SPSO decision report

Case: **201700473, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained on behalf of her father-in-law (Mr A) about the care and treatment he received from Victoria Hospital and Glenrothes Hospital over a six month admission period. Mrs C's concerns related to surgical treatment, nursing care, physiotherapy, speech and language therapy (SALT) and medical care.

We took independent advice from a general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus), two registered nurses and a consultant geriatrician (a doctor who specialises in medicine of the elderly). In relation to Mr A's surgical treatment, Mrs C felt that a perforated ulcer should have been identified at the time Mr A underwent an emergency operation. We found that it was reasonable that the perforated ulcer was not recognised at the time of the emergency surgery given a number of relevant factors. We did not uphold this aspect of Mrs C's complaint.

In relation to the nursing care, Mrs C was concerned that Mr A developed as significant pressure ulcer, monitoring of his fluid intake/output was poor and Parkinson's medication was not administered when it should have been. We found no evidence that administration of Mr A's Parkinson's medication was unreasonable. However, we found significant failings in relation to the prevention, monitoring and management of pressure ulcers and that fluid intake/output charts were not adequately completed. We upheld this aspect of Mrs C's complaint. However, we noted that the board had identified failings in regards to pressure ulcer damage and fluid monitoring and had taken steps to address these issues.

In relation to the physiotherapy treatment Mr A received, Mrs C was concerned that there was a lack of regular visits from the physiotherapist. We found that Mr A received regular visits from physiotherapy staff and that their care was appropriate. We did not uphold this aspect of Mrs C's complaint.

Mrs C was also concerned that there was a lack of visits from SALT and a lack of effective communication with other staff regarding Mr A's altered diet. We found that review by SALT was sporadic and not carried out in a timely manner at either hospital. We considered that Mr A's risk of aspiration pneumonia (a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs) would have been reduced had timely SALT review taken place. We upheld this aspect of Mrs C's complaint.

In relation to Mr A's medical care, Mrs C was concerned that communication about placing a do not attempt cardio-pulmonary resuscitation (DNACPR) mandate in place was inappropriate, Mr A's usual Parkinson's medication was not prescribed causing problems with his movement and interaction, and transfer arrangements were unreasonable. We found that the conversation which took place about DNACPR were appropriate and that the changes made to Mr A's Parkinsons medication was reasonable. We also found overall that the transfer arrangements were reasonable, however, we were critical that there was no evidence to show that a formal record of discharge was documented to support a thorough hand-over. We did not uphold Mrs C's complaint but made a recommendation to the board in light of this finding.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for the delays in SALT review and follow-up. 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:

- Staff should carry out pressure ulcer prevention and management in accordance with national guidance.
- SALT should ensure patients with complex needs are seen within agreed timescales.
- Complex patients should have a careful and thorough hand-over documented.