SPSO decision report

Case: **201303223, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs C complained about the care and treatment that her late mother (Mrs A) received in Belford Hospital. Mrs A had been admitted to hospital after collapsing. She was discharged home some fifteen days later with a package of care, and was later moved to respite care. Her condition, however, deteriorated and she died about a month after being discharged home. Mrs C said that hospital staff did not encourage Mrs A to eat or drink; did not tell her if Mrs A had a urine infection while she was in hospital; did not go through the discharge medication with her, and discharged Mrs A before she was ready.

We took independent advice on this complaint from our nursing adviser, who said that hospital staff had taken reasonable steps to encourage Mrs A to eat and drink, and there was no evidence that she had a urine infection. We also found that, taking into account the detailed notes and the fact that Mrs A was medically fit for discharge, it had been appropriate to discharge her home with a package of care in place. We found that, on balance, the level of communication with Mrs C had been reasonable. Although there was no record that the discharge medication was explained to Mrs C, this would not always be recorded. In view of all of this, we did not uphold this aspect of Mrs C's complaint.

Mrs C also complained that a community nurse's actions in respect of Mrs A's catheter (a thin tube used to drain and collect urine from the bladder) were unreasonable. Mrs A had a long-term catheter and this meant that there was a high risk of urinary infection. Good hygiene and prevention were, therefore, important. Mrs C said that the community nurses failed to change the catheter when it was reported to be badly blocked with sediment.

We found that a catheter care plan had been completed, which was good practice, and a good record of the care required. Our nursing adviser also said that community nurses had provided good care in relation to the catheter and had followed the guidance in the care plan. Changing the catheter when it was initially noted to have a lot of sedimentation might have caused further trauma, distress and a higher risk of infection. We considered that the care and treatment by the community nursing team in relation to the catheter had been reasonable.