

## SPSO decision report



**Case:** 202208181, Fife NHS Board  
**Sector:** Health  
**Subject:** Nurses / nursing care  
**Decision:** upheld, recommendations

### Summary

C complained on behalf of their spouse (A) about the care and treatment provided by the board before they died. A was an end of life patient having been diagnosed with incurable lung cancer. A developed symptoms likely caused by an obstruction of one of the major blood vessels attached to the heart and was scheduled to have a stent inserted through the blockage. C complained about their experience on the ward on the day of the procedure which, they said, caused great pain and distress.

We took independent advice from a registered senior nurse. We found that A lacked person centred information to prepare them for admission which caused distress, that there was a failure to provide a clear pathway for a patient diagnosed with end stage lung cancer the Peripheral Vascular Cannula (PVC)(insertion of a plastic conduit across the skin into a vein) process was not followed. We found that a pressure ulcer risk assessment was not undertaken and a plan of care not developed or implemented to prevent pressure damage. We also found that there was a failure to provide A with their prescribed steroids, despite requesting this. We noted record keeping failures during A's admission and found failings in the board's handling of the complaint, with the complaint not addressing all the issues raised by C and failings to fully investigate and respond to C about the PVC process. We upheld the complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/information-leaflets](http://www.spsso.org.uk/information-leaflets).

What we said should change to put things right in future:

- Patient records should be accurately completed, signed and dated with the appropriate level of information included, in accordance with the relevant nursing and midwifery standards.
- Patients should be appropriately assessed to prevent pressure ulcer damage, in accordance with the current pressure ulcer prevention and management standards.
- Patients should receive appropriate information to prepare them for a procedure, and to manage expectations about the admission. The board has said a draft patient information leaflet relating to the Superior Vena Cava Stent Insertion procedure has been developed and awaits final approval. The board should consider updating this leaflet to address person centred concerns.

In relation to complaints handling, we recommended:

- Relevant staff should be aware of the requirements of the complaints handling procedures, particularly with respect to investigating and addressing all the elements of a complaint.

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.