SPSO decision report

Case: **201609690, Tayside NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: not upheld, recommendations

Summary

Mr C complained about the care and treatment his late father (Mr A) received at Perth Royal Infirmary (hospital 1). Mr A was suffering from a chest infection and was also experiencing periods of delirium. Mr A was discharged from hospital 1 to a community hospital (hospital 2) in another health board area, but they refused to admit him due to his condition and he was transferred by ambulance to another hospital (hospital 3). Mr A was later admitted to hospital 2, where he died a short time later. Mr C complained that the decision to discharge Mr A from hospital 1 was unreasonable and that there was an unreasonable delay in replacing his hearing aids which were lost during his admission.

Mr C raised concerns that hospital 1 had treated Mr A for a chest infection, and hospital 2 also identified a chest infection. Mr C therefore considered that Mr A was discharged from hospital 1 with an unresolved infection and he questioned whether this was appropriate. We took independent medical advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly). We found that Mr A's observations were stable leading up to his discharge from hospital 1. We did not consider that there was any evidence to suggest Mr A was not fit for discharge. We noted that Mr A quickly developed a further infection but we did not consider that this was identifiable, or could reasonably have been predicted, at the time of discharge. Therefore, we did not uphold this aspect of Mr C's complaint. However, the adviser noted that there was no evidence of medical staff having formally assessed Mr A's delirium using a recognised screening tool and we therefore, made a recommendation regarding this.

In relation to the hearing aids, the board apologised to Mr C for the loss of these. In responding to our enquiries, they offered a fuller explanation of the steps followed in replacing them. We found that the timescale described for replacing the hearing aids was typical for such a process. Therefore, we did not uphold this aspect of Mr C's complaint, but we were critical of the level of explanation offered to Mr C when responding to his complaint. We provided some feedback to the board in this regard.

Recommendations

What we said should change to put things right in future:

- Medical staff should formally assess patients' delirium using a recommended screening tool, such as those recommended by Healthcare Improvement Scotland.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.