SPSO decision report

Case: **202409410, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their late spouse (A) received for a bowel perforation. A died in hospital following a cardiac arrest. C complained that the conservative, non-surgical approach taken to A's treatment led to a deterioration in their condition, leaving them unfit for surgery.

C also complained about the standard of A's medical records, which made it unclear whether clinical advice and treatments had been followed.

Furthermore, C complained that the board's complaint response contradicted information given at the time, particularly regarding the healing of the abdominal leak and plans for discharge. Instead, the board's response stated that the treatment had failed, A's condition was non-survivable, and the leak persisted. Given this, C questioned the board's decision to attempt cardiopulmonary resuscitation and the lack of palliative care for A.

We took independent advice from a consultant surgeon. We found that there were aspects of A's care which were reasonably managed including timely administration of intravenous antibiotics and a CT scan on admission. However, we found that there was a lack of urgency and clarity following the CT scan, and an absence of documented clinical reasoning such as treatment purpose, an escalation plan, and consideration of palliative care. High dependency care was not provided early despite signs of deterioration.

Communication with A and C was inadequate, with no documented discussions about the severity of A's condition or care decisions. We also found failings in fluid resuscitation and monitoring, with delayed reviews of A's response to treatment. 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/meaningful-apologies.

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

- Patients should receive reasonable surgical care at a level appropriate to their condition. In particular, patients should receive timely assessment and have a clear management plan in place. This should include appropriate monitoring, planned follow-up reviews, and repeat tests and investigations to assess the response to treatment. Fluid resuscitation should be adequate and fluid balance carefully monitored. Medical records should be comprehensive and completed in line with local and professional standards. Communication with a patient and their family about their care and treatment should be timely and transparent.

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.