SPSO decision report

Case: **201203658, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C complained about the care and treatment that her late mother (Mrs A) received in two hospitals. She said the board failed to appropriately manage her mother's intake of food and fluids; failed to adequately communicate with her mother and her family; handled her mother's transfer to the second hospital inappropriately; and unreasonably refused to discharge her mother from that hospital despite her wish to go home and her family's willingness to care for her.

We took independent advice from one of our medical advisers, a consultant geriatrician, and upheld most of Miss C's complaints. The adviser explained that in many respects the board managed Mrs A's intake of food and fluids appropriately. However, he was critical of the first hospital's failure to assess Mrs A's nutritional needs using a malnutrition universal screening tool, a universally recognised nursing standard used to identify adults who are at risk of malnutrition.

The adviser said that overall the level of communication by staff in this case was relatively good. However, he was critical of the board's timing of a 'do not resuscitate' decision (a decision that a doctor is not required to resuscitate the patient if their heart stops) and their failure to speak to Miss C face-to-face about that decision, once it had been made, or to discuss the issue of Mrs A not returning home. We also noted that the tone of one of the consultant's comments was rather insensitive.

Our investigation found significant failings by the board in their handling of Mrs A's transfer to the second hospital. These included the assessment for transfer, the transfer decision, the documentation transferred, speech and language therapy assessments before and after transfer, and engagement with Mrs A's family. We were also critical of the board for failing to advise Miss C, in their response to her complaint, about failings in her mother's transfer that were identified in the internal correspondence between the consultants at the time of the transfer.

We did not uphold the complaint about Mrs A's discharge from the second hospital, as we took the view that the board's actions were reasonable in the circumstances.

Recommendations

We recommended that the board:

- apologise to Miss C for each of the failings identified;
- feed back our decisions on these complaints to the staff involved to try to ensure that similar situations do not happen again; and
- review their transfer arrangements, including assessment for transfer, to try to ensure that such failings do not occur in future.