SPSO decision report

Case: **202411244, Forth Valley NHS Board**
Sector: Health
Subject: Medication and prescribing
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A). A was undergoing chemotherapy for terminal oesophageal cancer and was admitted to Forth Valley Royal Hospital with chest pains. Following issues with medication and diet at the hospital, A's family decided to discharge A. A died a short time later.

Some parts of C's complaint was addressed in the board's complaint response, and others during our preliminary investigation. We agreed to investigate the remaining issues regarding a dosage of painkiller administered to A and the board's response to C's complaints.

We took independent advice from a consultant geriatrician (specialist in medicine of the elderly). We found that a dosage of painkiller given to A was unreasonable. In addition, the available evidence did not clearly establish a number of facts or support the board's changing position in response to C's complaints and our enquiries around the prescription and administration of this dosage.

We found that the board's complaint responses were inaccurate or misleading in relation to when A's prescription was changed, A's condition on a particular date and the presence of A's spouse during a specific review of A . Although some of these issues had been identified by the board during our investigation, we found that the board did not seek comments from all relevant staff as part of their investigation. They also did not engage with discrepancies between C's account and the records or the issue of the family being allowed to give medication without this being recorded. Their response was misleading in parts.

Therefore, we upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the unreasonable medication administration and the errors in the complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Medication should be administered by hospital staff to ensure this is captured on the clinical record.
- Prescriptions should be accurately recorded and followed. Doses of opioid drugs should normally be increased incrementally.
- Structured tools should be used in the assessment of delirium and confusion.

In relation to complaints handling, we recommended:

- Complaint responses should be clear and accurate, include input from all relevant staff and identify all of the learning from a complaint.
- The board's responses to SPSO are consistent and the provision of inconsistent responses to SPSO are fully explained or acknowledged as such.

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.