SPSO decision report

Case: **201508844, Lothian NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Mr C complained about the medical and dental care and treatment he received from the prison health centre. He suffered from severe pain, particularly head and face pain, due to historic injuries and he raised concerns that adequate pain relief was not provided to him and that nursing staff regularly refused his requests to see a doctor. He also complained about delays in getting dental appointments and about the standard of treatment received, including that the dentist favoured extraction of his teeth over treating them.

We took independent advice from a GP adviser, who advised that the prison health centre were using a recognised system whereby nursing staff triage patient requests before making appointments. The adviser did not consider that Mr C was unreasonably prevented from seeing a doctor and said that, overall, healthcare staff reacted to his requests and treated his symptoms appropriately. We did not uphold these aspects of his complaint. However, we identified that some of Mr C's records were missing and we made a recommendation relating to record-keeping.

We also took independent advice from a dental adviser, who identified that Mr C initially submitted a routine appointment request, which he subsequently re-submitted indicating that his need for treatment had become urgent. He was seen within 12 weeks of his initial request and within a week of his urgent request. When he later submitted a further urgent request, he was not seen for two months, and apparently only after he had complained. We were advised that patients in the community could expect to be seen within six to eight weeks for routine appointments and within 24 hours for urgent appointments. We concluded that Mr C's wait for treatment was unreasonable and we upheld this aspect of his complaint. We were advised that, when Mr C was seen by a dentist, he was given appropriate advice and treatment and we did not uphold this aspect of his complaint.

Mr C also raised concerns about the way in which his complaints were handled by the board. We reviewed the board's investigation processes and replies to Mr C and did not consider that his complaints were responded to in a timely, accurate and comprehensive manner. We, therefore, upheld this aspect of his complaint, however, we were satisfied that appropriate action had since been taken by the board to improve their complaints handling.

Recommendations

We recommended that the board:

- ask prison healthcare staff to reflect on the identified record-keeping failure and seek to ensure compliance with the relevant professional guidance at all times;
- apologise to Mr C for the identified delays in arranging dental appointments for him;
- review the process for prioritising dental appointments in the relevant prison and inform us of the steps they have taken to avoid similar future delays; and
- apologise to Mr C for the identified failings in the handling of his complaints.