SPSO decision report

Case: **201704215, Lanarkshire NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

Mr C, who is an MSP, complained on behalf of his constituent (Mr A). He said that the board had failed to provide Mr A with reasonable care and treatment in Monklands Hospital. We took independent advice from a general medical adviser, a nursing adviser and from a consultant orthopaedic and trauma surgeon.

Firstly, Mr C complained that the board had unreasonably discharged Mr A with a bacterial infection and that he then had to be readmitted to hospital. We found that Mr A's discharge had been reasonable, as his symptoms appeared to be acceptably controlled at that time on oral medication; he had been appropriately reviewed; and no concerns about his discharge were raised. The blood tests results showing the infection did not become available until after he was discharged. We did not uphold this complaint.

Mr C also complained that staff failed to prevent Mr A falling on two occasions when he was readmitted to hospital. We found that there had been a failure to complete and document a falls risk assessment when Mr A was admitted in line with standards of care for older people in hospital. There was also a failure to document communication with the family. We upheld this complaint.

Mr A also complained that staff delayed in obtaining an X-ray after Mr A's falls. We found that an X-ray had not been clinically indicated after the first fall. An X- ray was then obtained after the second fall. On balance, we did not uphold this complaint.

Mr C also complained that staff had given Mr A too much morphine (a medication for pain relief). We found that the approach to this and the doses prescribed had been reasonable. We did not uphold this complaint.

Mr C also complained that staff failed to follow-up Mr A's care after his discharge from hospital. We found that, although an interim discharge letter was issued, a follow-up discharge summary was not issued. There was also insufficient information about how Mr A's hypertension (abnormally high blood pressure) was to be followed up. We upheld this complaint.

Finally, Mr C complained that the board had unreasonably prescribed an antiepileptic drug to Mr A beyond the maximum of ten years. There is no guidance that states it should not be prescribed for more than ten years and there was no clear evidence that this had caused Mr A's health problems. We did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for the failure to complete an appropriate risk assessment to prevent falls when he was admitted to hospital and to appropriately document communication with Mr A's family. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Risk assessment and care planning in relation to falls prevention should be carried out in line with guidance and policy, when the patient is admitted to hospital.
- Nursing staff should involve patients and families in care planning where appropriate and should keep clear records of conversations with families/carers using the relevant documents.