SPSO decision report

Case: **201808156, Fife NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the care and treatment provided to her late father (Mr A). Mr A had been diagnosed with advanced prostate cancer and was admitted to a community hospital for rehabilitation and intensive physiotherapy after he had undergone chemotherapy and radiotherapy. Mr A's care and treatment was provided by a team of medical professionals including a GP and nursing staff. Mr A's condition deteriorated and he died during his admission.

We took independent advice from a GP and a nurse.

Miss C was concerned that there was a failure to diagnose and treat Mr A's lower respiratory tract infection and pneumonia and questioned the administration of an antidepressant medication to Mr A. We found that the infection was identified appropriately and appropriate treatment was provided. In addition, it was reasonable to have prescribed the medication and that there was no connection between this and Mr A's deterioration and death.

Miss C also raised concerns about the physiotherapy and rehabilitation provided to Mr A and the input from the dietician service. We found that the records documented Mr C had received reasonable physiotherapy and dietary care.

In relation to Mr A's end of life care, we found that it was not required that a GP attend Mr A in the 24 hours before he died. We also found that appropriate nursing care was provided to Mr A.

For the reasons outlined above, we did not find evidence of unreasonable failings in the care and treatment provided to Mr A and, as such, we did not uphold this complaint.

Miss C further complained that there was a lack of reasonable communication with her and her family about Mr A's care and treatment. While we found there was evidence of appropriate communication about Mr A's care, including about Mr A's end of life care, we took account of the board's complaint response to Miss C which identified areas for improvement and learning and accepted that unintended distress was caused to Miss C and her family. Therefore, on balance, we upheld this complaint.

Miss C also considered that the board had failed to handle her complaint reasonably. We found that there was a reasonable and proportionate effort by the board to answer the issues raised by Miss C. We noted that the board offered to meet with Mr A's family. As such, we did not find that the board's handling of the complaint was unreasonable and, therefore, we did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C and her family for the failings identified by the board's complaint investigation in communication, in particular, around the end of life care provided to Mr A. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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.