SPSO decision report

Case: **201911193, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about medical treatment provided to their late spouse (A) following their transfer to a community hospital from a regional hospital, where A had been treated for a heart attack. C raised concern about several aspects of the care provided, including the frequency of medical reviews and communication with A's family about their condition.

We took independent advice from a consultant in care of the elderly. We found that A had been suffering from hypernatraemia (high sodium levels in the blood) at the time of their hospital transfer and that this condition required careful monitoring of A's fluid balance, planned daily medical reviews and frequent blood tests. Despite this, we noted that A had not been medically reviewed daily at the community hospital. Weekend medical cover was provided by an out-of-hours GP service, which would only attend if required. Given this, we found that the decision to transfer A to this hospital had been unreasonable.

We also found that the frequency of blood tests carried out was insufficient and that no medical review was carried out despite rising sodium levels in A's blood. We noted that A had not received intravenous fluids over a period of three days despite their oral intake documented as poor and that, when intravenous fluids had been administered, the particular type of fluids given had been inappropriate to treat hypernatraemia and may have worsened A's condition. However, it was not possible to say how this might have affected A's outcome given the generally poor prognosis associated with the condition and A's significant comorbidities. For these reasons, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in A's treatment. 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:

- Robust handover procedures should be in place so that staff taking over responsibility for patient care following transfer to community hospitals are clear about ongoing treatment and review requirements.
- Patients should only be transferred to community hospitals when it is clear that the required level of care can safely be provided following transfer.
- In patients presenting with conditions causing electrolyte imbalances, such as hypernatraemia, medical and nursing staff should be clear on (i) the frequency and the means by which such patients require to be reviewed including the frequency of blood tests and; (ii) the appropriate intravenous fluids to be used to manage such conditions.

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.