SPSO decision report

Case: **201903715, Lothian NHS Board - Acute Division**
Sector: Health
Subject: admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

C complained to the board about the decision to move them to another ward and the manner in which they were discharged while they were a patient at Royal Edinburgh Hospital. The board explained that beds are allocated according to clinical need and, due to extreme pressures on hospitals at that particular time, it was felt appropriate to move C to another ward as they were clinically stable. The board said appropriate referrals were made following C's discharge, however, as C did not return to the ward following an overnight pass, they were unable to complete their assessment for home treatment.

We took independent advice from a mental health nurse. We found that it was unavoidable that a patient had to be transferred to another ward due to the pressures on the wards at the time, and that the board followed a reasonable process in selecting C as a suitable candidate. We did not uphold this aspect of the complaint.

However, we found that while appropriate assessment was carried out, the board failed to appropriately manage C's discharge as they did not ensure that Intensive Home Treatment Team supports commenced when C left the hospital. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to ensure that the planned post-discharge inputs by the Intensive Home Treatment Team commenced at the point of discharge. 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:

- The board should take steps to ensure that planned post-discharge inputs by community-based services are followed through at the point of discharge and that said community-based services are timeously notified that discharge has taken place. This is especially important in circumstances where discharge has occurred in irregular circumstances which elevate the risk of the person becoming lost to follow-up.

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.