SPSO decision report

Case: **201902080, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their partner (A) following A's admission to University Hospital Hairmyres with drowsiness. There was an indication that A may have taken too much of their prescribed medication at home. C raised concerns that a period of deterioration during A's admission was due to poor care.

We took independent advice from an appropriately qualified adviser. We considered that A's deterioration was related to infection, and were unable to identify anything to suggest that their deterioration was due to poor care. We did not uphold this aspect of the complaint.

C complained that their concerns about A's deterioration were ignored, and that when they asked to speak to medical staff, this was not arranged. The board noted that C had been given the telephone number of the consultant's secretary, and that two doctors were on the ward during the day on weekdays and were available to speak to patients and relatives. We considered that nursing staff should have arranged for the ward doctors to speak to C, rather than providing a number to make an appointment with the consultant. We considered that this would have been simpler, quicker and more effective. We upheld this aspect of the complaint.

C also expressed concern about the arrangements in place for A's medication on discharge, including that they were not given a dosette box to assist them in managing the medication at home. We noted that there was concern that A's medication may have caused the symptoms which led to their admission, and as such they considered that the discharge medication should have received more care and attention. Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for not giving more care and attention to A's discharge medication. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets

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

- Care and attention should be given to arrangements for discharge medication, especially where there is evidence of a patient having had previous problems taking (or relatives having had problems administering) the correct medication.

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.