SPSO decision report

Case: **201508163, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the medical and nursing care and treatment provided to his wife (Mrs A) at Victoria Hospital from when she was diagnosed with advanced lung cancer until her death four months later. During this period, Mrs A had three admissions to Victoria Hospital. During her second admission, she was found to have spinal-cord compression and was admitted to the Western General Hospital for five days.

Mr C was concerned about a wide range of medical and nursing issues, including treatment and medication decisions; communication; whether appropriate investigations and tests were carried out within a reasonable time; the decision to transfer Mrs A to a hospice near the end of her life; record-keeping failings; nutrition; and monitoring. Mr C was also concerned that Mrs A had contracted diabetes and pneumonia, which he believed were hospital-acquired infections. He said that the board's failings hastened Mrs A's death. Finally, Mr C complained about the way the board handled his complaint.

We took independent advice from four advisers, who specialise in oncology, respiratory care, palliative care and nursing. In relation to the standard of medical care and treatment provided, we found that this was reasonable.

We were also satisfied that while Mrs A contracted diabetes and a chest infection, these were an accepted complication of the medication prescribed and/or prolonged hospital stay and low immunity, and that there was no evidence any hospital failings led to Mrs A's death.

With regard to the standard of nursing care and treatment provided, we found that while this was reasonable in a number of aspects, there were failings around record-keeping and in relation to completing assessment and monitoring for nutrition, wound management and blood glucose. We therefore upheld this part of Mr C's complaint. We also found failings in the way the board dealt with Mr C's complaint in that there were unreasonable delays.

Recommendations

We recommended that the board:

- inform us of the action taken to ensure compliance and better completion of documentation by nursing staff including action taken to ensure adequate training in light of the nursing adviser's comments; and
- provide a further apology for the failings identified.