# SPSO decision report

**Case:** **201302314, Highland NHS Board**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** some upheld, recommendations

## Summary

Ms C complained on behalf of an elderly lady (Mrs A) who was admitted to hospital as an emergency. Mrs A had terminal cancer and diabetes and a number of other health problems. Ms C complained that the standard of nursing care was unreasonable, and that Mrs A was discharged in an inappropriate manner. We took independent advice on this complaint from our nursing adviser and our hospital adviser.

In terms of nursing care, Ms C said that Mrs A was given no food or fluids while she was in the hospital's accident and emergency (A&E) department waiting to be admitted to a ward. Our nursing adviser said that these should not generally be provided in A&E, as this may compromise later treatment but that, given her circumstances, Mrs A should perhaps have been offered a drink of water. We saw nothing to suggest that the wait had an adverse impact on Mrs A's health, but we drew this matter to the board's attention. Ms C also complained that a nurse on the ward administered the wrong eye drops and did not follow hygiene procedures, and that a disruptive patient received attention while others were ignored. Our investigation found no specific evidence to show that the nursing care was unreasonable. We noted, however, that the board had acknowledged Mrs A's negative experience and had put in place an improvement plan and a period of supervision for the nurse, which we considered a reasonable response to Ms C's concerns.

On the day Mrs A was expected to be discharged, she did not see a doctor until late in the day. By that time, her husband (Mr A) - who would have driven her home - had left. Mr and Mrs A lived 75 miles from the hospital, and so, although Mrs A was considered fit to go home, the doctor agreed that she should not be discharged until next day. Despite this, Mrs A was discharged that evening, and was sent home alone in a taxi dressed in her bed clothes. The board said this happened due to a breakdown in communication between the ward and the bed manager. When Mrs A arrived at her house, her husband was not there and, as she had no keys with her, she had to wait for a short time in the taxi until he arrived.

We upheld this part of the complaint. Our medical adviser noted that the discharge documents were incomplete, and he was not able to identify who authorised the discharge. As Mrs A required a walking aid, he considered it particularly inappropriate for her to be discharged alone in a taxi. The board had already acknowledged that Mrs A's discharge was handled inappropriately. They had apologised, and reviewed their policy of discharging patients in taxis without outdoor clothing. However, we made recommendations as we took the view that there were wider issues to be addressed in their approach to discharge, in particular that checks that should be made and patients' individual circumstances recognised.

## Recommendations

We recommended that the board:

- further review their discharge planning arrangements in the light of the comments in our decision letter and provide the Ombudsman with a copy of their revised arrangements;
- review communications between wards and the bed manager to ensure that a situation like this does not

happen again; and

- draw our decision letter to the attention of the staff involved in Mrs A's discharge to ensure that they learn from the failings identified.