SPSO decision report

Case: **202001843, A Medical Practice in the Lanarkshire NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, no recommendations

Summary

C complained that the practice had failed to provide the correct prescription for their child (A). A had been diagnosed with type 1 diabetes and had been self-administering their medication with no issue. C said that this had changed and A found injections very painful. This had caused both A and the family significant distress. C said that the practice had prescribed the wrong type of needle and that this was not the type of needle specified by the hospital.

We took independent medical advice. We found that the practice had reasonably relied on their prescribing software. This was in line with both hospital and pharmacy requirements. The software had substituted a different product, and it was reasonable for this to have been prescribed. Additionally, the practice had responded timeously to C when they reported the problems A was having. Therefore, we did not uphold this aspect of C's complaint.

C also complained that the practice had failed to provide an adequate supply of needles.

The practice had accepted that A was not provided with the correct number of needles. They did not accept that they had not responded to C's requests for assistance timeously. We found that it was clear that C had not been prescribed the correct amount of needles and that it would be appropriate for the practice to reflect on this error, to improve future practice. Therefore, we upheld this aspect of C's complaint.

We noted that the practice had already committed to reviewing A and C's case through a Significant Event Analysis (SEA) and we asked them to provide us with a copy of their findings, as well as feeding them back to the board. We did not make any further recommendations.