SPSO decision report

Case: **201706075, Perth and Kinross Health and Social Care Partnership**
Sector: health and social care
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the health care and treatment he received for his leg ulcers in prison, in particular that there was a delay of over a year in starting his recommended treatment plan (using compression bandages).

We took independent advice from a nurse. We confirmed that compression bandaging was the recommended treatment plan for Mr C, as advised by the vascular surgeon (a specialist in the treatment of diseases affecting the vascular system including diseases of the arteries, veins and lymphatic vessels) who assessed him and as directed by the board's guidance. We found that there were unreasonable delays in relaying the recommended treatment plan to the prison health centre, in referring Mr C to a leg ulcer nurse specialist, and in initiating the recommended treatment plan. The vascular team could not initially provide this treatment to Mr C at an out-patient clinic and they recommended compression stockings as an alternative. We did not consider this was a reasonable alternative, and noted that the reason for not initially being able to provide compression therapy to Mr C was not recorded. Therefore, we upheld this aspect of Mr C's complaint.

Mr C also complained that he suffered significant pain that was not appropriately managed. We took independent advice from a GP. We found that Mr C was appropriately reviewed on a regular basis and was prescribed appropriate medication. We considered that the prescription was in line with relevant guidelines, including those which consider the safety and security implications of prescribing pain killers in a prison setting. Therefore, we did not uphold this aspect of Mr C's complaint.

Finally, Mr C also complained about the handling of his complaints and particularly that some did not receive a response. We noted that the board's file on the complaint did not appear to provide a comprehensive record, and did not demonstrate that the complaints were progressed through the Complaints Handling Procedure (CHP) in a timely and efficient way. We found that the response timescales were unreasonable and there was little evidence of the board having contacted Mr C to explain the delays and agree revised timescales. The responses also failed to demonstrate that each element of the complaint had been fully and fairly investigated. The board acknowledged that they did not comply with their CHP and informed us they have since been reviewing ways of working to ensure future compliance. We upheld this aspect of Mr C's complaint and made further recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the unreasonable delay in providing him with compression therapy for his leg wounds, and for failing to clearly explain the reasons for this delay.
- Apologise to Mr C for failing to appropriately deal with his complaints. The apologies should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- The board should reflect on Mr C's care and identify the reasons for the delay in providing him with compression therapy. They should then take appropriate steps to prevent similar future delays.

In relation to complaints handling, we recommended:

- When responding to complaints the board should follow their CHP, and all staff should be aware of this and the NHS Scotland Model CHP.