SPSO decision report

Case: **202101174, West Lothian Health and Social Care Partnership**
Sector: Health and Social Care
Subject: Clinical treatment / Diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment their parent (A) received from the partnership. A was referred to the partnership's Rapid Early Assessment Care Team (REACT) for Hospital at Home care due to shortness of breath upon exertion. A's condition did not improve with treatment and they subsequently developed sepsis (a life-threatening reaction to an infection) and died. C considered that A should have been admitted to hospital for treatment, rather than being expected to continue with oral antibiotics which were making no improvements to their condition.

We took independent advice from a consultant geriatrician (a specialist in medicine of the elderly). We found that the initial care provided by the REACT team was of a reasonable standard. However, we could not find clear evidence to support the decision to continue antibiotic treatment, which did not appear to be improving A's condition, without trying other options. We were critical of the decision to discharge A from the Hospital at Home service without a full medical review and treatment of their ongoing treatable symptoms. It was not clear whether these failings contributed to the deterioration in A's condition, but we found that clearer decision making and closer attention to A's treatable symptoms may have provided their family with some reassurance as to the standard of care they were receiving. Taking all of this into account, we upheld this part of C's complaint.

C also complained about the communication between the REACT team and A's GP practice. We did not consider there to be a systemic issue. However, as accepted by the partnership, there had been a clear delay in issuing the discharge letter after A's discharge from the Hospital at Home service. We found that if A had lived, there could have been significant implications for their ongoing care due to the request for monitoring and bloods not reaching the GP within the requested timescale. With this delay in mind, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the failings highlighted in this decision notice. 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 that the partnership raise this case for discussion at a mortality and morbidity meeting (or other such team forum) with a view to discussing: the delay in communicating with A's GP, the lack of medical input before their discharge, and the lack of evidence for continuing the same antibiotic for so long.
- (It is noted from the partnership's comments on our provisional decision that this case was discussed at a mortality and morbidity meeting last year, but the partnership have agreed to discuss the case with the team again in view of our findings).

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.