SPSO decision report

Case: **202201207, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment they received from the board in relation to an incident of extravasation (the leakage into surrounding tissue of medication administered intravenously) of chemotherapy into their arm. C told us that following the incident, their arm became painful and swollen and that they were left with loss of function in their hand and arm, despite being referred to the board's orthopaedic, plastic surgery and physiotherapy departments for further treatment. C considered that the aftercare they had received had been unreasonable and that there had been a lack of diagnosis in relation to the injury to their arm. C also complained about the attitude of nursing staff after the incident, which they felt lacked compassion.

The board told us that extravasation is a known risk of chemotherapy treatment but that once the extravasation was noticed, chemotherapy treatment was stopped immediately and that attempts were made to aspirate the fluid from C's arm. The board also noted that C was reviewed by an on-call plastic surgeon, all in accordance with their extravasation policy. The board acknowledged that, while C was subsequently seen by specialist in orthopaedics and physiotherapy, their recovery appeared to be slower than would normally be expected and that the long term implications were unclear.

We took independent advice from an oncologist and a nurse. We found that the board's response to the extravasation incident, both immediately and in the months that followed, was in keeping with their extravasation policy and established good practice. However, on review of the available documentation, there was no evidence to show that nursing staff had completed the necessary hourly checks of C's peripheral vascular cannula (through which the chemotherapy was administered) or that the extravasation incident had been discovered as a result of monitoring by nursing staff. This was unreasonable and contrary to professional nursing standards in relation to record-keeping. For this specific reason, we upheld C's complaint. However, there was no evidence within C's clinical records to confirm that the attitude of nursing staff had been poor.

We also found failings in the board's handling of C's complaint and made recommendations under our powers to monitor and promote best practice in relation to complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the complaint handling failings identified in this decision. 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:

- All relevant staff should be trained in and be aware of the relevant guidance in relation to PVC insertion, monitoring, maintenance and removal; and the completion of the relevant PVC monitoring documentation (this should include reference to the NMC Code Section 10). There should be a reliable method of

ensuring that a PVC chart/aide memoire/policy/guideline is included in each patient's record as required. Relevant documentation should where appropriate be marked “N/A” if the sections are not required, so it is apparent that they have not just been missed.

In relation to complaints handling, we recommended:

- The board should comply with their complaint handling guidance when investigating and responding to complaints.

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.