SPSO decision report

Case: **201200060, Borders NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her brother (Mr A) while he was both an out-patient and an in-patient in hospital. Mrs C also complained about the arrangements for discharging her brother from hospital, and of a lack of communication and/or consultation with Mr A's family.

Mr A had severe learning difficulties, significant health problems, and had developed dementia, but lived in his own home with the assistance of carers. In early 2011 he developed a number of further health problems and was admitted to hospital. After Mr A had been in hospital for some time, Mrs C was told that he was dying and it was recommended that he be transferred to another hospital for end of life care. Mr A's family took steps to surrender the tenancy of his home and to dispose of some of his belongings. However, Mr A's condition improved and about three months later he was deemed fit enough to be discharged. Mrs C complained that because of what she had been told earlier, Mr A was now homeless and had to be discharged to a nursing home. Mr A became unwell again two months later and was readmitted to hospital. He was discharged again but died a few hours later at his nursing home. Mrs C was particularly concerned that, during his transfer to the nursing home on a very cold and snowy day, Mr A was not dressed in the warm clothing she had ensured was available.

Our investigation, which included taking independent advice from two of our medical advisers, found that the care and treatment provided to Mr A had been reasonable overall. There was no evidence to suggest that he had not been adequately assessed or that his nutrition was inadequate, as Mrs C had feared. However, the advisers raised some concerns over a lack of clarity on issues of Mr A's lack of capacity; the waiting times for out-patient investigations; and information for relatives on NHS continuing care provision. Although we did not uphold Mrs C's complaint, we made recommendations to address these points.

Recommendations

We recommended that the board:

- consider implementing guidelines or targets on timescales for the provision of out-patient investigations such as echocardiograph;
- consider reviewing relevant patient documentation to clarify, where a patient lacks capacity, whether a legally appointed Attorney or Guardian is in place; and
- consider reviewing their policy on informing relatives in relevant situations about the option of NHS continuing care, the assessment process and the appeal process.