SPSO decision report

Case: **201401646, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained that the board unreasonably advised the Scottish Prison Service (SPS) that it was safe for him to be subject to metal detecting equipment, although he has an implantable cardioverter defibrillator (ICD) (a device that regulates irregular heart rhythms). Mr C also complained about the board's handling of his medication. He said that staff altered his medication inappropriately, and made mistakes in administration. He also said that there was no reason for his medication to be supervised (taken in front of prison staff, rather than given into the patient's keeping), as it was degrading to be required to open his mouth to show he had taken the medication, and this supervision resulted in him being harassed and bullied for his medication.

After investigating Mr C's complaints and taking independent medical advice from several specialists, we upheld Mr C's complaint about the administration of his medication. We found that, although a doctor decided to stop Mr C's naproxen (a drug used for pain relief and anti-inflammation, which can contribute to poor kidney function), Mr C's prescription record (kardex) was not updated to reflect this. This was because the kardex had to be recalled from the prison halls, and a different doctor was on duty when the kardex was returned to the health centre. As a result, Mr C was inappropriately given a further dose of naproxen in the next weekly medications. We also found that it was unreasonable for a hospital doctor to decide to restart Mr C's naproxen, although his clinical history showed that this had been stopped due to poor kidney function. Finally, we found that Mr C had been given incorrect dosages of medications on one occasion.

We did not uphold Mr C's complaint about security screening. Although health centre staff gave slightly different advice about this to prison staff at different times, we found that all of the advice given was reasonable. We also did not uphold Mr C's complaint about supervision of some of his medications (dihydrocodeine and tramadol – both prescribed for pain relief). In relation to dihydrocodeine, we found the board had complied with their local process for administering medication to prisoners who had recently arrived at the prison. In relation to tramadol, we found that the board's decision to administer this as supervised was reasonable, as tramadol is an abusable drug and the medication was supervised for Mr C's own safety and for general prison safety. We also found that it was reasonable for nurses to ask Mr C to open his mouth to show that he had taken the medication, as they needed to ensure that he took his prescribed medication and that this was not diverted, and the nurses were supported by prison staff who are able to request this kind of search under the prison rules.

Recommendations

We recommended that the board:

- issue a written apology to Mr C for the failings our investigation found;
- remind nursing staff of the need for care to be taken in administering and recording medications correctly;
- ensure there are clear and robust procedures for updating prescriptions to reflect GP decisions, including where kardexes need to be recalled from halls and/or where a different GP may need to amend the prescription; and
- raise our findings in relation to the restarting of naproxen to the attention of the relevant doctor for

reflection as part of his next annual appraisal.