

**SCOTTISH
PUBLIC
SERVICES
OMBUDSMAN**



People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 202400753, Lothian NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

The complainant (C) complained to me about the standard of medical and nursing care and treatment provided to their late parent (A) by Lothian NHS Board (the Board). In particular, C was concerned about how medical and nursing staff cared for and treated A when they developed the infection, staphylococcus aureus bacterium (SAB¹).

A was unwell and admitted to hospital where clinicians determined A had a urine infection and kidney issues. A received intravenous fluids by way of a peripheral venous cannula (PVC²) as part of their treatment. A few days later, the PVC showed signs of infection and tests confirmed that A had SAB, which was assumed to have arisen from the use of the PVC.

C complained to me that A's SAB infection was not managed in a reasonable way and that nursing staff actions in relation to the PVC were unreasonable. C also complained about the way their complaint was handled, and in particular about the adverse event review³ undertaken by the Board.

During my investigation I sought independent advice from a Consultant in Care of the Elderly and a Registered Nurse. Having considered and accepted the advice I received, I found that:

- i. The medical care and treatment A received was reasonable because: medical staff took regular and detailed reviews of A's care; the medical care of A's SAB

¹ Many SABs are a healthcare acquired infection (HAI), a type of serious infection which can lead to blood poisoning and needs significant and careful treatment.

² Peripheral Venous Cannula (PVC) or Peripherally Intravenous Cannula (PIVC) – a small tube that is put in the vein to allow medication such as antibiotics and fluids to be put into the blood.

³ A national framework for reviewing and learning from adverse events in NHS Scotland³ (the Framework) sets out guidance to help health boards manage adverse events.



infection was in keeping with the relevant guidance; and there was frequent communication with A's family about A's condition by medical staff.

- ii. A's condition was serious and significant when they were admitted; it was likely A was suffering from organ failure in addition to an antibiotic resistant urinary tract infection, and it was possible they may not have survived these conditions. Even so, the additional burden of the SAB infection made it much more likely that A's condition would worsen, and much less likely that A would survive.
- iii. The nursing care and treatment A received was not reasonable both in relation to record keeping and PVC care. There was a lack of documents relating directly to PVC care and maintenance with sections left blank or incomplete and overall, there was a lack of information recorded to guide nursing care. Nursing care also failed to meet the relevant guidance for PVC care and there were failings in relation to skin assessment and assessing a wound on A's arm.

Taking all of the above into account, I did not uphold C's complaint about the standard of medical care and treatment provided to A. I did uphold C's complaint about the standard of nursing care and treatment provided.

I also found that the Board's handling of C's complaint was unreasonable in relation to the adverse event review undertaken by the Board in that:

- i. the Board used the terms local adverse event review (LAER) and significant adverse event review (SAER) interchangeably even though there are key differences between the two types of review;
- ii. a SAER should have been undertaken - the case met the criteria for an SAER, given that A died from a SAB infection, under both the national and the Board's own criteria;
- iii. the family were not involved in the review process as they should have been;



- iv. the person carrying out the review would not have been in a position to judge the medical aspects of the care and treatment provided and it was not clear if the person who carried out the review was independent;
- v. the review missed pertinent facts, it did not refer to the national guidance for PVC care or identify key learning and improvements, and the recommendations were insufficient to ensure the event was not repeated.

I am concerned that my office is continuing to find substantive issues with the way in which health boards have conducted SAERs. A public report⁴, issued by my predecessor in February 2025, highlighted similar SAER findings and issues identified in this case. They also wrote to Healthcare Improvement Scotland (HIS) and the Scottish Government highlighting these concerns at this time. While I recognise and commend the revised Framework introduced by HIS in February 2025 and the work being undertaken by HIS in this regard, I consider more needs to be done by health boards to address the situation and to ensure SAERs are being carried out in line with the revised Framework.

⁴ Case [202300512](#), which cited cases [202100979](#); [202209575](#); [202100560](#); [202101928](#); [202105840](#); [202200588](#) – see [SPSO website](#).



Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Lothian NHS Board - Acute Services Division to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint (b) we found that the standard of nursing care and treatment was unreasonable in relation to: i. record-keeping; ii. PVC care and maintenance; iii. skin assessment and wound care; and iv. communication.	Apologise to C for the failings identified in this investigation in relation to the standard of nursing care and treatment and the review. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/meaningful-apologies	A copy or record of the apology. By: 23 October 2026



Rec. number	What we found	What the organisation should do	What we need to see
	Under complaint (c) we found we found that the way the Board dealt with C's complaint in relation to the SAER was unreasonable in that: i. the terms LAER and SAER were used interchangeably; ii. this case met the criteria for a SAER; iii. the family were not involved in the review process; iv. the person carrying out the review was not in a position to judge the medical aspects of the care and treatment provided and did not appear to be independent; v. the review missed an integral period of care; vi. the review did not identify key learning and improvements and the recommendations were insufficient to ensure the event was not repeated.		



We are asking Lothian NHS Board - Acute Services Division to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint (b) we found that the standard of nursing care and treatment was unreasonable in relation to: i. record-keeping; ii. PVC care and maintenance; iii. skin assessment and wound care; and iv. communication.	Patients who have PVCs should be cared for and treated in line with the relevant guidance. Patients who have SAB should receive nursing care and treatment in line with the relevant guidance. Patients' records should be completed to a reasonable standard and in line with the relevant Code. Skin assessment and wound care should be appropriately carried out and recorded. Patients and families should be updated about a patient's condition fully and within a reasonable time.	Evidence that my findings have been shared with relevant staff (in all clinical areas subject to the complaint) in a supportive manner for learning and improvement By: 25 January 2027 Evidence that the Board have reviewed their systems and the training needs of relevant nursing staff (in all clinical areas subject to the complaint) to ensure patients with PVCs are treated appropriately and in line with the relevant guidance and skin assessment/wound care is appropriately undertaken. Details of the review and action to be taken to be provided to SPSO By: 25 January 2027



Rec. number	What we found	Outcome needed	What we need to see
			Evidence that the Board have reviewed their systems and the training needs of relevant nursing staff (in all clinical areas subject to the complaint) to ensure patients with SAB are treated appropriately and in line with the relevant guidance. Details of the review and action to be taken to be provided to SPSO. By: 25 January 2027 Evidence that relevant nursing staff (in all clinical areas subject to the complaint) are complying with the guidance on care of PVCs and patients with SAB by the carrying out of an audit. Details of the audit and action to be taken to be provided to SPSO. By: 25 January 2027



Rec. number	What we found	Outcome needed	What we need to see
			Evidence that nursing staff (in all clinical areas subject to the complaint) are complying with the recordkeeping requirements of the Code by the carrying out of an audit. Details of the audit and action to be taken to be provided to SPSO. Evidence that this case will form part of the Board's wider nursing improvement programme. By: 25 January 2027



We are asking Lothian NHS Board - Acute Services Division to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint (c) we found we found that the way the Board dealt with C's complaint in relation to the SAER was unreasonable in that: vi. the terms LAER and SAER were used interchangeably; vii. the case met the criteria for an SAER; viii. the family were not involved in the review process; ix. the person carrying out the review would not	Local and Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward. Adverse event reviews should be held in line with relevant guidance. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spsso.org.uk/training-courses.	Evidence that my findings have been shared with relevant staff in a supportive manner for learning and improvement. By: 23 October 2026 Evidence that the Board have reviewed their process for carrying out adverse event reviews to ensure these reviews properly investigate, identify learnings, and develop system improvements to prevent similar incidents occurring and follow up with an audit in all areas subject to the complaint to ensure compliance. This includes reviewing their procedures for undertaking adverse event reviews to ensure compliance with the Framework. Details of the review and



Rec. number	What we found	Outcome needed	What we need to see
	have been in a position to judge the medical aspects of the care and treatment provided and did not appear to be independent; x. the review missed an integral period of care; xi. the review did not identify key learning and improvements and the recommendations were insufficient to ensure the event was not repeated.		action to be taken to be provided to SPSO. By: 25 January 2027 Evidence that the Board have ensured they have assessed and addressed any training needs for the carrying out of adverse event reviews in all clinical areas subject to the complaint. Details of the assessment and action to be taken to be provided to SPSO. Evidence that the Board have notified HIS of the findings of this investigation. By: 25 January 2027



Feedback

Points to note:

I accept the medical advice I received that the care of the PVC was not well documented in A's clinical notes, and that medical staff should have completed parts of the documentation relating to this care. The Board should reflect on this with relevant staff.



Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as C. The terms used to describe other people in the report are explained as they arise and in [Annex 1](#).



Introduction

1. C complained to my office about the standard of medical and nursing care and treatment provided to their late parent (A) by Lothian NHS Board. A was admitted to hospital in February 2023. During this admission, A developed an infection (staphylococcus aureus bacterium - SAB)⁵ which was assumed to have arisen from the use of a cannula, and died a short time later. C also complained to my office about the way the Board handled their complaint.
2. The complaints from C I have investigated are that:
 - (a) The Board failed to provide a reasonable standard of medical care and treatment to A during their admission to the Royal Infirmary of Edinburgh in February 2023 in relation to the SAB infection (*not upheld*);
 - (b) The Board failed to provide a reasonable standard of nursing care and treatment to A during their admission to the Royal Infirmary of Edinburgh in February 2023 in relation to the SAB infection (*upheld*); and
 - (c) The Board failed to deal with C's complaint in a reasonable way in relation to the significant adverse event review (SAER) (*upheld*).

Investigation

3. In order to investigate C's complaint, my complaints reviewer and I carefully reviewed the documentation provided by C and the Board in response to enquiries made of them. I also obtained independent advice from appropriately qualified medical and nursing advisers - a Consultant in Care of the Elderly (the Medical Adviser) and a registered nurse (the Nursing Adviser) - and considered the relevant guidelines, including the NHS model complaints procedures.
4. I have decided to issue a public report on C's complaint given my concerns about the serious clinical and complaint handling failings in this case. The lack of recognition of the systemic nature of these failings (see paragraphs 30 – 32 and 49) was also a

⁵ Staphylococcus aureus bacterium (SAB) – many SABs are a healthcare acquired infection (HAI), a type of serious infection which can lead to blood poisoning and needs significant and careful treatment.



critical factor in my decision to issue a public report, as was the significant failings I have identified in relation to the adverse event review that occurred.

5. This report includes the information that is required for me to explain the reasons for my decision on this case. It also contains some technical medical terms and descriptions which I have considered necessary to include in order to provide the appropriate level of detail both in relation to A's condition, and to the advice I have received and taken into account. Wherever possible, explanations for these terms are provided in the report and / or in [annex 1](#).

6. While I have not included every detail of the information considered, my complaints reviewer and I have reviewed all the information provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report.

Key events

Date of event	Details of event
1 February 2023	A was admitted to the Royal Infirmary of Edinburgh. A was initially under the care of the emergency department and later that day was transferred to the Acute Medical Unit (AMU). A number of tests were carried out. A had: an abnormal blood test (a significantly raised C-reactive protein, or CRP, of 50 ⁶); a kidney eGFR test ⁷ that was 35; and a urine sample that was positive for infection. A received intravenous fluids by way of a peripheral venous cannula (PVC ⁸) as part of their treatment for their kidney issues and infection.
3 February 2023	A's care was transferred to the Medicine of Elderly service.

⁶ Normal value is 0 – 5.

⁷ The estimated Glomerular Filtration Rate - a calculation used to assess kidney function and values less than 60 could indicate significant kidney impairment or chronic kidney disease.

⁸ Peripheral Venous Cannula (PVC) or Peripherally Intravenous Cannula (PIVC) – a small tube that is put in the vein to allow medication such as antibiotics and fluids to be put into the blood.



5 February 2023	An entry in A's clinical notes documented that: the PVC in A's left arm showed signs of 'tissuing' ⁹ ; the PVC was removed; and medical staff re-cannulated A's right arm. Medical staff noted 'left wrist swelling within marked area'.
6 February 2023	A's left wrist was noted to be hot and swollen with 'tracking' of the infection up to the elbow. Medical staff concluded this was an infection which initiated from the site of the PVC and changed A's antibiotics to gentamicin and flucloxacillin. An entry in A's medical records documented a conversation with a family member indicating medical staff informed them that A was 'likely to be in hospital for some time if/when A recovers from [their] infection'.
7 February 2023	A was transferred to ward 201 (the Acute Receiving Unit- ARU). A positive blood culture result was communicated to medical staff by the microbiology service who advised on medication and further investigations. A was also reviewed by the infection service who noted they had SAB and 'probable infected PVC source'. It was also noted that A's left wrist had a small central pustule consistent with PVC infection. A number of recommendations for treatment and investigation were made. No concerns were noted by the infection service about A's right arm.
9 February 2023	The infection service reviewed A.
12 February 2023	The infection service reviewed A. The evidence from A's blood tests (CRP – used to assess infection) indicated the infection was not responding to treatment.

⁹ Or extravasation – the tube has slipped out and fluids or medications are leaking into the surrounding tissue rather than the bloodstream.



16 February 2023	Medical staff contacted the infectious diseases team for advice in light of the results of a CT scan indicating a chest infection, and A's antibiotic was changed again.
17 February 2023	Medical staff noted A's right arm had broken skin, but no evidence of an infection. There was an entry in A's records noting that medical staff had a discussion with C about A's deterioration and the palliative care that would now be adopted (this included stopping the antibiotics).
21 February 2023	A sadly passed away. Medical staff formally referred A's death to the procurator fiscal (PF). In the referral form, medical staff suggested the cause of death was: 1a SAB, 1b Possible infected cannula site left forearm, 2 Hypoactive delirium, left ventricular thrombus, right sided pneumonia with pleural effusion.
5 May 2023	The PF's appointed pathologist issued their final report including the results of the post mortem. The pathologist's opinion was that A died from the effects of SAB on a background of antibiotic resistant urinary tract infection that was treated with intravenous therapy. The pathologist amended the cause of death to: SAB in A with antibiotic resistant Escherichia coli urinary tract infection ¹⁰ .
15 May 2023	A Senior Charge Nurse completed an adverse event review into the death of A.

¹⁰ The presence of Escherichia coli (or E. coli) is the primary bacterial agent responsible for most urinary tract infections.



(a) The Board failed to provide a reasonable standard of medical care and treatment to A during their admission to the Royal Infirmary of Edinburgh in February 2023 in relation to the SAB infection

Concerns raised by C

7. C raised the following concerns:

- i. A was not gravely ill on their admission to hospital and so the family believed A had not been looked after properly during their twenty day admission.
- ii. According to the records, including x-rays taken on admission, A's organs were not in a state of failure when they were admitted.
- iii. The organ failures were as a result of the SAB infection, which in turn was caused by a PVC inserted in A's left arm. However, there was a lack of reasonable explanations about how A developed the SAB.
- iv. It was not clear that all reasonable steps were taken to treat the infection. There were four occasions documented in A's clinical notes where the doctor in charge asked for a microbiology report but there was no evidence of such a report in A's clinical records.
- v. There was a wound on A's right arm, but there was no clarity from A's clinical records about the cause, and no evidence of any planned treatment.
- vi. When a doctor examined the wound in A's right arm, which had an odour, they visibly blanched and later asked for the wound to be redressed. C provided photos of the wound taken by their sibling demonstrating that the wound was not healing and may have adversely affected their clinical condition.



The Board's response to C's complaint

8. The main points of the Board's complaint response were:

- i. A was admitted to the emergency department on 1 February 2023 and later transferred to the AMU where medical staff documented A's acute kidney injury and sent a urine sample to be tested for infection (this was positive).
- ii. Medical staff reviewed A on 6 February 2023 who noted the signs of infection from A's left wrist to their elbow, and started antibiotics for the urine infection and the possible skin infection as well as pain relief.
- iii. Medical staff received a phone call (on 7 February 2023) from a microbiology consultant stating that a blood culture from the day before had started to show growth of SAB and recommended the antibiotic A received for a urinary tract infection be changed. Medical staff started A on the new antibiotic and at the dose recommended.
- iv. The microbiology consultant also advised medical staff to explore if A had any deep-seated infections and consider a possible source if this had not already been ascertained.
- v. An entry in A's clinical records (of 5 February 2023) raised the possibility that the SAB might have been related to a previous PVC site in A's left wrist and this was investigated. However, A had a concurrent infection and later tests confirmed A had multi-organ failure (and complications) which meant they would not survive the SAB infection.
- vi. A was reviewed further by the microbiology and infection service up until 16 February 2023.
- vii. The wound in A's right arm was noticed, recorded and treated and it did not have any impact on A's condition and would have healed in time if they had not already been dying.



- viii. In Scotland, certain causes of death, including SAB suspected to be a complication of an infected PVC site, required a formal referral to the PF. Medical staff noted entries in A's clinical notes about the possibility SAB might have been related to an infection to a previous PVC site in A's left wrist. Despite the aggressive treatment A received for the SAB, they died and so the PF was correctly notified.
- ix. The PF's appointed pathologist would issue a death certificate once their investigations were concluded.
- x. This complaint was not upheld.

Relevant guidance

9. In providing their advice, the Medical Adviser took account of Healthcare Improvement Scotland (HIS) guidance on management of SAB in adults. This sets out a quality of care indicators developed by the Scottish Antimicrobial Prescribing Group NHS Scotland containing the following:

the antimicrobial resistance and healthcare associated infection bundle for preventing infection when inserting and maintaining a PVC including an insertion bundle and maintenance bundle which should be followed (how it is implemented can be decided at local level).

And which stated:

PVC related bloodstream infections can occur if insertion and maintenance care is sub-optimal. Healthcare workers, therefore, have a duty to patients to optimise PVC care in order to prevent patient harm.

The objectives... to optimise peripheral vascular catheter care and thereby minimise the risk of bloodstream infection [and] to be able to demonstrate quality peripheral vascular catheter care.

In relation to the maintenance bundle, it contained:



When maintaining an inserted PVC and access the insertion site and line, clinicians should ensure that:

1. the clinical need for the PVC is reviewed and recorded every day;
2. the PVC site is assessed and PVC removed if for example there are signs of infection;
3. PVC dressings are intact and skin integrity is not compromised;
4. hand hygiene is performed immediately before accessing the line/site and aseptic technique is used for the care and maintenance of the PVC for example dressing change;
5. a single-use antiseptic containing 70% isopropyl alcohol is used to clean the access hub before accessing.

Advice obtained

10. The Medical Adviser told us:

- i. It was reasonable for medical staff to conclude at the time of admission that A may have had an infection (of their urinary system) and reduced kidney function in light of the evidence from test results taken then. This meant there was evidence that A had organ failure at the time of admission because their kidneys were not working as well as normal.
- ii. X-rays were not useful in determining if multi-organ failure was present; issues such as kidney failure could only be detected by blood tests.
- iii. The care of the PVC was not well documented in A's clinical notes, and medical staff should have completed parts of the documentation relating to this care.
- iv. Medical staff noted on 5 February 2023 the changes to A's left wrist but it did not appear they considered this represented a clear infection at that point. By 6 February 2023 the changes were such that medical staff



concluded this was an infection which initiated from the site of the previous PVC, and so changed A's antibiotics to more powerful ones.

- v. The evidence from A's clinical notes of communication between medical staff and A's family indicated that both the family and medical staff were aware of A's poor prognosis at that stage.
- vi. A's care changed (on 7 February 2023) when the blood cultures taken showed the presence of a specific bacteria, SAB in their blood. The evidence from the medical records indicated the infection service carefully examined A that day (and they did not note any concerns about their right arm¹¹). Their recommendations for treatment and investigation were acted on by the ward team.
- vii. This care was in line with the relevant HIS guidance on managing SAB. Some aspects of the guidance, such as MRI scanning were not possible, but this was because A could not tolerate this, and a CT scan was undertaken instead, which was reasonable.
- viii. This change in A's condition was communicated to C on 8 February 2023.
- ix. The infection service reviewed A again on 9 February 2023, and at this point A seemed relatively stable. Medical staff communicated this aspect of A's condition and care to C in more detail on 10 February 2023.
- x. There was discussion with A on 15 and 16 February 2023 about the little improvement in their condition, and the following day with A's family when A had deteriorated. Medical staff discussed the change to palliative care and stopping the antibiotics, instead a syringe driver with morphine medication would be used.
- xi. There were regular reviews of A's care including from specialists, and the medical treatment A received was in keeping with the national guidance in terms of investigations, specialist review and antibiotic treatments.

¹¹ The photos C provided were not sufficiently clear to allow any conclusions to be drawn from them.



- xii. Therefore, medical staff provided a reasonable standard of care for A, both during the time of their admission, and from the time of the diagnosis of SAB.
- xiii. Finally, it was likely the organ failure that A was already suffering from was significant at the time of admission, and A was sufficiently frail and unwell that it was possible they may not have survived. However, the additional burden of the SAB infection made it much more likely that A's condition would worsen, and much less likely that A would survive.

(a) Decision

11. The basis on which I reach conclusions and make decisions is 'reasonableness'. My investigation looks at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

12. C complained to me about the standard of medical care and treatment the Board provided to A during a hospital admission in relation to the SAB infection. In particular, C was concerned about whether the infection was properly treated given A was not gravely ill on admission.

13. I recognise it will be very difficult for C, in trying to come to terms with A's loss reading this report. They have my utmost sympathy. I also recognise that reading this report will be difficult for Board staff.

14. In reaching my decision, I have carefully considered both the Board and C's account, the evidence from A's clinical records and the advice I have received which I accept in full.

15. Taking all these considerations into account, I am satisfied that the medical care and treatment A received was reasonable because:

- i. medical staff took regular and detailed reviews of A's care;



- ii. the medical care of A's SAB infection was in keeping with the relevant guidance in terms of investigations, specialist review and antibiotic treatments; and
- iii. there was frequent communication with A's family about A's condition by medical staff.

16. C told my complaints reviewer they were concerned about the standard of medical care and treatment provided partly because they did not consider A was seriously unwell when they were admitted to hospital. While I acknowledge the strength of C's concerns in this respect, the medical advice I have received is that A was frail and unwell when they were admitted; it is likely the organ failure A was suffering from at the time of admission was significant and there were clear indications A's condition was serious in relation to their kidney function and urinary tract system to the extent that it is possible they may not have survived the conditions they were suffering from. I accept this advice.

17. Nevertheless, the Medical Adviser was also clear that the additional burden of the SAB infection made it much more likely that A's condition would worsen, and much less likely that A would survive. I consider this in more detail under complaint b).

18. In conclusion I am satisfied from the evidence provided and the advice I have received that the standard of medical care and treatment provided to A was reasonable and in line with the relevant guidance. I therefore do not uphold this complaint. I have, however, provided some feedback at the end of this report for medical staff in relation to the lack of completion of PVC care documentation.

(b) The Board failed to provide a reasonable standard of nursing care and treatment to A during their admission to the Royal Infirmary of Edinburgh in February 2023 in relation to the SAB infection

Concerns raised by C

19. C raised the following concerns:



- i. The failure to properly care for A's PVC (on their left arm) led to the infection that caused their death;
- ii. C's sibling had to draw the damage to A's right arm to the attention of nursing staff on 13 February 2023 and when the bandage was removed, there was an odour and the extent of the damage became clear;
- iii. Nursing staff failed to care for the wound on A's right arm (including dressing it properly) in a reasonable way.

The Board's response to C's complaint

20. The main points of the Board's complaint response were:

- i. A was seen by nursing staff who noticed (on 5 February 2023) that the PVC in A's left arm showed signs of 'tissuing', which implied it was no longer working and some fluids may have leached into the tissues rather than going into the vein.
- ii. When A was transferred to ward 201 (on 7 February 2023), nursing staff noticed that A's jumper was wet at their PVC site and it was found to be dislodged causing a tear on A's right arm. This was documented on A's wound chart. The wound was cleaned and redressed with protective padding secured with a bandage. This was to be reviewed on 11 February 2023 and only changed if the wound was leaking through the dressing.
- iii. On 13 February 2023, nursing staff asked medical staff to review the wound when C's sibling noticed the bandage. The bandage and dressing was removed for the medical staff to review and then redressed for further review as before.
- iv. When A was for palliative care (from 17 February 2023), the focus was on ensuring A was pain free and as comfortable as possible and the wound would not be redressed unless necessary. It was last treated that day by nursing staff.



- v. The wound had not gone unnoticed and unrecorded and it had no impact on A's condition. The wound would have healed in time had A not been dying from SAB.
- vi. This complaint was not upheld as the correct process was followed.

21. In response to my enquiries, the Board also said that:

- i. A was admitted to the AMU with a PVC in place and intravenous fluids running with no concerns documented.
- ii. All staff were required to complete competences in relation to PVC care.
- iii. While entries were present in A's clinical notes, there were no completed PVC bundles during A's stay in either the AMU or Medicine of the Elderly wards.
- iv. The AMU team believed the nursing care provided was appropriate, although they acknowledged that documentation was incomplete and were sorry for this omission.
- v. In 2025, the AMU team undertook an audit on intravenous cannulation, and the findings were shared with staff, alongside reminders regarding the importance of clear documentation, including completion of PVC bundles.
- vi. A was admitted to Ward 201 at 11:14 on 7 February 2023. Medical staff took bloods at 17:20, with no concerns documented in A's electronic patient record regarding the PVC site or a 'wet sleeve' (see paragraph 20.ii).
- vii. It has not been possible to locate any paper-based evidence that care rounding was completed on 7 February 2023 prior to the 'wet sleeve'



being identified that evening. Nursing care rounding records were only available from 8 February to 21 February 2023. This was unusual as care rounding should commence on the day of admission or transfer to the ward.

- viii. The team said if there had been any concerns regarding the PVC site earlier in the day, they believe these would not have gone unnoticed for a prolonged period. There was no evidence that concerns about a 'wet sleeve' were raised by any member of the multidisciplinary team or A's family prior to the night shift identifying this during care rounding.
- ix. The team were sorry that the documentation was incomplete and therefore unable to provide further comment on the care provided on A's arrival to the ward. This case has been highlighted directly with the team to reinforce the importance of completing, logging, and appropriately filing all care rounding documentation.
- x. From review of the records, the nursing care provided between 8 and 21 February 2023 was appropriate.

Relevant standards and guidelines

22. In providing their advice, the Nursing Adviser took account of: the SAB guidance, which included an insertion bundle and maintenance bundle for PVC care that should be followed (see paragraph 9); and the Nursing and Midwifery Code (the NMC Code). In particular sections 10 and 13 of the NMC Code relating to record keeping which state the following:

- i. Complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- ii. identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.



- iii. accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
- iv. make a timely referral to another practitioner when any action, care or treatment is required.

Advice obtained

23. The Nursing Adviser told us:

- i. There were no wound assessment charts, PVC insertion or maintenance bundles in the copy of clinical records provided, which was unreasonable especially given the direct reference of PVCs to the cause of A's death¹².
- ii. While the medical records contained full comprehensive detail in order to follow A's care and treatment, the nursing entries were scant relating to wound and PVC care. Overall, the nursing notes were inadequate and did not contain sufficient information to inform or guide staff in order to provide continuity of care.
- iii. The section relating to PVC and maintenance on 3 February 2023 was blank despite a PVC being in place.
- iv. Skin integrity was also noted on 3 February 2023 to be 'healthy, no concerns' which was in direct contrast to the nursing entry on admission to the emergency department which stated skin was 'dry' and also the entry on 6 February 2023 that 'skin remains fragile yet intact'. A's skin was also noted as "red" on 4 February 2023 (see paragraph vii below).
- v. The nursing entry on 5 February 2023 stated 'cannula in left arm showing signs of tissueing', then that 'Doctor informed, cannula removed and skin marked'. However, the member of nursing staff did not state that the skin

¹² The Board confirmed to my complaints reviewer during the investigation they have provided all relevant records in relation to cannula care.



was red or note any other signs or symptoms of infection or issues as there must have been (to necessitate the marking of that area, in order to monitor if the change in colour grew outside the marked line).

- vi. These examples demonstrated incomplete, inconsistent and inaccurate record keeping and were contrary to the NMC Code.
- vii. A's skin was recorded as 'red' on 4 February 2023, and the medical frailty review on 6 February 2023 noted the frailty of A's skin; however, an air mattress was not ordered until 7 February 2023, which was unreasonable.
- viii. There was a nursing entry (8 February 2023) stating that A had removed the PVC, but it was not clear how this was known as it may have come dislodged (as the Board's response indicated).
- ix. There was nothing in the nursing notes (on 10 February 2025) about PVC care even though A had been on continual intravenous fluids and antibiotics since admission and there were issues with PVC tissuing and requiring to be re-sited.
- x. The family were unaware of why the right arm was bandaged in the first place, which was unreasonable.
- xi. Then, on 13 February 2023, the family asked nursing staff to check the wound on A's right arm; staff should have checked the condition of the wound before this point and failure to do so was contrary to the NMC Code.
- xii. In conclusion, this case demonstrated clear deviations from the relevant guidance on PVC care (see paragraph 9).



- xiii. Moreover, the standard of nursing care, including record keeping and actions taken relating to the SAB infection, fell below a reasonable expected standard of care, especially given there were issues relating to PVC management and A had a SAB, which most likely resulted from a PVC site.

(b) Decision

24. C complained about the standard of nursing care that the Board provided to A in relation to the SAB. In particular, C was concerned about the care in relation to the PVC which led to the infection, and the wound in A's right arm. In reaching my decision, I have taken into account the evidence from A's clinical records and the advice I received from the Nursing Adviser.

25. The advice I have accepted is that the standard of nursing care was unreasonable, both in relation to record keeping and PVC care. In relation to record keeping, failings included lack of documents that related directly to PVC care and maintenance with sections in relation to PVC care left blank or incomplete and overall there was a lack of information recorded to guide nursing care. This is concerning.

26. In relation to PVC care, the advice I have accepted is that nursing care failed to meet the relevant guidance for PVC care (see paragraph 9), which is clear that sub-optimal insertion and maintenance of PVC could lead to bloodstream infections such as SAB, and that PVC care must be optimised to prevent harm. Based on the nursing records, there is no evidence that happened here, nor is there evidence that nursing care in relation to PVC care was of a reasonable standard.

27. I am highly critical of these failings by nursing staff in PVC care particularly in light of the PF report, that A contracted a SAB infection from a possible infected PVC site in their left forearm. I am also deeply troubled by the Board's conclusion that the standard of nursing care and treatment was appropriate in these circumstances. I address what I consider to be a lack of recognition of the systemic nature of these failures below (see paragraphs 30 – 32).



28. The nursing advice I have received and accept is that there were also failings in relation to skin assessment and wound care. Entries in relation to A's skin assessment are contradictory and there was a delay in ordering a pressure relieving mattress. The wound on A's right arm should have been reviewed before the family's request on 13 February 2023 and the family were unaware of why it had been bandaged, which was a failure in communication. In the Board's complaint response to C, it is stated that the plan was for the wound to have been checked on 11 February 2023 and the dressing changed if there was evidence of leakage. There is no evidence this review was carried out and the Board have not acknowledged or explained why this did not happen. These failures are unreasonable.

29. I am satisfied from the advice I have received that Board failed to provide a reasonable standard of nursing care to A in relation to: record keeping; PVC care; skin assessment and wound care; and communication. As such, I uphold this complaint.

30. In investigating this case and making my findings and recommendations, I have noted that my predecessor issued a decision report and two public reports that made a number of similar findings in relation to nursing care by the Board¹³. In response to these recommendations, the Board informed my office that they had commissioned a Board-wide, two-year improvement programme focusing on nursing care.

31. Subsequent contact with the Board in relation to the recommendations indicated they were aware of the potential for further complaints and that the wider organisational programme would address any gaps. Given this and given the nursing failings I have found in this case are similar to those found by my predecessor, I consider the lack of recognition of the systemic nature of these failings by the Board, and that this case should form part of their wider improvement programme, difficult to reconcile.

32. In conclusion, I am critical of the Board's position that the standard of nursing care was appropriate given the failings identified by my investigation. I am also concerned at the lack of recognition that this case provides further evidence of the wider systemic failures previously identified and should be taken into account as part of

¹³ Case references [202111459](#), [202307063](#), [202401128](#) – see reports on [SPSO website](#).



the Board wide improvement programme. As part of my recommendations I have asked the Board for evidence that it will now be taken into account as part of the Board wide improvement programme.

(c) The Board failed to deal with C's complaint in a reasonable way in relation to the SAER

Concerns raised by C

33. C raised the following concerns:

- i. The family had not been involved in the review process as they should have been;
- ii. The SAER was not broad enough to include all the elements of care and treatment A received during their hospital admission; and
- iii. The SAER had led to even more questions for the family about A's care and treatment and subsequent death.

The Board's response to C's complaint

34. The main points of the Board's complaint response were:

- i. The SAER did not include the care A received at the emergency department and AMU because the team responsible for A's care (Medicine of the Elderly) said the review concerned A's admission to ward 201 (7 February 2023) up to their death (21 February 2023).
- ii. Where SAB was suspected or confirmed, the Board required a SAER to be completed by the relevant directorate or department where the blood cultures were taken.
- iii. A SAER would normally be undertaken and authorised by people who were external to a patient's care for neutrality, transparency and independence reasons. The purpose of a SAER was to identify system or



procedural issues to learn from rather than answer specific questions from family members.

- iv. On reflection, the team should have provided a clearer explanation about the SAER process and given alternative options for family feedback and addressing concerns.
- v. There was a delay in sending the SAER to C, for which they apologised.
- vi. The Board partially upheld this complaint due to the communication shortcomings.

35. In response to my enquiries, the Board also said that:

- i. There was a specific process for recording any outcome of patient death with SAB (or another Hospital Acquired Infection - HAI) on part 1 or 2 of death certificates, and a full level 1 review (or SAER) would only be commissioned if it was clear that an adverse event had occurred which led to the death.
- ii. The HAI death process encouraged the use of the professional or clinical judgement of the Associate Medical Director or Associate Nurse Director to determine the level of review required following a death and this would include relevant information from an Infection Prevention and Control Team review.
- iii. If further review was agreed, it would usually be a Local Adverse Event Review (LAER) which used the same template as a level 1 SAER but would be conducted by local service management. This was in line with HIS Framework in place at the time.
- iv. In this case, a LAER was undertaken by a Senior Charge Nurse and, in line with the governance approval process, was fully approved by the Board



and Acute Services Medical and Nurse Directors. It concluded that there was no evidence of 'omission' causing the SAB, but lack of documentation regarding PVC.

- v. To clarify, the review undertaken in this case was not a SAER, it was a LAER. The organisation occasionally used some terminology interchangeably which may have caused some confusion and for which they apologised. The Board's response letter to C only referred to a SAER.
- vi. A dedicated Adverse Event (AE) improvement programme was in place which would include clarification of all types of review and associated documentation, including HAI deaths. Improvement in communication with patients and families about AE processes was a central part of this work and would include ensuring that patients and families fully understood the type of review taking place and what that entailed.

The Board's adverse event review

36. The review team comprised of a Senior Charge Nurse and the template used was for all Significant Adverse Events, which included those events resulting in death. The adverse event was described as 'Harm to person – Death' and stated that A died of multiple conditions including SAB. It was noted there was no clear documentation and the review outcome was that 'care or service delivery problems were identified and lessons can be learned though this did not affect the final outcome/event'. The lessons learned included that 'Drs and nurses reminded every day at safety brief about importance of documenting and dating PVC'. The recommendations were 'ensure PVC documented on Trak as soon as possible after insertion or removal... and PVC is dated and time of insertion noted'. The improvement plan included: 'All Medical Staff and Nursing Staff to ensure PVC documented on Trak. Nursing staff to check daily that PVC is not inflamed and has not gone over 3 days after insertion. Document on Trak the reason for PVC being in and if over 3 days document the reason why.'



Relevant guidance

37. A national framework for reviewing and learning from adverse events in NHS Scotland¹⁴ (the Framework) sets out guidance to help health boards manage adverse events. The Framework aims to provide an overarching approach to managing adverse events in healthcare ensuring that care providers can effectively manage these events and learn from them to improve safety and quality of care. The level of review will be determined by the category of the event and other factors such as the potential for learning. Category 1 includes events that may have contributed to or resulted in permanent harm. HIS also provides quality assurance on the identification, reviewing and learning from significant adverse events by, amongst other things, monitoring compliance of adherence to the principles in the Framework. The Framework was implemented in 2019 and revised in February 2025.

Advice obtained

38. The Medical Adviser told us:

- i. The LAER was superficial and it was not clear why a SAER was not undertaken given the Board's comments in their complaint response letter (see paragraph 34.ii). Also, the justification for the LAER in response to SPSO's enquires appeared contradictory (see paragraph 35).
- ii. The LAER did not take medical issues such as the national guidance for investigation and treatment of a patient with SAB into account when assessing the care of A. Furthermore, the review was undertaken by a qualified nurse, and so they would not be qualified to judge the medical decisions made in this case.
- iii. It is not clear how, or if, they were independent of the teams who provided care for A. The person carrying out the review should be independent of the wards who provided A's care; however, one of the documents

¹⁴ By Healthcare Improvement Scotland (HIS) in 2019.



provided suggested the Senior Charge Nurse who carried out the review worked in the ward involved in the care of A.

39. The Nursing Adviser told us:

- i. Where an event has resulted in the death of a patient this would require a SAER, not a LAER, and in this case the cause of death was the SAB infection. The Framework stated that a SAER was required for events that caused harm or required significant learning. This case met that criteria, and it was of note that referring the case to the PF reflected the seriousness of what happened.
- ii. It was misleading and confusing to the family (and staff involved) that different reviews and terminology were being used interchangeably. The Board acknowledged this (see paragraph 35.v), but without a clear action of how this was being addressed and when. The Board told C in their response that, according to their own clinical governance framework, a SAER should be carried out, which is what should have happened. 'SAER' was also stated multiple times in more than one Board response, when a LAER was never mentioned yet this was the route they chose to follow.
- iii. Moreover, the Framework stated that if a SAER was not required where a significant adverse event occurred then the reasons for the decision must be clearly documented. There was no evidence of an explanation of the Board's decision making to confirm how this case did not meet a SAER level review either in the clinical notes or in their response to SPSO enquiries, nor that this was explained to A's family. This was contrary to the Framework.
- iv. While the Board confirmed an improvement programme was in place, which included patients/families understanding the types of reviews and what they entailed, they did not acknowledge that they failed to involve the family in the review, which was contrary to the Framework (the current



and previous one in place at that time). Nor did they commit to ensuring patients/families were as fully involved as they wished to be in line with the revised Framework.

- v. The Board's offer to discuss the review with the family was made only after a formal complaint was raised and further enquiries from SPSO. The Board should clearly outline how their local implementation of the Framework could be evidenced regarding the clear and full involvement of patients and families.

And in response to the review itself:

- vi. There was no confirmation the review was carried out by someone who was external to the care of the patient to maintain neutrality, transparency and independence.
- vii. There was no date given of when the family were informed of the SAB on the review form.
- viii. The report stated they did not know when the PVC was inserted and by what team (the emergency department or AMU) which was placed in order to treat A's e-coli urine infection. This meant required documentation was not completed, which was an unreasonable failure in record keeping by a member of nursing staff. This was the case even though the evidence from the clinical notes showed a PVC was inserted in the emergency department (the notes stated that intravenous fluids were running and a second bag of fluids were due). The site of the first PVC was also not stated, which was unhelpful making it more difficult to trace back issues with left and/or right cannula sites on arm/hands.
- ix. The report did not state which site (on the body) the second canula was inserted (on 8 February 2023). Given that the site/s used were critical to this case, this should have been stated.



- x. The report highlighted a lack of documentation about PVC insertion in emergency department and AMU, and lack of documentation from ward 201 about insertion of new second PVC. However, there was no reference to the relevant guidance on PVC care to inform a change of practice.
- xi. The guidance included an insertion and maintenance bundle which should be followed, in addition to the over-arching clinical principles.
- xii. This case demonstrated clear deviations from nationally recognised safe PVC care, but the report's recommendations appeared weak and there was no mention of longer term monitoring and assessing the completion of the local insertion and maintenance PVC bundles to determine whether the basic recommendations stated in this review were being effective or if further actions were needed, e.g. renew education or a local focus.
- xiii. A one-off audit was to be completed at the end of June 2023 after the stated improvement actions were completed, but it was not clear where the audit was carried out (the issues in this case related to more than one clinical area).
- xiv. Furthermore, the audit results submitted were a very small snapshot. The issues in this case including care of PVCs concerned more than one clinical area and so it was not possible to compare it to anything and was therefore lacking in context in order to be able to demonstrate any improvements.
- xv. PVC audits were completed for all clinical areas on a regular basis in health boards therefore the Board would have wider information available but this had not been provided for context in this case. Nor had the Board provided trends in PVC audit results over time since the complaint to date.



(c) Decision

40. C complained about the way the adverse event review was carried out by the Board including the failure to involve them and look at the care provided to A from their admission. In reaching my decision, I have carefully considered: the information from the Board and C; the Framework; and the advice I have received.

41. Turning first to the Board's acknowledgement that they had erred by referring to a 'SAER' and not a 'LAER' in their complaint response etc, and that those terms were used at times interchangeably, the Board accepted and apologised for any confusion this led to for C and their family, which I welcome. However, I agree with the Nursing Adviser that the Board have not acknowledged the implications of their error in using these terms interchangeably for staff and families, and have not addressed this with staff through, for example, training.

42. There are key differences between the two types of reviews in relation to process (especially around family involvement where families should be involved in a SAER) and communication. Patients or their families (or both) should also reasonably expect that any harm caused, particularly the death of a loved one, is appropriately investigated and understood so that the adverse event was not repeated and patient safety and quality of care was improved. I do not see that being the case here. I am extremely critical of this and consider the Board's actions to be unreasonable in this regard.

43. Furthermore, the advice I have accepted is that this case clearly met the criteria for a level 1 SAER given A died from a SAB infection. The report of the review itself referred to the adverse event as a death and that the patient, A, died of multiple conditions including SAB¹⁵. In view of this, I consider the Board's decision to carry out a LAER was not reasonable and contrary to their own statements about the criteria for SAERs. Nor did I find any evidence that the Board explained the reasoning behind their decision to carry out a LAER as they should have done in the clinical notes and to the family directly. Under the Framework, the findings of a level 1 SAER should be reported

¹⁵ This report was issued before the pathologist amended the death certificate.



to HIS and there is no evidence this occurred, which may have been due to the failure to categorise this event correctly.

44. Moreover, the Medical Adviser said the person carrying out the review was not in a position to judge the medical aspects of the care provided and if it was in line with the relevant SAB guidance. I accept the advice I received.

45. The Nursing Adviser also raised a number of concerns about the review including that: it was missing pertinent facts; there was no reference to national guidance (for PVC care); the recommendations appeared weak in the absence of longer term monitoring and assessing completion against the guidance; and there was a failure to involve the family. Additionally, the PVC audit carried out in response to the review lacked context and was therefore insufficient and it was not clear if the person who carried out the review was independent. I accept the advice I received.

46. Finally, C complained about the failure by the review to look at the care provided from 7 February 2023, and not from A's admission. It is not clear to me from the Board's explanation what the rationale was for not looking at the care provided earlier than 7 February 2023. I consider that the review should have covered the care from when the PVC was inserted (in A's left arm) given the advice I have accepted that there were serious and significant issues relating to PVC management and the SAB infection resulting from this site.

47. It is clear the failings around the SAER process made what was already a difficult situation for C and the family much worse. This also represented significant local complaints procedure failures and, as such, I uphold the complaint.

48. The SAER failings in this case predate the revised Framework and HIS' programme, the Board's response to this investigation occurred after. I am therefore extremely concerned about the Board's explanation about why they did not carry out a SAER, as this is contrary to both the 2019 Framework; their own criteria; and the revised Framework. I am recommending the Board review, as a matter of urgency, their procedures to ensure they are complying with the current HIS Framework, and provide my office with evidence of this. Given that in this case I have found that a level 1 SAER



should have been carried out and HIS notified of the findings, I am also recommending the Board notify HIS of the findings of this investigation given their role to monitor compliance with the Framework.

49. Finally, in investigating this case, I want to place on record, alongside previous comments made by my predecessor, my significant concern that my office is continuing to find substantive issues with the way in which health boards have conducted SAERs. A public report¹⁶, issued by my predecessor in February 2025, highlighted similar SAER findings and issues identified in this case. They also wrote to HIS and the Scottish Government highlighting these concerns at this time. While I recognise and commend the revised Framework introduced by HIS in February 2025 and the work being undertaken by HIS in this regard, I consider more needs to be done by health boards to address the situation and to ensure SAERs are being carried out in line with the revised Framework.

¹⁶ Case [202300512](#), which cited cases [202100979](#); [202209575](#); [202100560](#); [202101928](#); [202105840](#); [202200588](#) – see [SPSO website](#).



Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Lothian NHS Board - Acute Services Division to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
4.	Under complaint (b) we found that the standard of nursing care and treatment was unreasonable in relation to: v. record-keeping; vi. PVC care and maintenance; vii. skin assessment and wound care; and viii. communication.	Apologise to C for the failings identified in this investigation in relation to the standard of nursing care and treatment and the review. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/meaningful-apologies	A copy or record of the apology. By: 23 October 2026



Rec. number	What we found	What the organisation should do	What we need to see
	Under complaint (c) we found we found that the way the Board dealt with C's complaint in relation to the SAER was unreasonable in that: vii. the terms LAER and SAER were used interchangeably; viii. this case met the criteria for a SAER; ix. the family were not involved in the review process; x. the person carrying out the review was not in a position to judge the medical aspects of the care and treatment provided and did not appear to be independent; xi. the review missed an integral period of care; xii. the review did not identify key learning and improvements and the recommendations were insufficient to ensure the event was not repeated.		



We are asking Lothian NHS Board - Acute Services Division to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
5.	Under complaint (b) we found that the standard of nursing care and treatment was unreasonable in relation to: v. record-keeping; vi. PVC care and maintenance; vii. skin assessment and wound care; and viii. communication.	Patients who have PVCs should be cared for and treated in line with the relevant guidance. Patients who have SAB should receive nursing care and treatment in line with the relevant guidance. Patients' records should be completed to a reasonable standard and in line with the relevant Code. Skin assessment and wound care should be appropriately carried out and recorded. Patients and families should be updated about a patient's condition fully and within a reasonable time.	Evidence that my findings have been shared with relevant staff (in all clinical areas subject to the complaint) in a supportive manner for learning and improvement By: 23 October 2026 Evidence that the Board have reviewed their systems and the training needs of relevant nursing staff (in all clinical areas subject to the complaint) to ensure patients with PVCs are treated appropriately and in line with the relevant guidance and skin assessment/wound care is appropriately undertaken. Details of the review and action to be taken to be provided to SPSO By: 25 January 2027



Rec. number	What we found	Outcome needed	What we need to see
			Evidence that the Board have reviewed their systems and the training needs of relevant nursing staff (in all clinical areas subject to the complaint) to ensure patients with SAB are treated appropriately and in line with the relevant guidance. Details of the review and action to be taken to be provided to SPSO. By: 25 January 2027 Evidence that relevant nursing staff (in all clinical areas subject to the complaint) are complying with the guidance on care of PVCs and patients with SAB by the carrying out of an audit. Details of the audit and action to be taken to be provided to SPSO. By: 25 January 2027



Rec. number	What we found	Outcome needed	What we need to see
			Evidence that nursing staff (in all clinical areas subject to the complaint) are complying with the recordkeeping requirements of the Code by the carrying out of an audit. Details of the audit and action to be taken to be provided to SPSO. Evidence that this case will form part of the Board's wider nursing improvement programme. By: 25 January 2027



We are asking Lothian NHS Board - Acute Services Division to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
6.	Under complaint (c) we found that the way the Board dealt with C's complaint in relation to the SAER was unreasonable in that: xii. the terms LAER and SAER were used interchangeably; xiii. the case met the criteria for an SAER; xiv. the family were not involved in the review process; xv. the person carrying out the review would not have been in a position to judge the medical aspects of the care and treatment provided and did not appear to be independent; xvi. the review missed an integral period of care;	Local and Significant adverse event reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward. Adverse event reviews should be held in line with relevant guidance. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spsso.org.uk/training-courses.	Evidence that my findings have been shared with relevant staff in a supportive manner for learning and improvement. By: 23 October 2026 Evidence that the Board have reviewed their process for carrying out adverse event reviews to ensure these reviews properly investigate, identify learnings, and develop system improvements to prevent similar incidents



Rec. number	What we found	Outcome needed	What we need to see
	xvii. the review did not identify key learning and improvements and the recommendations were insufficient to ensure the event was not repeated.		occurring and follow up with an audit in all areas subject to the complaint to ensure compliance. This includes reviewing their procedures for undertaking adverse event reviews to ensure compliance with the Framework. Details of the review and action to be taken to be provided to SPSO. By: 25 January 2027 Evidence that the Board have ensured they have assessed and addressed



Rec. number	What we found	Outcome needed	What we need to see
			any training needs for the carrying out of adverse event reviews in all clinical areas subject to the complaint. Details of the assessment and action to be taken to be provided to SPSO. Evidence that the Board have notified HIS of the findings of this investigation. By: 25 January 2027



Feedback

Points to note:

I accept the medical advice I received that the care of the PVC was not well documented in A's clinical notes, and that medical staff should have completed parts of the documentation relating to this care. The Board should reflect on this with relevant staff.



Terms used in the report

Annex 1

A	The aggrieved
C	The complainant, A's adult child
The Medical Adviser	A consultant in care of the elderly to add some white space between rows.
The Nursing Adviser	A registered nurse
SAB	Staphylococcus aureus bacterium, a serious infection which can lead to blood poisoning and needs significant and careful treatment
SAER	Significant adverse event review
PVC	Peripheral Venous Cannula (PVC) or Peripherally Intravenous Cannula (PIVC) – a small tube that is put in the vein to allow medication such as antibiotics and fluids to be put into the blood.



List of legislation and policies considered

Annex 2

Healthcare Improvement Scotland's guidance on management of SAB in adults

The Nursing and Midwifery Code (NMC)

A national framework for reviewing and learning from adverse events in NHS Scotland by
Healthcare Improvement Scotland