SPSO decision report

Case: **202004303, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) who had a number of medical conditions. During an admission to hospital, A's condition deteriorated, and they died.

C complained that A's deterioration was not appropriately managed and that they contracted Listeria Meningitis (a serious disease in which there is inflammation of the membranes of the brain and spinal cord, caused by bacterial infection) and Clostridium Difficile (C-Diff; infection of the large intestine triggered by long term use of antibiotics). C also complained that a medication to treat diarrhoea was inappropriately prescribed because A had a diagnosis of ulcerative colitis. C further complained that staff did not communicate with A's family that they were suspected of having sepsis. C also raised concerns about the board's handling of their complaint and the standard of record keeping which was referred to in their complaint response.

The board acknowledged that the medication to treat diarrhoea should not normally be prescribed in patients with ulcerative colitis and that there was no clear record of the discussions that were held with A's family. The board confirmed that Public Health investigated the source of listeria meningitis and concluded it was not likely a hospital-based transmission.

We took independent medical advice from a consultant gastroenterologist (a doctor specialising in the treatment of conditions affecting the liver, intestine and pancreas). We found that A's overall care and treatment was reasonable. A was appropriately treated with intravenous steroids and antibiotics and the decision to not provide surgical intervention was reasonable. It was noted that A was at high risk of developing C-Diff given that they had been prescribed a strong immune suppressant. With regards to the listeria meningitis breakout, we found that the board appropriately sought external review and specialist public health and microbiology advice. We also found that the standard of record keeping was reasonable. Therefore, we did not uphold these aspects of the complaint. However, we found that there was insufficient evidence of clear communication with A's family about their condition and the fact that they had sepsis, and that the board failed to provide a full response to the complaints raised. We upheld these aspects of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to communicate with A's family that they were suspected of having sepsis and for failing to provide a full response to the complaints raised. 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:

- Staff should understand the importance of, and ensure that they communicate clearly with patients and their families about their condition.

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.