

## SPSO decision report



**Case:** 202304800, Lothian NHS Board  
**Sector:** Health  
**Subject:** Clinical treatment / diagnosis  
**Decision:** upheld, recommendations

### Summary

C complained that the board failed to provide reasonable personal care and treatment to their sibling (A). A was admitted to hospital to initiate and titrate Clozapine (an antipsychotic drug used to treat schizophrenia and other psychotic disorders). A had a history of diabetes and experienced episodes of incontinence which placed A at greater risk of infection. C complained that the discharge letter did not mention a pressure sore which was treated by A's GP upon discharge. This could have resulted in A's Clozapine treatment being temporarily suspended.

We took independent advice from a mental health nurse and from a wound-care specialist nurse. We found that A's feet were examined following concerns raised by C. However, no treatment was prescribed and the doctor's advice about caring for A's feet was not passed on to C. We found that there was no conclusive evidence to determine whether A had a pressure sore or an ulcer which might have impacted on A's Clozapine treatment. We also found that it was reasonable for the board to conclude that the wound A had was not a pressure ulcer. However, the board failed to evidence that relevant assessments relating to pressure ulcer risk and skin inspections were carried out. We also found that there was no person centred care plan in place to identify A's needs in relation to activities of daily living, including personal hygiene. We found that the immediate discharge letter was dated the day after discharge which suggests it was not available to C at the point of discharge, or on the same day, when it should have been. Therefore, we upheld C's complaint.

### Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific personal care and treatment failings. The apology should meet the standards set out in the SPSO guidelines on apology available at [HYPERLINK "http://www.spsso.org.uk/information-leaflets"](http://www.spsso.org.uk/information-leaflets) [www.spsso.org.uk/information-leaflets](http://www.spsso.org.uk/information-leaflets) .

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

- Patients should be appropriately assessed and treated by staff. Where clinical needs are identified via assessment, corresponding interventions should be planned and initiated to address the situation and prevent complications arising. Care should be provided in line with the assessments carried out and in a timely manner. Records about a patient's care and treatment and decisions made should be clearly and accurately documented and accord with the relevant professional standards and guidelines and reflect a person-centred approach. Patient's records should include clear details explaining why a decision about care and treatment has been made, and show that this has been communicated appropriately.
- The board should ensure that immediate discharge information reaches the GP as soon as is practicable in every case, ideally on the day of discharge, in order that GPs receive essential information that enables continuity of care.

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.