SPSO decision report

Case: **201400663, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his late brother, Mr A (who had a significant mental health condition), when he was admitted to University Hospital Ayr with internal bleeding. Following treatment, Mr A was transferred to East Ayrshire Community Hospital with a view to discharging him home a few days later. However, when Mr A's support workers came to the hospital to take him home, they raised concerns about his condition and he was readmitted to University Hospital Ayr. Mr A had further internal bleeding and several weeks later a scan showed that he had had a stroke. He was later discharged to a nursing home, where he became severely disabled and in need of constant attention before his death some six months later.

Mr C complained that if it were not for Mr A's support workers querying his discharge, he would have been sent home and died. Mr C also believed that the result of the stroke would not have been as serious if Mr A had received adequate care and treatment sooner. Mr C was also unhappy with communication from a stroke consultant about the possibility of stem cell treatment, and the board's response to the complaint, saying it was not an accurate reflection of what happened.

We took independent advice from one of our medical advisers after which we upheld Mr C's complaint. Our investigation found that Mr A was clinically unstable when he was transferred to the community hospital, that healthcare professionals failed to check a blood test before the transfer, and that the stroke consultant's discussion with Mr C unreasonably raised his hopes for curative treatment. However, we found that healthcare professionals had diagnosed Mr A's stroke within a reasonable time. In relation to Mr C's complaint about the board's response to his complaint, we found shortcomings in the board's response and made a recommendation to the board about this.

Recommendations

We recommended that the board:

- inform us of how they intend to ensure the safety of transfers to community hospitals, particularly for vulnerable adults with severe mental health problems such as Mr A;
- provide a copy of the latest audit of the appropriateness of admissions to the community hospital;
- feedback the failings identified in relation to checking a blood test and communication about stem cell treatment to the relevant healthcare professionals;
- bring the failures identified to the attention of relevant complaints staff; and
- apologise to Mr C for the failings this investigation identified.