SPSO decision report

Case: **201103345, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C and Mr C are sister and brother. Their elderly father (Mr A) was admitted to a hospital as an emergency with a suspected urinary tract infection, and was discharged home five days later. Ms C was unhappy that although she held a power of attorney for her father, no senior member of staff contacted her to discuss Mr A's care, in particular the changes that were made to his heart medication. The hospital clinician's view was that Mr A suffered from several illnesses and his admission was precipitated by increasing confusion and reduced mobility. The clinician said that the medicine changes made in hospital took account of Mr A's condition at the time of his first admission. Mr A was readmitted to the hospital about four weeks later and tests confirmed he had suffered a heart attack. He died there three days later. Both Ms C and Mr C said that the hospital withdrew Mr A's life supporting medication during his first admission and they made several complaints linked to this.

We took independent advice from one of our medical advisers, who considered all the clinical aspects of the case. We took account of his advice along with the documentation provided by Ms C and Mr C and the board. The adviser said that life supporting medication was not withdrawn, and that Mr A's age, frailty and his other illnesses had to be taken into account. However, the adviser also said that consideration should have been given to Mr A's future symptom control when he was discharged home after his first admission, so we made recommendations to the board about this. The adviser also said that there was no evidence that a review by a doctor was not independent. Although, therefore, we did not uphold the complaints about Mr A's clinical treatment, we considered that the board had offered unsatisfactory explanations to Ms C and Mr C when they complained and we upheld this aspect of the complaint.

Recommendations

We recommended that the board:

- feedback the learning from this complaint to all staff;
- ensure that when changes in medicine(s) are made to patients with diminished capacity, such changes are discussed with their carers;
- ensure that, when medicines are changed prior to a patient's discharge home, consideration is given for appropriate follow-up or monitoring of the patient;
- ensure that information entered in case records is an accurate reflection of events;
- apologise to Ms C and Mr C for the failures identified in this case; and
- ensure that the rationale for changes in medication is clearly documented.