SPSO decision report



Case: 202311002, Fife NHS Board

Sector: Health

Subject: Clinical treatment / diagnosis

Decision: upheld, recommendations

Summary

C complained about the care and treatment their parent (A) received during a hospital admission. C complained about the way episodes of agitation and aggression were managed by the board including in respect of administration of medicines; bruising to A during episodes of restraint and lack of dignity; a failure to manage their nutritional needs; and poor communication with A's family.

The board's response to C's complaint advised that medication had been used to settle A when other measures had been unsuccessful. The board said that A's weight loss had been recognised and a referral had been made to the dietician, however, they had been discharged from hospital before a review could take place. It was recognised that documentation including fluid and food intake charts were incomplete and steps would be taken to ensure improved compliance. The board considered there had been good communication with A's family, however, they apologised for the lack of empathy reported by C, which staff would be asked to reflect on for future learning.

We took independent advice from a senior nurse adviser and a consultant geriatrician (specialist in medicine of the elderly). We found that there were aspects of A's care which were reasonably managed particularly in relation to the way episodes of agitation and aggression had been managed on the ward. We found there were aspects of A's care which were unreasonably managed particularly in relation to management of their nutritional needs, record keeping and communication.

On balance, we considered the board failed to provide a reasonable standard of care and treatment to A and we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

 Apologise to C for the failings identified in this report. 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 should ensure effective communication with family members, particularly in circumstances where Adults With Incapacity is in place.

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.