# SPSO decision report

**Case:** **202309879, Forth Valley NHS Board**
**Sector:** Health
**Subject:** Nurses / nursing care
**Decision:** upheld, recommendations

## Summary

C's spouse (A) who had prostate cancer was admitted to the Clinical assessment unit (CAU) of the hospital following a few days of deteriorating health. During their admission, A remained in the CAU for three days before leaving the building without staff being aware of this. A contacted C in confusion and told C that they had not received food or hydration, had not been washed and had not been able to sleep. C returned A to the hospital on the condition that A was moved to a ward, which they were. The next day C was told that A had suffered an unwitnessed fall and was to be discharged to attend an oncology appointment. A also had lesions on their groin which had developed and not been cared for during their admission. A died within two weeks of being discharged.

C complained to the board. The board accepted that there were a number of areas for improvement in the care and treatment that A had received, apologised and advised of actions that they would take or had taken to address these matters. C was dissatisfied with the board's responses and raised their complaints with SPSO.

The board identified further areas where the care they had provided to A had not been reasonable and advised of further actions that they would take to address these. Given this, we upheld C's complaint that the board did not provide reasonable care to A, with specific reference to care of lesions on A's groin and the discharge of A.

We took independent advice from a nursing adviser. We found that the board, in considering how best to reflect on A's care and treatment, had focussed too narrowly on A's fall, that they should have considered the experience of A and their family more broadly and that relevant guidance indicates a Significant Adverse Event Review should have been carried out. We also found that there was a delay in providing a response to C's complaints and that C had not been updated regularly while the complaints were being considered. We also found that the actions proposed and taken by the board to address the issue of patients remaining in the CAU for prolonged periods would not fully address the areas for improvement identified. Therefore, we upheld the complaint that the board did not respond reasonably to C's complaint.

## Recommendations

What we asked the organisation to do in this case:

- Provide a further apology to C which acknowledges that specific areas of unreasonable care provided to A were found as a result of both the board's consideration of C's complaint and the Board's consideration of subsequent enquiries by the SPSO. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/meaningful-apologies" www.spso.org.uk/meaningful-apologies .
- Provide a further apology to C which acknowledges that:
- relevant guidance indicates an SAER should have been carried out regarding A's experiences,
- regular updates were not provided to C during the investigation of their complaint
- the actions proposed and taken by the board did not fully address the areas for improvement identified by their investigation of the issue of patients remaining in the CAU for prolonged periods.

- The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- The Board develop policies on actions to be taken to escalate discharge for patients remaining in the CAU for prolonged periods, and to address the lack of access to shower facilities for patients in the CAU.
- The board’s consideration of whether to undertake SAERs takes into account patient experiences reasonably widely and relevant guidance.