SPSO decision report

Case: **201105517, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C, complained to us about the care and treatment of her late mother (Mrs A) who had a complex medical history, including bowel cancer. After falling, Mrs A was admitted to a hospital high dependency unit. She was given a blood transfusion and antibiotics for a urinary tract infection. As doctors thought Mrs A had suffered a stroke she was moved to the stroke ward at 03:30.

Shortly after admission to the stroke ward, Mrs A stopped eating, experienced constipation and complained to her daughter of knee pain. Six days after she was moved there, her condition deteriorated rapidly and Mrs C's husband telephoned Mrs C saying that the hospital had called to say that Mrs A had taken a bad turn and Mrs C should go to the hospital. Mrs A passed away shortly afterwards. The death certificate noted Mrs A's cause of death as toxins and a perforated bowel.

Mrs C complained about these events, saying that staff should have dealt with Mrs A's problems sooner and that her mother was transferred from one ward to another at an inappropriate time. She also said that she suspected that the suppositories or other medical interventions might have caused her mother's deterioration and death, and was unhappy about the attitude of nursing staff. She said that they showed unprofessional attitudes to her and her mother and failed to properly contact her on the morning of Mrs A's death.

The board's reply to Mrs C's complaint recognised that there were some problems with communication between nurses and Mrs A's family. They also recognised that the early morning transfer between the high dependency unit and the stroke ward was inappropriate as there was no clinical need for it to be done at this time. They agreed that staff should have known to contact Mrs C directly on the morning of her mother's death. They apologised and ensured that the relevant managers were made aware of the issues.

We did not uphold Mrs C's complaints. After reviewing the board's file and Mrs A's medical records, and taking independent advice from our medical and nursing advisers, we found that the general quality of care provided was reasonable. We also considered that the board had taken reasonable steps to resolve the issues about communication, transfer and contact. We considered that the medication provided to Mrs A during her stay was appropriate and could not reasonably be linked to Mrs A's death. We found no evidence of unprofessional behaviour by nursing staff towards Mrs C or her family.