SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201300363, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C, who is a Member of Parliament, complained on behalf of his constituent (Mrs B) about the care and treatment that her father (Mr A) received at Kilsyth Victoria Cottage Hospital. The hospital is a rehabilitation facility, and medical cover is provided by GPs from a local medical practice. Mr A was admitted to the hospital because of general weakness and after having fallen at home. He remained there for approximately six weeks before being discharged to a nursing home. Mrs B was dissatisfied that her father was given dihydrocodeine (strong pain relief) for a chest infection, which she felt made him unwell. Mrs B also felt that her father was discharged from hospital too early.

In responding to the complaint, the board explained that the dihydrocodeine had been prescribed for pain relief and not for a chest infection. They also said that Mr A's discharge was appropriate as his observations (including his temperature, blood pressure, pulse and oxygen levels) were satisfactory.

We took independent advice on Mr A's case from our GP medical advisers. Our investigation found that the records made by medical staff about why dihydrocodeine had been prescribed were poor. The drug prescribing sheet recorded that it was prescribed for pain, but there was no record showing where the pain was located or how bad it was. However, the board provided further evidence that Mr A had sustained a fracture after falling several months earlier and was prescribed dihydrocodeine four times a day for this, indefinitely. We concluded that it was reasonable to prescribe dihydrocodeine and that the dosage was appropriately changed to an 'as required' basis, and so we did not uphold this complaint.

In terms of Mr A's discharge from hospital, we found a lack of detailed entries by the GPs to show that they assessed Mr A's condition properly during his admission, and that he was not reviewed by a GP on the day he was discharged, despite having had a high temperature for three days. We were critical of this, and also noted that although the board told us that Mr A's observations were satisfactory they also said that they were not within his usual range. We, therefore, upheld this complaint as we could not conclude from the evidence that Mr A's discharge was reasonable.

Recommendations

We recommended that the board:

- emphasise to GPs at the hospital the necessity of clearly recording the reasons for prescribing medication in the clinical records, and that the nursing staff accurately record a patient's level of pain;
- apologise to Mr C for the failings identified in our investigation;
- draw to the attention of medical staff at the hospital the importance of ensuring discharge paperwork has been checked and signed by medical staff; and
- carry out an audit of clinical records at the hospital to ensure the medical staff are recording sufficient information regarding a patient's medical history, general condition and examinations carried out.