SPSO decision report

Case: **201203233, Tayside NHS Board**
Sector: health
Subject: communication, staff attitude, dignity, confidentiality
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that a hospital provided to her brother (Mr A) after he was admitted with increasing confusion and suspected pneumonia. Mrs C, who was her brother's welfare guardian, was concerned that he was not given enough fluids and food; he was discharged prematurely and was readmitted a few hours later; there was a failure to diagnose his fractured leg; changes were made to his medication; and about poor communication.

After taking independent advice from three of our medical advisers (a nurse, a consultant physician and a consultant psychiatrist), we found that nursing staff did not fully take into account Mr A's specific needs. He had a long standing mental illness and, despite knowing that there was a problem with him eating and drinking, there was no specific information on how to manage this. We found that Mr A's fluid intake was not properly monitored and there was a lack of consideration given to blood test results that indicated possible signs of dehydration.

We did not consider that Mr A's discharge was unreasonable, because dehydration is difficult to diagnose. Hospital staff had taken steps to speak with Mr A's community psychiatric nurse (CPN) to establish his usual behaviour, and it was agreed that the CPN would visit him at home later that day to see if he needed psychiatric review. In addition, when it was known that his blood test results were abnormal, he was readmitted to hospital. Although we could not be certain when Mr A fractured his leg, he was promptly reviewed and diagnosed after bruising and swelling were identified.

We were also of the view that it was appropriate to stop some of Mr A's medication (which had a sedating effect) because this could make his pneumonia worse. However, we considered that medical staff could have explained this to the family when Mr A was first admitted to hospital. In addition, although we found that the hospital obtained appropriate information from Mr A's GP, we thought that nursing staff could have sought advice sooner from the CPN about Mr A's eating and drinking.

Recommendations

We recommended that the board:

- review fluid intake and output monitoring for patients with communication difficulties who have suspected or actual dehydration, and audit their documentation of patients from the ward Mr A was in;
- ensure that the educational and training needs of nursing staff in the ward have been met in terms of holistically managing patients with mental illness;
- draw to the attention of relevant staff involved in Mr A's care the importance of ensuring that relatives, particularly those with welfare guardianship, are fully informed of the reasons for any changes in treatment in a timely manner and that the content of discussions are sufficiently documented; and
- apologise to Mrs C and Mr A for the failings we identified.