SPSO decision report

Case: **202301564, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their family member (A) during their admission to hospital, following a fall at their home. A was admitted to hospital after falling unwell, and for management of their underlying heath issues.

A was discharged but had to be re-admitted to hospital two days later. C raised concerns that A did not receive appropriate care and treatment during their admission, that they should not have been discharged and that medical staff did not properly communicate A's care plan during the admission.

In response to the complaint, the board explained that staff were aware of, and managed, A's pre-existing health conditions and that appropriate investigations were undertaken to investigate their symptoms. A's weight loss during admission was noted and the board explained monitoring of this aspect of their care could have been better. The board explained that A was assessed as being medically fit for discharge and this was discussed with family.

We took independent advice from a consultant in the care of the elderly and from a registered nurse. We found that whilst the general management of A's underlying health conditions and symptoms was reasonable, in the initial days of their admission A was administered within correct medication and there was a missed opportunity to perform an x-ray to investigate A's symptoms. For these reasons, we found that A's care and treatment was unreasonable.

We also found that medical staff failed to recognise the status of A's family members as Power of Attorney, and did not appropriately communicate with A or their Power of Attorney with respect to their care. The communication with A and their family was unreasonable. We upheld this complaint.

Finally, we found that appropriate assessments were carried out to determine A was fit for discharge and we did not uphold this complaint

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failures 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:

- Clinicians should be aware of the importance of ensuring patients are prescribed appropriate medication for pre-existing medical conditions. Clinicians should ensure that appropriate investigations and assessments are carried out for patients on admission to hospital.

- The board should be aware of, and follow Assessment, Planning, Implementation and Evaluation processes. As such the Board should keep appropriate documentation to evidence basic care provided to patients.
- Clinicians should be aware of the legislation with respect to the AWI process and the importance of ensuring POA's are identified and included in communications and decision making around relevant patient care.

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.