

SPSO decision report



Case: 202310183, Lanarkshire NHS Board
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the standard of care provided by the board to their parent (A). A had a complex medical history including depression for which they were on three types of anti-depressants. This was noted when A was admitted to hospital but staff failed to provide A with their prescribed medication and inform A and their family that the medication had not been given to them. This led to A's mental health deteriorating.

We took independent advice from a registered nurse. We found that the board failed to deliver the required service in relation to medicines, maintain adequate recordkeeping, communicate appropriately, recognise the harm done to A and undertake the appropriate review. Therefore, we upheld this part of C's complaint.

C complained that the board failed to deal with their complaint in a reasonable way. We found that the board's investigation did not look into an important part of the complaint and that their response did not address the impact on A as a result of the medication being withheld. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this investigation in relation to the standard of medical care and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at [HYPERLINK "http://www.spsso.org.uk/information-leaflet"](http://www.spsso.org.uk/information-leaflet) www.spsso.org.uk/information-leaflet .

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

- Clinical records should appropriately document the action taken to ensure prescribed medication has been reconciled and administered to the patient and medicine reconciliation documentation appropriately completed. Where clinical staff are unable to do so, there should be appropriate communication with the patient and/or their family about this.
- Where an adverse event occurs there should be a thorough review in line with relevant national guidance to ensure that there is appropriate learning and service improvement to enhance patient safety. Where an incident occurs that falls within the Duty of Candour legislation, the board's Duty of Candour processes should be activated without delay.
- Patients admitted to hospital should have their prescribed medicine reconciled without delay and in line with the relevant standards.

In relation to complaints handling, we recommended:

- Complaints should be investigated fully and the complaint response should address all the points raised in line with the Model Complaints Handling Procedure.

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.