SPSO decision report

Case: **202203659, Borders NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received during their attendance at A&E. A was seen in A&E as a GP referral to the hospital's medical team. C complained that the medical team failed to recognise the nature and severity of A's condition and their general vulnerability, that they failed to institute an appropriate and timely treatment plan and that there was a failure in record keeping. C also complained that A was discharged home without appropriate medication, without an appropriate discharge letter and without alerting their family and that the board had ignored their Duty of Candour and Ethics Code.

When responding to C's complaint, the board accepted that there were failings in relation to some aspects of A's care and treatment. They apologised that C had not been informed about A being discharged. They explained that this had been shared with relevant staff and that they were making changes to ensure families and carers were contacted prior to the patient being discharged. The board also accepted that A should have been provided with a copy of their discharge letter given their vulnerability. They explained that consideration would be given to printing off discharge letters and giving them to medical patients in certain circumstances. Further, the board accepted that there had been failings in relation to record keeping and in relation to A's medical notes. They indicated that this would be brought to the attention of the relevant staff, would be part of the medical induction and would be discussed in a clinical forum.

We took independent advice from a consultant in emergency medicine. We found that the care and treatment given to A whilst in A&E was reasonable as was the decision to discharge A. There was no evidence to suggest that A's death was linked to any aspect of the care and treatment they received in A&E. However, we found that, in addition to the failings identified by the board that are detailed above, there was no evidence that the board had any process in place to examine this type of case to ascertain whether it met the threshold for a Significant Adverse Event Review (SAER). We upheld the complaint.

We also found that there was a failure by the board to fully address the issues raised when responding to C's complaint and that there were undue delays in updating C and responding to them about their complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failings identified. 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:

- There should be clarity around the board's policy and processes for identifying and initiating a SAER (Significant Adverse Event Review) in cases where a patient has come to series harm (death) shortly after discharge.

In relation to complaints handling, we recommended:

- Complaint responses should consider and respond fully to the issues raised in accordance with The Model Complaints Handling Procedure. They should take into account any relevant national or local guidance in both the investigation and response, and identify and action learning. Complainants should also be kept updated on their complaints in line with the Model Complaints Handling Procedure. Additionally, learning from complaints and the learning should be shared throughout the organisation so that actions and improvements can be implemented to prevent the same issues happening again.

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.