SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201508499, Grampian NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C, an advocacy worker, complained about the care and treatment Mr A received during and following an admission to Dr Gray's Hospital, Elgin. Mr A was admitted in a critically ill state, suffering from sepsis due to a chest infection; alcohol withdrawal; and possible effects of malnutrition. The sodium levels in his blood were noted to have been dangerously low and he was prescribed intravenous (IV) fluids to try to raise them. However, as a result of the sodium levels rising too quickly, Mr A developed a neurological condition known as osmotic demyelination syndrome and was left profoundly incapacitated. Mr C complained that Mr A's incapacity, which includes profound speech problems and walking difficulties, was as a result of inappropriate administration of IV fluids.

We took independent medical advice from a consultant physician, who did not consider that Mr A's sodium levels were adequately monitored. They noted that there were long periods between reviews of blood tests and no evidence that Mr A's fluid prescription was ever adjusted according to his sodium levels. They said that the rapid rise in sodium levels did not appear to have been considered at all until neurological deterioration was apparent. We accepted this advice and upheld the complaint. We were critical of the board for not having proactively arranged to formally review Mr A's care given the unfortunate outcome, and for not having identified learning points following their investigation of Mr C's complaint.

Mr C also complained that, when Mr A was formally certified as not having had capacity to make decisions about his medical treatment, the board did not appoint an advocate. We noted that subsequent discussions about Mr A's care and treatment were documented with his daughter (Miss A) and other relatives. We were advised that, as Mr A had living relatives and was not without representation, there was no requirement to appoint an advocate. We did not uphold this complaint. In addition, Mr C complained that a decision not to resuscitate Mr A in the event of heart or lung failure was not discussed with Miss A. Although the extent to which this was discussed with Miss A was not

clear, it appeared that she was made aware of the decision retrospectively. We were advised that it would be reasonable for medical staff to take such a decision, and discuss it with family afterwards, if there is sudden deterioration at a time when family could not be reached. However, this was not the case with Mr A and his poor health was chronic in nature, with no signs of recovery over time. We, therefore, concluded that there was an opportunity for the decision to have been discussed and agreed with Miss A prior to it being taken. Given this, and the fact that there was no clear evidence of an explicit discussion afterwards, we upheld this complaint.

Finally, Mr C also complained about a lack of medical review following Mr A's discharge, noting that he had not had any further contact from the hospital. We were advised that hospital follow-up would only be arranged if there was any potential benefit from review in a specialist led clinic. In Mr A's case, we were informed that there was no routine requirement for further medical input and that any necessary medical interventions for complications could reasonably be handled by his GP. We, therefore, did not uphold this complaint. However, we noted that the discharge arrangements did not appear to have been made clear to Mr A. While these were set out in the discharge letter that was sent to his GP, we identified that this was not sent until almost four months after discharge. We considered this unacceptable and made some further recommendations.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) carry out an adverse event review of this care episode, taking account of the failings this investigation has identified, and inform us of the steps they have taken to avoid a similar future occurrence;	25 April 2017
(ii) apologise to Mr A for their failure to appropriately manage his fluid intake and for the serious impact this failing has had on his health and quality of life;	24 February 2017
(iii) carry out a review of the DNACPR process and take steps to ensure that these decisions are appropriately discussed with patients' representatives, where possible;	25 April 2017
(iv) apologise to Mr A and Miss A for failing to appropriately discuss the DNACPR decision with	24 February 2017

	Miss A;	
(v)	provide us with an assurance that processes are in place to avoid similar future delays in discharge summaries being sent to GPs; and	25 April 2017
(vi)	apologise to Mr A for the delay in sending the discharge summary to his GP.	24 February 2017

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C and the aggrieved as Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C, an advocacy worker, complained to the Ombudsman about the care and treatment Mr A received during and following an admission to Dr Gray's Hospital, Elgin, between January and April 2015. The complaints from Mr C I have investigated are that Grampian NHS Board (the Board):

(a) unreasonably gave an excess of intravenous (IV) fluids, and failed to reasonably monitor sodium levels (*upheld*);
(b) failed, unreasonably, to appoint an advocate (*not upheld*);
(c) made a 'do not attempt resuscitation' decision without reasonable discussion or consultation (*upheld*); and
(d) failed to arrange appropriate medical review following discharge from hospital (*not upheld*).

Investigation

2. In order to investigate Mr C's complaint, my complaints reviewer examined all the information provided by both Mr C and the Board, and obtained independent clinical advice from a consultant physician (Adviser 1). As Adviser 1 is based in England and was not familiar with the terms of the Adults with Incapacity (Scotland) Act 2000, my complaints reviewer also discussed complaint (b) with a consultant physician based in Scotland (Adviser 2). In this case, we have decided to issue a public report on Mr C's complaint due to the significant personal injustice sustained by Mr A.

3. 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.

Background

4. Mr A was admitted to hospital on 16 January 2015, having collapsed. It was noted that he had alcohol problems and that he was suffering from sepsis due to a respiratory infection and possible effects from malnutrition. His sodium levels were noted to have been dangerously low and he was prescribed IV fluids to try to raise them. The subsequent quick rise of sodium in his bloodstream over the next 24 to 48 hours appears to have resulted in him developing a neurological condition known as osmotic demyelination syndrome. He was left profoundly incapacitated and remained in hospital for three months with input from physiotherapists, occupational therapists and speech and language therapists. He has subsequently needed to walk with a stick and has been left with balance and speech problems.

(a) The Board unreasonably gave an excess of IV fluids, and failed to reasonably monitor sodium levels

Concerns raised by Mr C

5. In complaining to the Board, Mr C noted that Mr A had been drinking alcohol the day prior to admission and had been admitted having collapsed, feeling unwell and suffering from alcohol withdrawal. Mr C said that, subsequent to the administration of IV fluids, Mr A was left profoundly incapacitated and continued to be so for the next three months, which he spent in hospital. Mr C noted that Mr A was a fit and able man prior to admission, with normal speech and physical ability, but that he now had restricted abilities and felt socially and physically isolated. He said he was now unable to carry weights; had balance problems; a severely restricted ability to speak; and was required to use a stick to walk and a hoist to enable him to use a bath. He noted that Mr A considered his condition to have resulted from the administration of inappropriate IV fluids.

The Board's response

6. In responding, the Board noted that Mr A was admitted to hospital as a medical emergency in a critically ill state, suffering from sepsis due to a respiratory infection and possible effects of malnutrition and alcohol withdrawal. They said he improved initially but then developed osmotic demyelination syndrome. They explained that this was a serious condition relating to damage to a part of the brain as a result of fluid shifts within the body and changes in sodium levels. They advised that this condition can occur when the sodium level in the blood is initially low and rises suddenly.

7. The Board noted that Mr A had risk factors for this condition because of alcohol misuse and probable malnutrition and infection. They said it was not easily predictable or manageable, noting that the body's sodium level is controlled by a variety of factors and that it was not easy to control all the variables. They said it was generally accepted to try to allow the sodium level to rise slowly. They noted that this unfortunately did not occur in Mr A's case and said they had reflected on the factors that may have contributed to this. They explained that a very low sodium can, in itself, lead to brain damage from cerebral oedema and that sodium, therefore, needs to be given acutely. They advised that, due to Mr A's unusual condition and unfortunate outcome, they had discussed his case at their Medical Unit meeting shortly after his admission. They said that, while in retrospect it would appear that Mr A's sodium level rose

more than they would have liked, the doctors present felt it was difficult to see what could have been managed differently. They noted that formulas existed for calculating the possible changes in sodium levels in response to IV fluids given but said it was generally accepted that these are not accurate and not commonly used in standard medical practice. They said the management is to give a little and monitor its effect.

8. The Board noted that Mr A was initially seen in the Emergency Department and was then managed by close supervision in the High Dependency Unit. They said the admitting consultant had noted that Mr A was in a dreadful state at the time of admission and that the question was not simply of what fluids to give him, but also of giving him enough volume as he was extremely septic from a chest infection. They said the case review had highlighted that Mr A was given too much salt initially but said it was difficult to know exactly what to give him, given the need for volume for blood pressure support and rehydration, as well as simply salt replacement. They noted that Mr A's sodium level was measured four times in the first 24 hours but they were still unable to control it, which they said was probably due to him having been unable to drink oral fluids and the level of sepsis affecting his kidney function. They noted how much fluid Mr A was given over the first three days and did not consider that this was excessive for someone with sepsis.

9. The Board observed that Mr A's sodium rose by 13 millimoles per litre (mmol/l) in the first 24 hours when they would have wanted this to have risen by less than 10 mmol/l in this period. They noted that Mr A's general condition initially improved but, as is common with osmotic demyelination syndrome, there is a delay of a day or two before neurological deterioration, which can cause permanent brain damage. They noted that Mr A's physical problems and a follow-up brain Magnetic Resonance Imaging (MRI) scan were compatible with this.

10. In concluding, the Board conveyed their sympathies that Mr A's outcome was poor but said he was desperately ill and his management very complex, and they were unable to control his sodium level as they would have wished. They considered that it was too simplistic to say that all Mr A's problems were due to excess IV fluids.

Complaint to the SPSO

11. In bringing his complaint to my office, Mr C noted Mr A's belief that he was wrongly administered fluids following admission, which resulted in his quality of life being severely compromised. He noted that the Board's response conceded that Mr A was given too much salt. He highlighted that Mr A was a fit and active man, and that he did not have any speech problems, prior to admission. He advised that he now has profound speech difficulties, which have contributed to social isolation as he is unable to conduct normal conversation and he perceives that many people consider him to be mentally retarded. He also advised that Mr A has considerable problems with balance and is unable to carry weights, such as shopping. He noted that rails have been installed in Mr A's flat as he has difficulty with steps and that he now walks with a stick.

Advice obtained

12. Adviser 1 reviewed Mr A's records and said that inappropriate IV fluids appeared to have been prescribed to Mr A in the hours after admission, resulting in a more rapid rise in the sodium level in the bloodstream than would be recommended. They noted that appropriate fluid (0.9 percent sodium chloride) was prescribed for initial fluid resuscitation in someone presenting dehydrated, and that 3375 millilitres of IV fluid was prescribed in the first 24 hours, but said there was no record of either the strength of sodium in the IV fluids, or the rate of fluid delivery, having been altered in view of the rapidly rising bloodstream sodium.

13. From the evidence available, Adviser 1 did not consider that Mr A's bloodstream sodium was adequately monitored during the period after admission when the sodium level was low and rising quickly. They noted that a number of blood tests were taken but either not acted on, potentially not reviewed, or reviewed but the rapid rise in sodium not noted or acted upon. They observed that the consultant's review of Mr A on 16 January 2015 indicated that low sodium was known about and that it needed to be managed with judicious use of IV fluids. Adviser 1 said the monitoring strategy appeared to have been to repeat the blood tests in the morning.

14. Adviser 1 noted that a blood test after the initial admission test actually indicated that the sodium had dropped further, and the next test showed that it had risen significantly – 13 mmol/l from the admission test and 15 mmol/l from the lowest level. This test was carried out at 00:21 on 17 January 2015 and

does not appear to have been reviewed until a ward round at 12:30 that day. Adviser 1 considered that the test should have been reviewed promptly rather than 12 hours later. They noted that the maximum recommended daily increase in these circumstances is 8 to 10 mmol/l and they considered that Mr A's fluid prescription should have been reviewed and adjusted to avoid any further increase in the following 12 hours. Adviser 1 said there was no evidence of a systematic process of review of abnormal blood tests during the early admission, and no evidence that a target/maximum rise of sodium had been considered or any parameters provided for adjusting the fluid prescription or calling for senior advice. They stated that the significance of a very rapid rise in sodium does not seem to have been considered at all until the neurological deterioration.

15. Adviser 1 agreed with the Board that calculations for correcting sodium are not routinely used in standard medical practice. However, they said there was no evidence to indicate that such calculations were considered and discarded, or that any other strategy was put in place instead. They noted that the Board's stated approach of giving a little IV fluids and monitoring the effect was correct in theory, but that there was no evidence to suggest that this approach was followed. Adviser 1 explained that the approach of giving a measured amount of IV fluid and monitoring the effect (using physical examination and observations such as pulse and blood pressure to ascertain hydration status, and blood tests to measure sodium levels in the bloodstream) would be the best practice in treating such low sodium. They said the rate of rise of sodium should be charted and, if too high or low, different IV fluids can be used, such as high strength sodium or no sodium fluid (or even a drug called desmopressin, which affects the way the kidneys process water). Adviser 1 stated that this approach, unfortunately, does not seem to have been followed in practice, with long periods between review of the blood tests and no evidence that the fluid prescription was ever adjusted according to the sodium levels.

16. Adviser 1 did not agree with the Board's statement that it was difficult to see how they could have managed Mr A differently. While acknowledging that the management of very low sodium is difficult, particularly when there are other clinical issues such as recent alcohol withdrawal and chest infection, Adviser 1 considered that there were better ways to manage the situation than that described in Mr A's notes. They noted that Mr A had at least two factors (alcohol misuse and malnutrition) which rendered him at higher risk of osmotic demyelination syndrome if low sodium levels were corrected too quickly. They

considered it likely that the rapid rise in bloodstream sodium levels in the 24 to 48 hours after admission caused osmotic demyelination of the brain in Mr A's case. They said this position was supported by the evidence from an early computerised tomography scan and later MRI scan, along with the clinical findings of neurological abnormalities occurring after admission.

17. Adviser 1 said there did not appear to be any evidence from the Board's response to the complaint that this scenario might not happen again. They said there appeared to have been little reflective learning from the treatment of someone with severe hyponatraemia (low sodium) with inappropriate IV fluids. They acknowledged that the doctors involved may reasonably not have known the details of best practice but said they should be aware of the difficulties in treatment and the need to seek expert advice if unsure. They noted that guidance from the National Institute for Health and Care Excellence (NICE) on IV therapy in adults in hospital, while not offering direct advice on the rare and complex management of severe low sodium levels in the bloodstream, does suggest seeking expert advice under these circumstances.

18. Adviser 1 said it is unclear if the Board regarded the case as a potentially avoidable episode of iatrogenic harm to a patient, and if the governance structures of the hospital have carefully reviewed it. They considered that it should have been noted as an adverse incident and investigated prior to the complaint. In particular, Adviser 1 said that the lack of robust response to blood tests was notable, where blood tests appear to have been taken but not reviewed or acted upon, and they did not consider the Board's response to the complaint to have evidenced any change to practice in this regard.

(a) Decision

19. It does not appear to be a point of dispute that the inappropriately fast rise in sodium in Mr A's blood resulted in him developing a serious neurological condition, which has had a significant impact on his quality of life. The Board have highlighted that Mr A's management was very complex, which I accept, and they explained that their approach was to give a little IV fluids and monitor the effect, aiming to allow the sodium level to rise slowly. They acknowledged that Mr A was given too much salt initially and that his sodium level rose much faster than they would have liked. However, they said they did not see how they could have managed Mr A differently. This is concerning in light of the advice I have received.

20. I am advised that there is little evidence of the Board having adhered to their advised approach of closely monitoring the effects of the fluid provision. Blood tests were taken but there is no evidence of these having been systematically reviewed and responded to, with no indication of any adjustments to Mr A's fluid prescription in response to his rapidly rising sodium levels. I am advised that this rise does not appear to have been considered until neurological deterioration was apparent. Mr A had risk factors for this condition and if the medical staff were not confident in managing his symptoms, they should have considered seeking expert advice. In the circumstances, I uphold this complaint.

21. While I note that medical staff subsequently discussed Mr A's management, I am concerned that the Board did not arrange a formal review of this serious case in light of the unfortunate outcome. I am further concerned that the Board's investigation of the complaint, despite acknowledging that failings in care were evident, did not identify learning points and did not result in robust remedial action being taken. I, therefore, recommend the following.

(a) Recommendations

22. I recommend that the Board should:	*Completion date*
(i) carry out an adverse event review of this care episode, taking account of the failings this investigation has identified, and inform us of the steps they have taken to avoid a similar future occurrence; and	25 April 2017
(ii) apologise to Mr A for their failure to appropriately manage his fluid intake and for the serious impact this failing has had on his health and quality of life.	24 February 2017

(b) The Board failed, unreasonably, to appoint an advocate

Concerns raised by Mr C

23. Mr C complained to the Board that, when Mr A was certified on 20 January 2015 as not having capacity, in terms of Section 47 of the Adults with Incapacity (Scotland) Act 2000, no advocate appeared to have been appointed at that time.

The Board's response

24. The Board noted that Mr A was acutely unwell on admission and unable to communicate. They advised that Section 47 of the Adults with Incapacity

(Scotland) Act 2000 is invoked by healthcare professionals, allowing them the authority to do what is reasonable in the circumstances in relation to medical treatment. They said that Section 47 is specifically about timeous delivery of procedures or treatment designed to safeguard or promote physical wellbeing. They stated that delaying treatment to appoint an advocate would not have been reasonable given how acutely unwell Mr A was on admission. They noted that there was a documented discussion with Mr A's daughter (Miss A), as his noted next-of-kin, throughout this time. They said the Section 47 was appropriately reviewed and revoked prior to discharge.

Complaint to the SPSO

25. Mr C complained that no effort was made by the Board to appoint an advocate. He considered that they were incorrect to state that to do so would have delayed treatment, noting that Mr A spent much of his time in hospital without advocacy other than Miss A, who lived in England.

Relevant legislation

26. Section 47 of the Adults with Incapacity (Scotland) Act 2000 applies where the medical practitioner primarily responsible for the medical treatment of an adult has certified that they are of the opinion that the adult is incapable in relation to a decision about medical treatment. The certificate gives the medical practitioner authority, over a specified period, to do what is reasonable in the circumstances in relation to the medical treatment in question, which includes any procedure or treatment designed to safeguard or promote physical or mental health.

Advice obtained

27. Adviser 1 noted that Mr A did seem to have lacked capacity to make decisions about his health at the time of the decision and formal declaration of incapacity. They observed that there was appropriate documentation of a multi-disciplinary discussion having occurred prior to this declaration being made. Furthermore, they noted that Mr A did have living relatives, whom discussions were noted with, and he was not, therefore, without representation. On this basis, Adviser 1 regarded it reasonable practice to have undertaken this process.

28. Adviser 2 confirmed that there is no legal requirement to appoint an advocate. They explained that an advocate is not appointed in every case of a patient with incapacity and that it is, in fact, quite rare and might only be

considered in circumstances where there are significant concerns and/or disagreement between the parties involved. They agreed with Adviser 1's comments, noting in particular that Mr A had living relatives to represent him, and they considered the Board's response to this issue to have been reasonable.

(b) Decision

29. I am assured that, in light of Mr A's condition at the time, it was reasonable for medical staff to have issued the incapacity declaration. This decision appears to have been appropriately discussed within the healthcare team, and the discussion about Mr A's treatment included discussion with Miss A, in keeping with the principles of the Adults with Incapacity legislation. Crucially, I am advised that there was no legal requirement for the Board to appoint an advocate and that it would not be normal practice to do so in such circumstances, where Mr A was not without family representation and there was no evidence at that time of disagreement over medical treatment. I, therefore, do not uphold this complaint.

(c) The Board made a 'do not attempt resuscitation' decision without reasonable discussion or consultation

Concerns raised by Mr C

30. Mr C complained about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision that was taken on 10 February 2015. He noted that there was no reference to this having been discussed with Mr A or a relevant other person.

The Board's response

31. The Board noted that Mr A became significantly compromised and said that appropriate consideration was given to the likely benefits, burdens and risks of Cardiopulmonary Resuscitation (CPR). They advised that this resulted in a clinical decision to apply the DNACPR and said that appropriate documentation was completed at the time this was signed on 10 February 2015. They mistakenly noted that Miss A was overseas and said it was recorded on 10 February 2015 that discussion would take place with her on her next visit. They noted that it was then recorded on 12 February 2015 that Miss A was aware of the situation.

Complaint to the SPSO

32. Mr C complained that the DNACPR decision was not discussed with Miss A or agreed to by her. He said that the only discussion consisted of words to the effect of 'how would your father feel about being on life support'. Mr C noted that no documentation was given to Miss A and no documentation was completed by her. Miss A noted that she was present from 6 February 2015 to 9 February 2015 and suggested that there would have been an opportunity for the matter to have been discussed with her then.

Advice obtained

33. Adviser 1 noted that Mr A's clinical condition on 10 February 2015 appears to have been one of significant neurological deficit without improvement, and complete dependency on medical and nursing support. They considered that, in the event of cardiac or respiratory arrest requiring attempted CPR, Mr A would have had a poor change of recovery despite CPR, and was likely to have suffered further deterioration of neurological status. They noted that he was felt to have been a poor candidate for care on the intensive therapy unit (ITU). Adviser 1 said that these factors would support the decision to make the DNACPR order and they considered that this was reasonable in the circumstances.

34. Adviser 1 explained that, if the patient is able to contribute to the discussion, they should be consulted on resuscitation status. If not, as in Mr A's case, they advised that the next-of-kin should be involved. They said that, ideally, the decision not to resuscitate is mutually agreed on the basis of extreme poor health and the minimal chances of recovery if a cardiopulmonary arrest were to occur (noting again that chances of recovery were very poor in Mr A's case). However, they noted that the decision may be prompted by changes in health out-of-hours, such that careful discussion with the family is not possible at that time. If that was the case, they advised that it would be good practice to discuss the decision with the family at the next possible opportunity.

35. Adviser 1 noted that the decision in Mr A's case appears to have been taken electively, at a time of chronic very poor health for Mr A with no signs of neurological recovery after a prolonged period of supportive care. They said the decision appeared to have been taken by medical staff without reference to the family and then possibly discussed in retrospect shortly afterwards. However, he noted Miss A's indication that the decision was not explicitly

discussed with her. They said the action taken might be thought of as adequate but not best practice, as Mr A's condition was poor but stable and there appeared to have been time to arrange a meeting with Miss A. Adviser 1 said that, if the DNACPR decision was not discussed with Miss A at all, then that would be regarded as poor practice, noting that Miss A visited Mr A in hospital, and was available by telephone. They considered that the DNACPR process would merit review.

(c) Decision

36. While I am advised that the DNACPR decision was reasonable in the circumstances, the question here is whether this was appropriately discussed with Miss A. The Board noted that medical staff took this decision and planned to discuss it with Miss A when she next visited. This could be considered a reasonable approach where there has been a sudden deterioration in health at a time when the family cannot be reached. However, in this case, Mr A's poor health was chronic in nature and there had been no signs of recovery over time. I am advised that his condition was stable and that there would have been time for medical staff to arrange to discuss matters with Miss A before taking the DNACPR decision. It was noted in Mr A's records, two days after the decision, that Miss A was 'aware of poor prognosis + understands that in the case of any sudden deterioration, an ITU opinion will be sought but unlikely to take a positive view'. Miss A is clear that the DNACPR decision was not specifically discussed with her. As there appears to have been an opportunity for DNACPR to have been discussed and agreed with Miss A prior to the decision being taken, and as there is no clear evidence of this having been explicitly discussed with her in retrospect, I uphold this complaint and make the following recommendations.

(c) Recommendations

37. I recommend that the Board should:	*Completion date*
(i) carry out a review of the DNACPR process and take steps to ensure that these decisions are appropriately discussed with patients' representatives, where possible; and	25 April 2017
(ii) apologise to Mr A and Miss A for failing to appropriately discuss the DNACPR decision with Miss A.	24 February 2017

(d) The Board failed to arrange appropriate medical review following discharge from hospital

Concerns raised by Mr C

38. Mr C complained that, as of February 2016, Mr A had not had any contact with any person employed at the hospital following his discharge in April 2015. He said that this raised concerns as to how seriously Mr A's condition was viewed by the hospital and about his 'non-existent after care'.

The Board's response

39. The Board noted that Mr A was discharged back to the care of his GP and deemed not to require any further acute medical review or follow-up at that time. In addition, they noted that their ward based occupational therapist carried out full assessments of Mr A at ward level, within his home, and in a local supermarket setting, where he was found to be fully independent at all levels. They also noted that a referral was made to the Home from Hospital Team for assessment of Mr A's community care needs. They provided a time line of interventions by social workers and therapists prior to and following discharge.

Complaint to the SPSO

40. When writing to my office, Mr C noted that his complaint derived from the fact that Mr A was discharged from hospital a year previously, having suffered major trauma and being left severely debilitated. He stated that, since his discharge, Mr A had not had any medical monitoring or review, which he considered was at best a poor reflection of the seriousness with which the medical profession regarded his condition. Mr C said his impression is that the Board used social work interventions as a smoke screen to avoid addressing his complaint about 'a complete lack of interest, concern or involvement from a medical perspective' in and for Mr A.

The SPSO's enquiries

41. The Board advised my complaints reviewer that Mr A was totally independent on discharge. They noted that he was able to leave the ward independently on multiple occasions throughout the day and was assessed by occupational health in the community and in the local supermarket. They advised that he was discharged back to the care of his own GP, with a range of support in place, and was deemed not to require any further acute medical review or follow-up at that time.

Advice obtained

42. Adviser 1 explained that medical out-patient consultations should only be arranged if there is a potential benefit by specialised hospital consultant led clinic review. They said it would be unusual to discharge someone after such a prolonged hospital stay without being explicit about follow-up arrangements. However, they said it is reasonable to argue that osmotic demyelination syndrome and its long term neurological consequences are not amenable to any medical intervention. They noted that the treatment for this is supportive care, particular nursing, physiotherapy and occupational therapy, with medical support for complications. They considered that follow-up could be through the GP but said it would be good practice to be explicit about this at the time of discharge, such that the patient/carers are not anticipating hospital follow-up and are disappointed if it does not occur.

43. Adviser 1 said it was not clear from the notes whether this lack of hospital follow-up was explained to Mr A, who at the time seemed to have been functioning at a reasonable level for discharge. They noted that the hand written discharge summary dated 17 April 2015 had no follow-up information and, while it was explicitly stated in the typed discharge summary sent to the GP that no hospital/clinic appointment was necessary, this summary was dated 4 August 2015. Adviser 1 said it was not acceptable practice for a discharge summary to be sent four months after discharge in a complex case where the patient has ongoing neurological deficit. They suggested that assurances should be sought that there are processes in place to avoid this in future.

(d) Decision

44. The advice I received indicates that hospital follow-up would only be arranged if there was any potential benefit from further review in a specialist led clinic. In Mr A's case, it appears that there was no routine requirement for further medical input and any necessary medical interventions for complications could reasonably have been handled by his GP. As such, I cannot conclude that there was an unreasonable failure to arrange further hospital review for Mr A following his discharge and I do not uphold this complaint.

45. However, I am advised that it would be good practice for discharge plans to be explicitly discussed with the patient. I note that Mr A was anticipating further specialist review and does not appear to have been aware that no further hospital appointments would be arranged. While this was made clear in the discharge summary sent to Mr A's GP, the discharge took place on

17 April 2015 and the summary was not sent until 4 August 2015. This was an unacceptable delay and I have the following recommendations to make.

(d) Recommendations

46. I recommend that the Board:	*Completion date*
(i) provide us with an assurance that processes are in place to avoid similar future delays in discharge summaries being sent to GPs; and	25 April 2017
(ii) apologise to Mr A for the delay in sending the discharge summary to his GP.	24 February 2017

47. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	the complainant - an advocacy worker
Mr A	the aggrieved
the Board	Grampian NHS Board
IV	intravenous – administered into a vein
Adviser 1	consultant physician
Adviser 2	consultant physician
mmol/l	millimoles per litre – a measure of substance concentration
MRI	magnetic resonance imaging
NICE	National Institute for Health and Care Excellence
Miss A	the daughter of the aggrieved
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
CPR	cardiopulmonary resuscitation
ITU	Intensive Therapy Unit

Annex 2

Glossary of terms

cerebral oedema	excess fluid in the brain
desmopressin	a drug which affects the way the kidneys process water
hyponatraemia	low sodium level in the blood
iatrogenic	relating to illness caused by medical examination or treatment
sepsis	blood infection

Annex 3

List of legislation and policies considered

National Institute for Health and Care Excellence (NICE) clinical guideline (CG174) – Intravenous fluid therapy in adults in hospital (December 2013)

The Adults with Incapacity (Scotland) Act 2000