SPSO decision report

Case: **201003723, Tayside NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained to us about the board's care and treatment of his late brother (Mr A) prior to his death. Mr A, who was elderly, was due to be admitted to hospital for an endoscopic examination. In anticipation of this, he was given medication the day before, but became very ill and was instead admitted to hospital on the day of the planned procedure, as an emergency. The next day, a Tuesday, Mr A had a colonoscopy and he was then considered ready for discharge in a few days. It was proposed he would be discharged on Friday or Monday, subject to the availability of an ambulance. However, he was returned to his care home by ambulance on the Saturday. Unfortunately, he was returned back to the hospital later that day in a very poor state, and died the next day. Mr C was of the view that his brother was unreasonably discharged from hospital. He also complained that the board's communication with his family was inadequate.

We fully upheld Mr C's complaints. Our investigation showed that there was little information in Mr A's clinical notes and our medical adviser pointed out that nothing at all was noted about his condition on the day that he was discharged. Accordingly, Mr A may well have not been ready and fit for discharge. Similarly, there was very little record of any discussion with Mr A and his family about his care and treatment.

Recommendations

We recommended that the board:

- apologise for the distress caused to Mr C and his brother at the time of Mr A's discharge from hospital;
- formally apologise to Mr C for their failures in communication;
- stress to their staff the importance of effective communication; and
- further review the quality of the content of their clinical notes as they were not held in accordance with relevant guidelines. They should report back to the Ombudsman about the action they take in this regard.