

## SPSO decision report

**Case:** 201709222, Lothian NHS Board - Acute Division  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

Mr C complained that there was a delay in him receiving medication at St John's hospital when he was admitted after having seizures during the night.

We took independent advice from a hospital doctor. We found that, when Mr C initially arrived in A&E at the hospital, a consultant set out a plan for the medication he was to receive. We found that Mr C was to be prescribed and administered medication in A&E, but that when he was transferred to a ward this had not happened and he ultimately did not receive his medication until he was seen by a doctor the following morning.

We found that Mr C should have received the medication in A&E, and we upheld his complaint. We noted that the delay in receiving the medication did not put Mr C at high risk of having another seizure, however we considered that this should have been communicated to him. The board said that they had already taken action to ensure that medical staff in A&E were aware of the importance of giving medications to patients when appropriate. We asked for evidence of this.

We also noted that in their complaints responses the board issued inconsistent accounts of what staff were aware of, and when they were aware of it, on the night of Mr C's admission, and so we made some recommendations regarding this.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for issuing unclear accounts of what the medical staff were aware of, and when. To confirm this was because it is not possible to determine exactly what the doctors were aware of, on the evening of Mr C's admission to the following morning, due to a lack of clinical nursing notes. The apology should meet the standards set out in the SPSO guidelines on apology available at [www.spsso.org.uk/leaflets-and-guidance](http://www.spsso.org.uk/leaflets-and-guidance).

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

- Ensure accurate records are kept in the clinical nursing notes regarding what is communicated by the patient and what is communicated to the medical staff.

In relation to complaints handling, we recommended:

- To explain to a complainant when it is not possible to provide a definitive account of events and provide the reason why.