SPSO decision report

Case: **202403102, Fife NHS Board**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

C complained about their parent (A)'s discharge from Queen Margaret Hospital following a period of post-surgical rehabilitation. C raised concerns that the discharge was rushed and not properly planned, that there a lack of rehabilitation on the ward prior to discharge, that there was a lack of home assessment, a poor coordination of care services, and insufficient communication and involvement in discharge planning. The board acknowledged some gaps, apologised for aspects of the planning and communication, and outlined steps taken to improve discharge processes, including better coordination of services, clearer communication, and changes to assessment procedures.

We took independent advice from a nursing adviser. We found that A's mobility and required supports were not reasonably assessed, taking into account information available from the family and home environment. A was discharged home and leftalone upstairs overnight when they were not able to safely manage the stairs. While there appeared to have been reasonable rehabilitation input from therapy staff while on the ward, there was little evidence of ward staff having supported A with mobilising between therapy sessions. We were concerned that staff appeared to have relied on the fact C agreed to go ahead with the planned discharge when asked on the morning of discharge.

Overall, we found that the discharge was not reasonable. The decision to proceed did not adequately consider A's mobility, safety, and home circumstances, and there was a lack of coordination and oversight. While the board had recognised some failings and taken steps to improve practice, this did not go far enough in accepting responsibility for this failed discharge. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the failings we found. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies.

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

- Hospitals should work closely with other providers to ensure planned community supports are appropriate and in place for discharge.
- The board should take a co-ordinated approach to discharge planning, with documented involvement of the patient and family and how any concerns or risks have been addressed.
- Where mobility is a significant element in a planned discharge, ward notes should evidence a patient's current status, how they are working towards achieving physiotherapy or occupational therapy goals, and support given by staff to mobilise.

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.