SPSO decision report

Case: **201204594, Lothian NHS Board**
Sector: health
Subject: admission, discharge & transfer procedures
Outcome: upheld, recommendations

Summary

Mr C complained on behalf of his late aunt (Mrs A) who was admitted to hospital from her nursing home with sudden pain in her legs. She had been previously diagnosed with dementia (her solicitor held welfare power of attorney) and chronic peripheral vascular disease (a long-term condition where the blood supply to the leg muscles is restricted). Mrs A was prescribed medication for pain and agitation and discharged back to the nursing home the next day. The hospital wrote to her GP and the nursing home detailing her care and said that the vascular surgical team felt that this represented an acute episode of her long term vascular disease, but had decided that surgery was not in her best interests and she should be treated with simple pain relief. They said Mrs A had complained of some pain before discharge and it was decided that this would be better controlled in her normal environment at the nursing home. The nursing home, meanwhile, had identified that Mrs A needed morphine on the day of her discharge and three days later, for the first time, there was an entry in her medical records about palliative care (care purely to prevent or relieve suffering). She was prescribed additional medication for palliative care on the following day, and the nursing home requested more morphine for her. Mrs A died six days after being discharged from hospital.

Mr C said that Mrs A's GP, nursing home and solicitor all knew that she was terminally ill when she was discharged from hospital and that this diagnosis was made while she was a patient there. Mr C said that within a few days of Mrs A being discharged, the GP told Mrs A's solicitor that she had a major inoperable blood clot in one of her main arteries and was being kept comfortable at the nursing home, but that otherwise nothing beneficial could be done and that the 'time-frame' could be days. Mr C also complained that the board failed to provide him with a proper answer about why Mrs A was not immediately referred for palliative care.

After taking independent advice from a medical adviser, who specialises in care of the elderly, we upheld Mr C's complaints. The adviser said that the care and treatment in relation to diagnosis, discharge, communication and record-keeping was below a reasonable standard and impacted adversely on the board's decision-making about palliative care. Mrs A was a vulnerable adult, and we found that the clinicians underestimated her symptoms and their severity and significance, leading to an inaccurate diagnosis and a failure to meet her palliative care needs. We also found that the board failed to provide a detailed explanation of the clinical thinking at the time of Mrs A's discharge to justify their position, which would have added to the distress of Mrs A's family.

Recommendations

We recommended that the board:

- ensure that the failures identified are raised as part of the annual appraisal process of relevant staff;
- review the admission of older adults to assess whether staff have sufficient expertise (such as consultant geriatricians) to assess such patients;
- bring the failures in record-keeping to the attention of relevant staff;
- bring the failures identified in this investigation to the attention of the board's complaints team; and
- apologise for the failures identified this investigation.