SPSO decision report

Case: **202208523, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

C complained on behalf of their spouse (A) about the board not issuing a discharge plan at the point A was discharged from hospital for palliative care before A passed away. As their carer, C wanted to know how to provide care and support for A. C said that this plan was subsequently requested a number of times but not provided. C also complained that following A's death, their GP provided a copy of the Inpatient Discharge Summary which said 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR). C said that they had not been aware a decision had been made on this and as A's Power of Attorney, and in order to safeguard A, DNACPR should not have been discussed with A without C being present.

We took independent advice from a registered consultant geriatrician (a doctor specialising in medical care for the elderly). We found that the board could not have provided C with a discharge plan as C did not attend hospital that day. We also found that A was not given clear discharge information despite this being complex and their care needs being high. There was also a failure to subsequently provide C with a copy of the discharge plan when requested, and record keeping failures during A's discharge. We also found that the board failed to communicate with C that a DNACPR decision had been made with A. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Open and honest discussions should be held with the patient and relevant others with regard to timely decisions about DNACPR and in accordance with relevant DNACPR guidance. This is particularly important where patients have Aphasia (language disorder) and where patients are discharged home for end of life care.
- Patients should be discharged with appropriate documentation which is clear and should be completed so that full discharge information is provided. This should include post discharge requests for further copies.

In relation to complaints handling, we recommended:

- The board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and that learning from complaints is used to drive service development and improvement.

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.