SPSO decision report

Case: **201104145, Tayside NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Mrs C suffered from lung cancer and chronic obstructive pulmonary disease (a disease of the lungs in which the airways become narrowed). She was receiving chemotherapy but after the second cycle her condition deteriorated and she was admitted to hospital, where she died a few days later.

Her daughter, Miss C, was concerned that while her mother was in hospital one of her medications, which was given by injection, was not always administered. She said that at times the injections were prepared and then left by her mother's bedside if they were not given. Miss C also complained that a pain relieving patch was not administered. The board said that the patch had been administered but was later removed. There was conflicting information from the board and Miss C about when this happened.

We investigated and took independent advice from one of our medical advisers, a senior and experienced nurse. She said that the Nursing and Midwifery Council (NMC) issue guidance on the preparation and administration of drugs and that the practices demonstrated in this case did not comply with that guidance. We upheld both complaints.

Miss C said that there were inaccuracies in the fluid monitoring charts, but we could not establish the accuracy of these, given the time that has passed since. The board did say that Mrs C, who was a retired nurse, liked to maintain her independence where possible and preferred to go to the bathroom when she was able. They said that this may have introduced some inaccuracy to the charts. Our investigation found that it was reasonable to allow Mrs C to maintain her independence where possible. The nursing adviser reviewed the charts and had no concerns, and we did not uphold this complaint.

Finally, we upheld Miss C's complaint about complaints handling. We found that there were unacceptable delays in responding to Miss C's complaints. The final response took four months rather than the 20 working days required by the NHS guidance on complaints handling. In addition, our investigation found that although it largely reflected the NHS guidance, the board's complaints procedure did not fully comply with it.

Recommendations

We recommended that the board:

- apologise for the deficiencies identified by our investigation;
- provide an update on the changes to the evening medication round;
- ensure all staff are aware of and comply with the NMC standards and board policy on administration of medication;
- report on the integration of the policy on the administration of medication to the board's staff induction programme;
- provide an update on the progress of changes to the complaints and advice team; and
- ensure that their complaints procedure fully reflects the NHS guidance on complaints handling.