SPSO decision report

Case: **202000641, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the treatment a family member (A) had received from the board. A was admitted to hospital three times over a short period with severe stomach and back pain. Following A's third admission, they were diagnosed with kidney failure and discharged to receive palliative care. A died a short time later. C complained that the board had missed opportunities during A's earlier admissions to identify their deteriorating kidney function. C said that an earlier diagnosis could have prolonged A's life expectancy as treatment could have commenced sooner.

C also complained that on A's second admission, their discharge had been unreasonably managed by the board. C complained that A was left all day in the discharge lounge in their nightwear and that staff failed to properly communicate A's discharge arrangements to the family. A was later returned to their nursing home in a taxi instead of an ambulance. C said that this was extremely distressing and undignified for A, and had been unacceptable given A's age and poor health.

We took independent clinical advice from a consultant geriatrician (a specialist in the care of the elderly). Whilst there had been a reasonable approach to investigating A's symptoms on their first admission, we found that there were missed opportunities by the board to diagnose A's kidney failure and infection, and the family's concerns had not been given appropriate consideration during the second admission. On the third admission, there was a delay in the clinical consideration of A's abnormal blood results, and in recognising the severity of their condition. We also noted from the board's own investigations that there had been a failure to move A's personal belongings between wards. Therefore on balance, we upheld this aspect of the complaint.

We also found that A was not clinically fit to be discharged from hospital following their second admission, and given their age, fragility and poor health, that their discharge arrangements had been poorly managed. These failings included A's lengthy wait in the discharge lounge, and A's transportation in their nightwear via taxi. We further noted from the board's own investigation that A had been discharged with the wrong discharge letter and medication, and that there had been a failure to communicate A's discharge arrangements to the family. As a result, we upheld this aspect of the complaint.

We also provided feedback to the board in respect of their record-keeping, reminding them of the importance of ensuring patient records are detailed and fully documented.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family that opportunities were missed to diagnose A's kidney failure and infection, and for not properly taking account of their concerns during A's second hospital admission. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

- Apologise to A's family for discharging A from hospital when they were not clinically fit, and for the poor management of A's discharge arrangements. The apology should meet the standards setout in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to A's family for the delay in the clinical consideration of A's abnormal blood results, and in recognising the severity of A's condition during their third hospital admission. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Ensure abnormal blood results in a patient's clinical records are followed up appropriately.
- Ensure that relevant staff have appropriately reflected on the complex nature of this case.
- If a patient is elderly, frail or in poor health, patient discharge arrangements should be carefully assessed to ensure that they are appropriate, taking account of discharge wait times, a patient's clothing and methods of transportation.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.