SPSO decision report

Case: **202007948, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their parent (A) received from the board. A was admitted to hospital and later discharged into a care home. C complained that during A's admission to hospital, communication with the family was very poor. Despite numerous requests for a call from clinical staff, no contact was made and the family were left with very little information as to A's condition or the treatment that they were receiving. C complained that as a result of this the family did not have sufficient information to make informed decisions about A's care. C said that they could see that A's health was declining. A died a few days later.

A's discharge notes recorded that they had vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain. It causes problems with reasoning, planning, judgment, and memory), significant cognitive impairment, and lacked capacity for health and welfare decisions. C highlighted that A's hospital records made no mention of a dementia diagnosis and that this was never discussed with the family. C questioned whether A's capacity to consent to changes in their medication and about treatment was properly assessed.

C complained about poor communication from the clinical team and about the assessment and treatment of A prior to the decision to transfer them to the care home. C said that, had the family known the extent of A's deterioration, they would have arranged for them to be cared for at home, rather than in the care home.

In their response to C's complaint the board acknowledged C's concerns about not speaking with clinical staff. They said that attempts were made for A to be assessed by a Mental Health Liaison Nurse but that this was not possible due to A's level of distress. A was deemed medically stable for discharge to a care home. C was dissatisfied with the board's response and brought their complaint to our office.

We took independent advice from a consultant geriatrician adviser (an expert in the health and care of older adults). We found that A was initially appropriately assessed for capacity to make decisions but that this was not appropriately reviewed during their admission. Further reviews could have resulted in further investigations of A's condition. As a result, we found that the assessment and treatment of A was unreasonable.

With respect to the assessment of A prior to discharge, we found that discharge went ahead without proper consideration of their condition at the time and was therefore unreasonable. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the issues highlighted. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/informa.on-leaflets.

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

- The board should provide us with a full and detailed update as to the outcome of the reviews outlined in their action plan and any resulting changes to policies or procedures.

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.