# SPSO decision report

**Case:** **201400666, Borders NHS Board**
**Sector:** health
**Subject:** admission / discharge / transfer procedures
**Outcome:** upheld, recommendations

## Summary

Mrs C complained about the care that her mother (Mrs A) received in Borders General Hospital. Mrs A had a collapse/fall while she was alone at home and was taken to A&E. As Mrs A had a pacemaker and had a number of issues with her heart while she was at the hospital, she was transferred to another hospital in a different NHS board area for specialist investigations (the second hospital). Tests there showed that there were no abnormalities with Mrs A's pacemaker. She was scheduled for transfer back to Borders General Hospital but an outbreak there of norovirus (winter vomiting bug) prevented this. The second hospita carried out further tests, and Mrs A was diagnosed with pulmonary emboli (blockages in the blood vessels that carry blood from the heart to the lungs, usually caused by blood clots). She was prescribed warfarin (a medicine that prevents blood clotting) to treat this and a few days later was transferred back to Borders General Hospital. The medical transfer documentation did not include information about the new diagnosis and treatment, although the nursing transfer document specifically identified them. When Mrs A was readmitted to Borders General Hospital, staff only considered the medical transfer documents, and missed the pulmonary emboli diagnosis.

Mrs C had been concerned about her mother's ability to cope at home, but as Mrs A was considered to be medically fit to return there, she was discharged two days after she went back to Borders General Hospital. She became increasingly breathless, however, and was readmitted two days later where the pulmonary emboli diagnosis was picked up and treated.

Mrs C complained to the board about the care Mrs A received. The board apologised for the errors in communication between Borders General Hospital and the second hospital. They also advised that steps would be taken to ensure that the issue was followed up with the second hospital and that doctors would now check both medical and nursing transfer documents when admitting patients.

After taking independent advice from one of our medical advisers who is a consultant physician, we upheld Mrs C's complaint. The adviser considered that the failure to identify Mrs A's diagnosis of pulmonary emboli from the nursing transfer document was unreasonable and that insufficient effort was made to assess her before she was discharged. We were also critical that there appeared to have been a delay in the board carrying out the actions advised in their response to Mrs C's complaint.

## Recommendations

We recommended that the board:

- apologise for the standard of care and treatment provided to Mrs A during the period relating to the complaint;
- take steps to ensure that actions agreed following a complaint investigation are followed up promptly;
- consider the adviser's comments about taking the views of family members into account and determine whether there are lessons that can be learned; and
- make medical staff involved in Mrs A's care aware of the adviser's concerns regarding the decision to

discharge, including the lack of documentation, to ensure that a similar situation does not occur in future.