an emergency should be carried out in a timely manner.
- Difficulties with IV access should be escalated in an appropriate and timely manner.
- Fluid balance charts should be fully completed when indicated.
- Appropriate clinicians should be involved in the review of patient care to ensure that comprehensive responses to complaints are provided.

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.