SPSO decision report

Case: **201601868, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the care her mother (Mrs A) received at the medical assessment unit at the Western General Hospital. Mrs A was admitted to the hospital after her GP noted that she had a low pulse.

Miss C raised a number of concerns about the nursing care her mother received. In particular, Miss C complained about the cleanliness of the cubicle where her mother was assessed, the delay in providing a bed, the lack of provision for Mrs A to raise her legs, the uncertainty of nursing staff in relation to cardiac monitoring and a delay in nursing staff inserting a cannula (a very small tube which is placed into a vein, usually in the back of a patient's hand or in their arm). We took independent advice from a nursing adviser and a medical adviser. We found that the board had apologised to Miss C for a number of failings and had identified actions to improve care. The nursing adviser considered that the board should take further steps to improve care. We upheld this complaint and made a number of recommendations.

Miss C also raised concerns that there had been a delay in doctors prescribing her mother intravenous medication. We found that Mrs A had been prescribed oral medication on the day of admission and that the following day she had been prescribed intravenous medication. The medical adviser considered that the doctor's decision to prescribe oral medication rather than intravenous medication on the day of admission was reasonable. The adviser concluded that Mrs A received good overall care, and said she did not have a life threatening degree of heart failure to justify the need for immediate intravenous treatment. We did not uphold this complaint.

Recommendations

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

- Documentation of cannula care should be carried out in accordance with national guidelines.
- Systems should be in place to monitor the number of complaints concerning chair and trolley allocation to identify whether this is an ongoing problem within the department.
- The impact of changes that the board has made, including changes to the cleaning schedule, should be monitored to ensure progress is made towards quality improvement.

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.