SPSO decision report

Case: **201201725, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained on behalf of his father (Mr A) about the care and treatment he received when he was admitted to hospital three times over a period of about eleven days. Mr A had a history of high blood pressure and arthritis, as well as a history of heavy drinking, for which he was being treated by his GP with Antabuse (a drug that causes an unpleasant reaction when taken with alcohol). Mr A was taken to hospital after suffering a seizure. He was complaining of shaking in his right arm and leg, speech disturbance and confusion, and had a three-day history of headache. He was admitted overnight for observation and investigation and was discharged the next day. Mr A's wife (Mrs A) and daughter went to collect him and felt that the attitude of the staff on the ward changed towards him when Mrs A mentioned that he was taking Antabuse. Despite Mrs A and her daughter telling staff that they thought Mr A was still confused and unwell, he was discharged.

Mr A was re-admitted to hospital later that night suffering from confusion and hallucinations. He was again kept in overnight and discharged the next day. Mrs A was told that his condition had been brought on by his previous lifestyle. The family said that Mr A remained confused and disorientated over the next week. He then suffered four or five fits at home and was taken by ambulance to the hospital, where he was again admitted. Mrs A phoned the hospital the next morning to ask if she could bring in some personal items for her husband at lunchtime, and was told that she could do so. However, when she phoned again at 11:45 she was told that Mr A had been discharged some ten or 15 minutes previously.

Mrs A and a friend went to the hospital and also reported to the police that Mr A was missing. He was later found sitting at the main entrance to the hospital dressed only in a vest, cardigan, jogging bottoms and slippers. He had a supply of medication with him that he had been given on discharge from the ward. He had no money with which to phone home or pay for a taxi. His family say he was generally confused and did not know what the supply of medicines he had were or when he had last had his regular medication. It was only after Mr C made a verbal complaint to the hospital that someone phoned and spoke to Mr A's daughter and explained the medication. The caller did not phone Mr C or respond to his verbal complaint as he had been expecting them to do. Mr C, therefore, made a written complaint but was dissatisfied with the response he received.

We upheld Mr C's complaints. Our investigation, which included taking independent advice from two of our medical advisers, found that while in general the investigations of Mr A's condition were reasonable, there were some deficiencies in the care and treatment provided. In particular, the discharge planning and documentation were inadequate. There were also insufficient arrangements made for Mr A to be followed up in the community after his discharge from hospital.

Recommendations

We recommended that the board:

- apologise to Mr A and his family for the failings identified;
- consider the introduction of structured pathways for patients presenting with complications of alcohol

consumption to standardise appropriate treatment, discharge and follow-up; and

- ensure that all relevant staff are aware of and properly trained to apply the board's admissions and discharge planning guidelines.