SPSO decision report

Case: **201104124, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

An advocacy worker (Ms C) complained on behalf of Mrs A, whose husband (Mr A) had been treated by the board. Mr A had become ill in October 2010, and his GP prescribed antibiotics for a presumed chest infection. Mrs A became concerned about his condition later the same day, however, and believed that her husband was having a stroke. Mr A attended the accident and emergency department of a hospital and was admitted. Records show that Mr A was found to be confused, with slurred speech and impaired mobility, but investigations found that he had not had a stroke and did not have an infection. No confirmed cause was established for his confusion, and he was discharged with a suspected Transient Ischaemic Attack (a type of stroke, sometimes called a mini stroke, that shows no evidence on CT scans but resolves in around 24 hours).

Mrs A complained that Mr A was discharged home whilst still very confused. She questioned the level of investigation into his condition. She also said that her husband had been diagnosed with lung cancer six months after his hospital admission and asked whether this should have been diagnosed at the time.

After taking advice from our medical adviser, we upheld two of Mrs A's complaints. We found that staff thoroughly investigated the cause of Mr A's confusion and reached appropriate conclusions. A chest x-ray taken during his admission did show an abnormality that was suspicious of, but not diagnostic of, cancer. We noted that the radiologist's report recommended investigation of this once Mr A's condition improved, but found no evidence of follow-up arrangements being made or of Mr A and his family being told of the finding.

We were unable to comment as to the extent of Mr A's confusion when he was discharged home, as when he was admitted the board failed to obtain detailed information from Mrs A about his usual state. However, we noted that a care plan and discharge plan were completed stating that arrangements had been made to provide Mr A with support at home, but found no evidence of the described actions having been taken. There was also a lack of evidence of staff discussing discharge arrangements with Mrs A. As such, we were left with doubts as to whether it was appropriate to discharge Mr A.

We did not uphold Mrs A's complaint that the board failed to provide a follow-up appointment for her husband, as we could not find evidence to show that this should have happened.

Recommendations

We recommended that the board:

- apologise to Mrs A for the issues highlighted in our decision;
- draw Mr A's case to their staff's attention to ensure that discharge arrangements are properly followed up and documented and that patients' families are routinely consulted about their perceptions of the need for support at the time of discharge; and
- consider carrying out an audit of actions that are actually undertaken in the discharge planning process against the benchmark of their discharge planning documentation.