

Case: 201101840, Lanarkshire NHS Board
Sector: health
Subject: communication, staff attitude, dignity, confidentiality
Outcome: upheld, recommendations

Summary

Mr C complained about the treatment that his late mother (Mrs A) received in hospital. Mrs A had been admitted for a suspected stroke. A diagnosis of a TIA (transient ischaemic attack or 'mini-stroke') was made and Mrs A was discharged on a Friday to a facility staffed by mental health staff. Mr C and the mental health staff were concerned about Mrs A's condition and tried to arrange for Mrs A to be transferred back to the hospital but were told this could only happen after she had been assessed by a clinician. Mrs A was assessed on the Monday and was transferred back to the hospital, where tests revealed she had suffered a stroke. Mr C complained that Mrs A had not been fit for discharge on the Friday. The board conducted a significant event review which concluded that there was a breakdown in communications and staff at the facility did not follow recognised procedures and made several recommendations. Mr C also complained that the board failed to respond to his requests to meet with senior staff.

After taking advice from two of our advisers, a consultant physician and a senior nurse, we upheld Mr C's complaints. We found that poor record-keeping at the time of transfer contributed to a breakdown in communication between medical and nursing staff about Mrs A's condition, and that the board should have kept Mr C updated about plans for a meeting with staff.

Recommendations

We recommended that the board:

- share our findings with the staff involved and remind them of the importance of completing comprehensive discharge documentation to assist the receiving clinicians;
- apologise to Mr C for the way in which it dealt with his request to meet senior managers; and
- apologise to Mr C for the failings identified during this investigation.