SPSO decision report

Case: **201204572, Lothian NHS Board**
Sector: health
Subject: communication, staff attitude, dignity, confidentiality
Outcome: some upheld, recommendations

Summary

Mrs C's 85-year-old father (Mr A) suffered from dementia, and had a history of heart problems and abdominal cancer. Mrs C complained that he was twice discharged from the Royal Infirmary of Edinburgh when he was not fit for discharge. She also complained about a lack of communication within the healthcare team, and between staff and Mr A and the family.

In November 2012 Mr A was admitted to hospital for treatment of blood clots in his wrist and arm which were surgically removed. After five days in hospital Mr A was discharged. Mrs C came to collect him but, as they were leaving the ward, Mr A fainted. He was re-admitted and discharged again four days later. Two weeks after the second discharge Mr A was admitted again to treat an infection in his arm where he had had the surgery. This time he was in hospital for five days before being discharged.

Our investigation, which included taking independent advice from our medical and nursing advisers, found that both discharge decisions had been reasonable, in that Mr A was clinically stable and the various investigations and observation results were within the normal range. Both advisers commented that Mr A's collapse on leaving the ward following the first discharge could not have been predicted, as it was due to his existing heart condition, which could cause sudden and unpredictable symptoms.

On the matter of communication, however, we did find some failings. Both advisers expressed concern at some of the verbal and written communication, and in particular about an event when Mr A was taken alone by ambulance to the hospital's emergency department. Ambulance staff had noted that he was confused and unsteady on his feet. When he arrived at the hospital Mr A was reviewed by a triage nurse (who assesses a patient's condition and the urgency of treatment required) who noted that he had dementia. Despite this, he was moved several times during the 80 minutes he spent in the emergency department, and our medical adviser said that this would have added to Mr A's confusion. In addition, when he was moved there was no evidence that information about him was shared between members of the healthcare team. Mr A later left the department unaccompanied and arrived home as Mrs C was preparing to go to hospital to see him. Although a staff member had seen Mr A leaving alone in a taxi, no one had contacted Mrs C to alert her to this.

Recommendations

We recommended that the board:

- apologise for the failings identified in our investigation;
- consider putting in place a protocol for the monitoring and supervision of dementia patients within the accident and emergency department; and
- feed back to the staff involved in this complaint the importance of effective communication between staff and patients' families / carers.