Scottish Parliament Region: North East Scotland

Case 200503520: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant raised concerns on behalf of his 72-year-old mother about her discharge from hospital and her condition at discharge, which he felt was worse than when she was admitted. She died at home a few days later.

Specific complaint and conclusion

The complaint which has been investigated is the decision to discharge (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendation.

Main Investigation Report

Introduction

1. I shall refer to the complainant and his mother as Mr C and Mrs C, Tayside NHS Board as the Board, Ninewells Hospital as the Hospital and Mrs C's consultant physician as Consultant 1. A reminder of the abbreviations is at Annex 1. On 20 March 2006 the Ombudsman received Mr C's complaint about his mother's discharge from the Hospital. He considered that her condition was worse than when she had been admitted almost a fortnight earlier and he explained in a telephone call to me that it was obvious that her condition was worse because, most sadly, she died a few days after discharge.

2. The complaint from Mr C which I have investigated is the decision to discharge.

Investigation

3. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a consultant physician, whom I shall refer to as the Adviser. His role was to explain, and comment on, the clinical aspects of the complaint. We examined the Board's complaint file, further information from the Board in answer to my enquiries, and Mrs C's clinical records. To identify any gaps and discrepancies in the evidence, the content of relevant correspondence on file was checked against information in the clinical records and was compared with my own and the adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. That applies also to the adviser's advice, which has been checked to ensure that it was clear and (where appropriate) was based on the evidence. Therefore, I accept that advice. In line with the practice of this office, the standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The decision to discharge

5. Mrs C's general practitioner (GP) referred her to the Hospital on 22 December 2005. His notes outline a three-week gradual deterioration, poor eating, low urine output for seven to ten days, drowsiness and a lack of communication. The GP wondered if she might have kidney failure. The Hospital notes on admission say that Mrs C's husband told staff that for four days his wife had not passed urine or spoken and was usually bed-bound, with a left sided weakness. Mrs C herself did speak on admission, remarking that her mood was low. Consultant 1 saw Mrs C that evening. Examination revealed dehydration (over-dryness of the body); tests which were markers of kidney function revealed nothing abnormal. Mrs C was given intravenous fluids (in other words, directly into the veins, rather than by mouth, to be more effective). However, urine output remained low.

6. The nursing records for very early on 23 December record Mrs C as more responsive – talking and opening her eyes when being turned in bed. That day, an ultrasound scan was done urgently at Consultant 1's request and showed nothing abnormal. By 24 December, however, Mrs C was starting to take some food and fluid by mouth. Doctors' notes for the 28th record her as feeling better, eating and drinking and (on the 30th) as saying that she felt she was back to normal and wanted to return home. Mrs C would have been discharged at around this time, but the holiday period delayed the home care package that was being arranged for her. Discharge was, therefore, planned for 4 January 2006. Nursing notes for 30 December record the family as accepting this. On 2 January 2006 some of Mrs C's medication was stopped because her liver function had worsened, although this had improved by 4 January. Her increased urine output showed that her kidney function had also improved. In other words, Mrs C had not suffered the kidney failure about which her GP had been concerned. On 3 January the discharge and home care arrangements were in place, and discharge took place, as planned, on the 4th, after Mrs C was seen again by Consultant 1. Sadly, Mrs C died a few days later, at home.

7. Paragraphs 5 and 6 outline Mrs C's condition before, and during, her time in hospital. This paragraph summarises the Adviser's views about the decision to discharge her. Clearly, Mrs C's health was still poor at discharge. However, the acute aspects (in other words, the short-term, non-chronic, aspects) of her illness

had been dealt with and there was no further need for her to remain in hospital. An appropriate home care package was put in place. This included arrangements with the district nursing team for the acute care of Mrs C's groin area because of a skin condition which was linked to her loose bowels whilst in the Hospital. To sum up, the decision to discharge was reasonable and the discharge could properly have taken place earlier if the holiday period had not held up the care package arrangements.

Conclusion

8. Mr C considered that his mother's condition was worse at discharge than at her admission. He felt this was clear because she died so soon after returning home. I note also the Board's notes of their meeting with Mr C about his complaint. There, Mr C is recorded as saying that, a few hours after returning home, Mrs C was in such pain that the GP was called and prescribed morphine, a strong pain reliever.

9. However, it would not be appropriate for me to judge the discharge in the light of what happened later. My decision should be based only on the evidence that was available to the Hospital staff between the discharge decision and the discharge. That is because that is the only evidence on which they could base their discharge decision. That evidence showed that the acute aspects of Mrs C's illness had been dealt with and that she no longer needed in-patient hospital care. Based on that evidence, the Hospital took the appropriate decision to discharge Mrs C. In all the circumstances, therefore, I do not uphold the complaint.

Recommendation

10. The Ombudsman has no recommendation to make.

27 February 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's mother
The Board	Tayside NHS Board
The Hospital	Ninewells Hospital
Consultant 1	Mrs C's consultant physician
The Adviser	The Ombudsman's clinical adviser
GP	Mrs C's general practitioner