SPSO decision report

Case: **201700619, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: not upheld, no recommendations

Summary

Mrs C complained about the care and treatment provided to her late husband (Mr A). Mr A was admitted to Victoria Hospital day surgery for an operation. Mrs C called the hospital the next morning to advise that Mr A was unwell, and was told to call his GP. Following GP review, Mr A was admitted to hospital, where he was subsequently diagnosed with necrotising fasciitis (a very aggressive bacterial infection). He died in hospital less than two weeks later.

The board carried out an investigation into the source of Mr A's infection, but concluded that they could not say whether the infection was acquired in hospital or in the community. Mrs C complained about the infection, and that the nurse she spoke to on the phone the day after the surgery was not more supportive. In response to Mrs C's complaint, the board met with her family and explained their findings. The board apologised for the poor communication by the nurse, and shared Mrs C's concerns with the ward for reflection and learning. The board also put in place new procedures for responding to calls from patients or family. Mrs C remained dissatisfied with the board's response, and she brought her complaint to us.

Mrs C complained to us that the board unreasonably failed to prevent infection during Mr A's operation. We took independent advice from a general and colorectal surgeon, and from a nurse. We found that, whilst some aspects of the surgical care could have been improved, staff had taken reasonable steps to reduce the risk of infection during the operation, although it was not possible to eliminate the risk entirely. We also found that, once Mr A was re-admitted, staff identified his infection and began antibiotics promptly. We found that the board had carried out a reasonable and timely investigation into the source of the infection, and we agreed with their finding that it was not possible to know with certainty where this was acquired. We did not uphold this aspect of Mrs C's complaint.

Mrs C also complained that the board failed to provide adequate support when she called the hospital the morning after Mr A's surgery. We found that it was appropriate for the nurse to refer Mrs C to the GP because Mr A required an assessment of his medical condition, which the nurse was not qualified to give. Whilst we were not able to comment on the tone or tenor of this conversation, we noted that the board had taken appropriate steps by sharing Mrs C's concerns with nursing staff for reflection. We did not uphold this aspect of the complaint.