SPSO decision report

Case: **201508170, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the management of her husband (Mr A)'s cardiology care by staff at the Victoria Hospital. Mr A suffered a heart attack and later developed heart failure. Mrs C was also concerned about how staff had communicated with the family and the standard of the nursing care Mr A received. In addition, Mrs C felt that her complaint had not been dealt with appropriately.

As Mr A had a number of attendances at the emergency department, we took independent advice from a consultant in emergency care, a consultant cardiologist and a nursing adviser.

The advice we received was that the management of Mr A's cardiac problems was reasonable, although the cardiology adviser highlighted that the co-ordination of Mr A's care could have been better, an issue that the board themselves had identified during their consideration of Mrs C's complaint. We made recommendations to the board in this regard but did not uphold this part of Mrs C's complaint.

We upheld Mrs C's complaint about communication. We found that the board had already identified and apologised for some communication issues. The advice we received was that there was a lack of evidence that Mr A and his family had been provided with information about his initial signs of heart failure. We made recommendations to address the failings identified.

We upheld Mrs C's complaint about nursing care as we found that a number of failings in the care provided had already been identified. The nursing adviser was critical of an incident where there was failure to maintain Mr A's dignity. We made a number of recommendations in relation to this part of Mrs C's concerns.

Finally, we upheld Mrs C's concerns about the handling of her complaint by the board. The board acknowledged that they had not dealt with the complaint in line with their timescales and had not kept Mrs C updated. They advised that this had been addressed going forwards.

Recommendations

We recommended that the board:

- consider how this case could be used to promote learning on the importance of co-ordination of care;
- provide an update on the co-ordination of care since the time of this complaint;
- apologise for the failure to provide information on heart failure at the relevant time;
- take steps to ensure that appropriate information is provided to patients and their families about medical conditions and that this communication is clearly recorded in the notes;
- consider using this case for staff learning and development to highlight the importance of maintaining patient dignity;
- ensure that staff involved in the failure to maintain patient dignity reflect on this complaint at appraisal;
- provide evidence that action has been taken to address the issues identified during their investigation of

the complaints raised in this case; and

- provide supporting evidence that steps have been taken to prevent future communication and complaints handling failings.