SPSO decision report

Case: **201203568, Tayside NHS Board**
Sector: health
Subject: admission, discharge & transfer procedures
Outcome: upheld, recommendations

Summary

Mr C's mother (Mrs A) suffers from angina and vascular dementia (a common form of dementia, caused by problems in the supply of blood to the brain). Mr C holds welfare power of attorney for her. Mrs A was admitted to hospital after she collapsed. She was discharged home after two days but was readmitted several weeks later, following episodes of dizziness and falls. She was discharged again, but six days later was admitted (by her GP) for a third time due to chest pain, shortness of breath and poor balance. It was noted in her medical records that at the point of admission she was not 'coping in her social environment'.

Mr C said that he only found out on the day of the second discharge that Mrs A was being sent home to an empty house with no other family members present. This was despite Mr C specifically requesting that Mrs A's return home should be fully coordinated with the local care team to ensure her effective transition from hospital to home. He said that there was no effective liaison with the local care team. When he raised concerns, the hospital arranged for a health care assistant to accompany Mrs A home.

Mr C also said that the referring GP had asked the board to carry out a medical and social care assessment of Mrs A in relation to her third admission. Nearly two weeks after she was admitted, he found out it had not been completed and that staff were not aware of the request. He said that staff assumed Mrs A would return home on the same care package. The review was then carried out, but Mr C believes this was only because he insisted.

After taking independent advice on this case from one of our medical advisers, we upheld Mr C's complaints. Our adviser said that when people with dementia are being transferred home from hospital, there should be a proactive risk assessment. This should consider the person's physical and cognitive abilities, the home circumstances and whether anyone will be at home to receive them on arrival. The board failed in this respect. We also accepted the adviser's comments that there was no evidence that Mrs A was involved in her care in any meaningful way or that involvement of her relatives occurred in a planned or proactive manner. These failings were exacerbated by failures in record-keeping. Related to this, the board failed to formally assess Mrs A's capacity to consent to treatment, despite the evidence that her capacity was impaired, and they failed to acknowledge and effectively respond to Mr C's welfare power of attorney status.

In relation to the discharge, our adviser said that while there was no evidence the GP requested an assessment, in light of the evidence available to staff from Mrs A's second admission to hospital, a review of her care package should have been planned. Having said that, the adviser also said that the referral to the hospital discharge team took place within a reasonable time. However, it was not clear to us that without Mr C's intervention, this would have taken place, particularly in light of the failures in record-keeping.

Recommendations

We recommended that the board:

- ensure that communication with relatives and/or carers of people with dementia is a planned process - in

particular with regard to discharge;

- ensure that the standard documentation is effectively utilised and completed;
- ensure that all staff are aware of the legislation with particular reference to consent, capacity and record-keeping, including completing section 47 certificates and recording that relatives and/or carers have welfare power of attorney;
- bring the failures identified to the attention of relevant clinical staff; and
- apologise to Mr C for the failures identified.