# SPSO decision report

**Case:** **202301849, Fife NHS Board**
**Sector:** Health
**Subject:** Nurses / nursing care
**Decision:** upheld, recommendations

## Summary

C complained that the board failed to provide their late relative (A) with reasonable nursing care whilst in hospital. C told us that they felt nursing staff did not take A seriously when they reported pain, that information given was not passed to medical staff as agreed, and that A was left feeling abandoned and ignored.

The board said that A was admitted with a blockage in their bowel which was likely caused by bowels being stuck together after a previous operation. A underwent surgery to free the bowel and was cared for initially in the surgical high dependency unit. The board said that due to A's co-morbidities, A began to experience worsening symptoms, including very advanced heart failure and respiratory issues. The correct diagnosis was made for heart failure and A was receiving correct treatment for this.

We took independent clinical advice from a specialist nurse practitioner. We found that the nursing notes were completed to an acceptable standard with the exception of the infection control documentation. The board's infection prevention control team identified and documented some issues with the documentation relating to a possible clostridium difficile infection (a type of bacteria that can cause a bowel infection). The nursing notes indicated a lack of recording and documentation of when A's bowels had moved and there were no stool charts completed. There was a non-compliance of the completion of clostridium difficile infection paperwork. We considered that this indicated a lack of understanding in nursing staff of the importance of the infection control guidance and that the process was not followed or recorded appropriately. This indicates that the management of infection control in A's care was unreasonable.

We found that there was no evidence that matters raised by the family were recorded in the notes, or escalated to medical staff as the family thought. We also found that other documentation was incomplete, specifically, the 'Getting to Know Me' documentation, which is a document that records what matters to the patient, helps to understand the patient, and enhances their case. The fact this was incomplete, was unreasonable. As such, we upheld the complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with a reasonable level of nursing care. 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:

- All of the recommendations of the guidance on the prevention and control of clostridium difficile infection should be implemented. All relevant documentation should be clearly and accurately documented in a patient's records to a reasonable standard.

- Staff should ensure that the Getting to Know Me documentation is reasonably completed and understand the importance of and act upon concerns raised by patients and their families about their condition.

In relation to complaints handling, we recommended:

- Responses should be completed in line with the NHS Model Complaints Handling Procedure. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.

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.