SPSO decision report

Case: **202001929, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the treatment provided to their parent (A) by the board. A had prostate cancer for a number of years. A's symptoms worsened in the period complained about and it transpired that the cancer had spread to A's liver. C considered that the care and treatment provided by the board in the period prior to A's death was unreasonable, with the board failing to reasonably respond to A's worsening condition.

We took independent advice from a consultant in palliative medicine (caregiving approach aimed at optimising quality of life and reducing suffering among people with serious, complex illness), a registered general nurse and community health specialist nurse practitioner.

C's first complaint was that the board failed to reasonably respond to A's reduced haemoglobin levels. We found that A's haemoglobin levels were appropriately managed with regular review and assessment of symptoms, and the prescribing and monitoring of 'safer' medication before planning a transfusion. We noted that there was appropriate escalation of the transfusion date once doctors became aware that the haemoglobin had fallen further. Based on A's condition at the time, the initial planned date of admission for transfusion was reasonable. As such, we did not uphold this aspect of C's complaint.

C complained that the board failed to reasonably manage A's pain. We found that the levels of pain medication prescribed were reasonable. We noted that pain was not identified as a problem or symptom during A's hospital stay, therefore, discharge without regular morphine medication was reasonable. On discharge, the board appropriately handed over care to the GP, the local hospice and community palliative care. We found that when A exhibited pain, they were reviewed in line with guidance and appropriate medication was prescribed. District nurses administered pain medication through the 'just in case' medications prescribed while A was at home. As such, we did not uphold this aspect of C's complaint.

C complained that the board failed to reasonably discharge A from hospital. We found that, while the decision to discharge A was a reasonable one, and most services were appropriately notified of A's discharge, district nurses were not, impacting on the support provided by this service immediately after discharge. There was also a failing in providing a reasonable level of support for A to dress immediately prior to discharge. As such, we upheld this aspect of C's complaint. We noted that the board were sorry that more support was not offered.

C complained that the board unreasonably failed to provide a new mattress in a timely manner. We found that, while the delay in notifying the district nurses of the arrival of the mattress was unfortunate, we accepted that the board provided a mattress within 24 hours which was a reasonable response to an equipment request. We accepted that the district nurses were unaware of delivery on the day of delivery but once they became aware, a plan to transfer A was put in place. We considered that the delay in transfer was due to a holistic assessment of A's needs at that time which was appropriate in the circumstances. As such, on balance, we did not uphold this aspect of C's complaint.

Finally, C complained that the board failed to provide reasonable nursing care when transferring A to the new mattress. We found that the board had provided reasonable nursing care when transferring A onto the mattress, based on the records available. We noted that pain medication was administered prior to the transfer, which was reasonable. As such, we did not uphold this aspect of C's complaint. However, we noted that there was limited documentation of the event and fed this back to the board.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in A's discharge. 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:

- Referrals to the palliative care team should contain all relevant information.
- The rapid discharge algorithm for last days of life should be followed for future discharges.
- When there is the presence of confusion and/or deteriorating function in a patient, assistance should be considered to ensure a patient is dressed appropriately before leaving the ward.

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.