SPSO decision report

Case: **201700464, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, who is a patient adviser, complained on behalf of her client (Mrs A) about the care and treatment provided to Mrs A at the Royal Infirmary of Edinburgh. Mrs A attended hospital for a planned coronary artery bypass graft (a surgical procedure used to treat coronary heart disease). After a week of in-patient care, medical staff were satisfied that Mrs A had recovered well and was fit to be discharged. Mrs A became unwell shortly following discharge and was re-admitted to a different hospital with an infection. Ms C raised a number of concerns on behalf of Mrs A, who felt that the care provided by the board was inadequate.

Firstly, Ms C complained that staff failed to monitor Mrs A's condition appropriately. We took advice from a cardiac surgery adviser and a nursing adviser. We found that appropriate monitoring did take place during Mrs A's recovery from surgery and that appropriate records of this were maintained. We did not uphold this part of the complaint.

Ms C also raised concern that staff did not listen to and document concerns raised by Mrs A, and did not keep appropriate records of attempted blood tests. We found no evidence in the records that staff did not listen to and document Mrs A's concerns about her health. We were also satisfied that the medical and nursing records were maintained to a reasonable standard. We did not uphold this aspect of the complaint.

Finally, Ms C complained that Mrs A was inappropriately discharged home with an infection. Ms C raised concern that Mrs A was left waiting for a number of hours in the discharge lounge whilst her condition deteriorated and that staff then failed to readmit her to the ward. We found no evidence from the records of the admission that Mrs A had an infection prior to discharge. However, the advice we received highlighted that Mrs A remained in atrial fibrillation (fast irregular heartbeat) on the day of discharge, and that medical staff should have discussed this, and any potential issues that might ensue, with Mrs A prior to discharge. We found no evidence that Mrs A or her husband had reported that her condition was deteriorating whilst she was in the discharge lounge. However, we noted that the board had advised that the senior charge nurse responsible for the discharge lounge had reminded their team that patients who became unwell should be returned to the ward and they were satisfied that the correct procedure would be followed in future.

We were unable to conclude that the complication Mrs A experienced following discharge was as a result of unreasonable care and treatment from staff at the Royal Infirmary of Edinburgh. However, we upheld the complaint and made recommendations because there was no evidence that staff discussed atrial fibrillation with Mrs A prior to discharge.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs A for failing to discuss atrial fibrillation, and what she should do if she became more unwell, with her prior to discharge. The apology should meet the standards set out in the SPSO guidelines

on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Where a patient is in atrial fibrillation, but is otherwise ready for discharge, staff should inform the patient of any complications atrial fibrillation might present, what to do if they become more unwell, and confirm with the patient that they feel ready for discharge. This discussion should be documented in the patient's records.

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.