SPSO decision report

Case: **201907894, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to us about the care and treatment provided to their late parent (A). A was admitted to Forth Valley Royal Hospital. A few weeks later, A was transferred to Stirling Community Hospital. A developed pneumonia (a chest infection) and was transferred back to Forth Valley Royal Hospital a few days later. A's condition deteriorated and they died.

C complained about A's medical treatment; in particular, that there was a delay in responding to A's chest infection. We took independent advice from a geriatric (medicine of the elderly) adviser. We found that when A's condition worsened at Stirling Community Hospital, A should have been urgently reviewed by medical staff in case A had sepsis (a severe complication of infection). We found that when A's condition worsened significantly at Forth Valley Royal Hospital, A was not given prompt and appropriate antibiotic treatment for possible sepsis. We found that A was not reviewed by medical staff within reasonable timeframes. We also found that anticipatory care planning had not taken place with A and their family, given it was likely A had been nearing the end of their life before they had developed pneumonia. We upheld this complaint.

C also complained about A's nursing care at Forth Valley Royal Hospital; in particular, that A was not given appropriate falls care, and, that A was not given enough help with personal care. We took independent advice from an acute nursing adviser. We found that nursing staff should have formed and recorded a specific plan to address A's risk of falls at night/overnight, as that was when A was at highest risk of falling. We also found that there was a lack of evidence of regular and appropriate care rounding to meet A's personal care needs. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in A's medical and nursing care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- If a patient is particularly at risk of falls at night or overnight, a clear plan should be put in place to address this and it should be recorded appropriately.
- If a patient or their relatives/carers raise concerns about the patient's medical care, this should be escalated to the senior medical staff overseeing their care; and concerns about nursing care should be escalated to senior nursing staff.
- If a patient's condition has worsened and it could be due to sepsis, this should be recognised and treated appropriately, in line with the board's antibiotic protocol.
- Patients should be given timely and appropriate nursing care.
- Senior medical staff should be updated if their patient's condition materially changes.

- There should be safe and effective medical handover between medical teams so patients are re-assessed within appropriate timeframes.
- Where appropriate, there should be sensitive and timely discussions with patients and their relatives/carers about anticipatory care planning.

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.