SPSO decision report

Case: **201900831, Lanarkshire NHS Board**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

C complained about the board's decision to discharge their late parent (A) from University Hospital Monklands. A had metastatic cancer (cancer that has spread from the part of the body where it started) and had been admitted to hospital with blood in their urine. A was treated with antibiotics and antifungals, however, their infection markers remained elevated. As A showed no other signs of infection, their elevated infection markers were attributed to their cancer and they were discharged home. A was readmitted to hospital the following day with a deep vein thrombosis (DVT, blood clot in a vein). Their condition deteriorated and they died eight days later.

C complained that A had been discharged from the hospital before they were fit to return home. C also raised concerns about the hospital staff's communication regarding A's condition and discharge. C considered that failings by the board meant that A endured unnecessary suffering which distressed family members.

We took independent advice from a consultant geriatrician (a specialist in medicine of the elderly). We were satisfied that the hospital staff communicated clearly and regularly with C throughout A's admission to the extent that C was kept informed as to how A was fairing on the ward. We were also satisfied that nursing and clinical staff appropriately monitored and recorded changes in A's mobility and attempted to provide physiotherapy when A was willing and able to participate.

We found that, in the days before A's discharge, C had raised concerns with the nursing staff regarding A's foot being swollen. We noted that this should have raised the suspicion of a DVT specifically and that investigations should have been carried out prior to A being discharged. Whilst the nursing staff advised C that their concerns would be passed on to the medical team, we found no evidence of this happening and concluded that an opportunity was missed to investigate and diagnose A's DVT prior to their discharge. We upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this decision. The apology should meet the standards setout in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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.