SPSO decision report

Case: **202202079, Grampian NHS Board**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

C complained about the care and treatment they received from the board. C suffered a subarachnoid haemorrhage (a form of stroke caused by bleeding on the surface of the brain). Following a period of admission to different hospitals, C was discharged home. C complained that the board failed to communicate appropriately with them after their admission, that they were not fit for discharge and that inadequate rehabilitation plans were made in the community. C chose to stay at a relative's property and was eventually admitted to a rehabilitation unit but believed this had affected their prognosis. C also complained that the board failed to respond reasonably to their concerns about the COVID-19 vaccine they had received.

We took independent advice from a consultant neurologist (specialist in the diagnosis and treatment of disorders of the nervous system) and an occupational therapist. We found that communication with C was unclear and confusing and did not always address the main points C was raising. Therefore, we upheld this part of C's complaint.

In relation to C's discharge, we noted that more consideration could have been given to supporting C prior to their discharge, given C's concerns at the time. However, we found the decision making to be appropriate and did not uphold this part of C's complaint.

In relation to plans for C's rehabilitation, we found that the board made reasonable plans and attempted to commence the initial assessment that would have established what support C required. However, we found that there was a failure to provide C with written information about the plans for their rehabilitation. C was unable to retain this information when given verbally which meant they were unaware of the plan and could not access the support available to them when they were unable to return to their property as quickly as anticipated. Therefore, we upheld this part of C's complaint.

We also found that the board failed to follow up on a commitment given to C to explore any potential link between the COVID-19 vaccine and C's brain injury. They also failed to support C's attempts to gather information to assess the risk of further vaccine doses. Therefore, we upheld this part of the complaint.

C also complained about the board's handling of their complaint. We found that although there were some failings, in the circumstances the board were operating under at the time these were apologised for and reasonably addressed. We did not uphold this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

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

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

- That the board confirm what action they have taken to ensure patients with brain injuries are provided with discharge information in a format they can understand and refer back to after leaving hospital. The Board should share this decision with the clinical team involved in C's care with a view to identifying points of learning.

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.