SPSO decision report

Case: **201808511, Fife NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C attended an appointment at Victoria Hospital to have a stent (a splint placed temporarily inside a duct, canal, or blood vessel to aid healing or relieve an obstruction) removed. The procedure, scheduled for the morning, was not performed until the evening, and when C was transferred to a ward they had not eaten for over 24 hours or drunk for around 18 hours. The board accepted that C had been fasted of food and liquid for longer than guidelines recommended. The board apologised for this and committed to reviewing their fasting guidelines and discussing these with staff. C had also not received all of their regularly required medication during this time in the hospital. The board apologised for this and explained that a full medication history should have been obtained via discussion with C and took steps to improve medicines management. During the process of complaining about their experiences, C agreed with a patient relations officer that a meeting to discuss their complaints, as offered in the board's first response to them, would be arranged. C subsequently received a second response from the board but no further communication about the expected meeting.

We investigated C's complaints about these matters. We upheld C's complaint about being fasted for an unreasonable length of time and found the actions that the board had committed to had not been undertaken. We upheld C's complaint about the failure to provide their regularly prescribed medication, given these had not been provided and there was no evidence a medication history had been completed as per normal processes. The board explained that they had decided the second response was the appropriate way to provide the clarification that a meeting would have delivered. Given C had reached a similar conclusion and had not pursued the matter further with the board, we did not uphold their complaint about the board's failure to complete the arrangements.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide them with their regularly prescribed medication. 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:

- The board to complete a medication history for all patients as per normal processes.
- The board to fulfil their commitment to reviewing fasting guidelines and discussing these with all staff.

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.