SPSO decision report

Case: **201600908, Tayside NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

Mr C complained to us that the board had failed to properly assess his mother (Mrs A) before she was discharged from Perth Royal Infirmary. He said that, as a result of this, Mrs A had to go into a care home for full-time care, which had cost the family over £20,000 in charges. We took independent advice from a consultant geriatrician. We found that Mrs A had been discharged without being adequately assessed. There was no evidence of a multi-disciplinary team discussion or of adequate occupational therapy input in the discharge planning process. In addition, we found that that the physiotherapy and nursing notes indicated that she should have had further assessment. Mr C had also raised concerns several times to different members of staff about Mrs A's ability to return home. We found that Mrs A should not have been discharged on the day that she was. In view of this, we upheld the complaint. However, it was likely that she would have been reviewed again a week later and it was possible that a reasonable decision could have been made at that time that she could be discharged. This could have been either to her own home or to a nursing home.

Mr C also complained that the board had not informed him of, or acted in accordance with, the relevant Scottish Government guidance on intermediary care following hospital discharge. The relevant guidance is normally used where care homes are being considered. In view of the fact that Mrs A had been discharged home, we found that there was no need to use the guidance. Although we found that staff had not taken sufficient account of Mr C's views at the time of Mrs A's discharge, on balance, we did not uphold this aspect of the complaint.

Finally, Mr C complained to us about the board's handling of his complaint. We found that the board had delayed in responding to Mr C and that the communication with him about a meeting had not been clear. In addition, the board's response said that it had been reasonable to discharge Mrs A. In view of these failings, we upheld the complaint.

Recommendations

We recommended that the board:

- issue a written apology to Mr C for the failure to appropriately assess Mrs A before she was discharged from hospital;
- reimburse Mrs A for the first seven days of her nursing home costs;
- provide evidence to us that they have taken steps to ensure that patients in the hospital receive care in line with Standard 5 of the 'Scottish Standard of Care for Hip Fracture Patients' in relation to discharge planning;
- issue a written apology to Mr C for their failings in relation to the handling of his complaint;
- feed back our findings on the handling of Mr C's complaint to the staff involved; and
- provide evidence to this office that they have taken steps to ensure that multi-disciplinary team meetings are documented in the records of patients.