SPSO decision report

Case: **202300133, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that their late partner (A)'s discharge from hospital was unreasonable. A was admitted to hospital with pneumonia and was discharged after ten days. Less than two weeks after discharge, A collapsed and was readmitted to hospital. A died a few days later. C questioned whether A had been fit for discharge. They also raised concerns about not receiving adequate education on the new medications that A was prescribed on discharge.

The board noted that A's infection had improved with antibiotic therapy and that they had been stable and well enough for discharge home. They explained the rationale for the medications that A had been prescribed and apologised that medical staff did not have a better discussion with them at the time of A's discharge.

We took independent advice from a consultant in acute and general medicine. We found that A's oxygen levels had been stable and their discharge was clinically reasonable. However, we noted that A's sodium level had been low during their admission but had improved on discharge. We found that no follow-up arrangements were made to ensure that A's sodium level was continuing to improve after their discharge. The working diagnosis on A's readmission was that they had had a seizure due to low sodium which led to hypoxia (deficiency in the amount of oxygen reaching the tissues) and cardiac arrest. It is possible that the fall in A's sodium level could have been detected had there been follow-up to re-check this. Therefore, we upheld C's complaint.

We also noted a discrepancy between the working diagnosis on A's re-admission and the recorded cause of death on the death certificate. This was not identified by the board. Therefore, C was not provided with a coherent narrative of events surrounding A's death and we made a recommendation to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this report. 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 robust discharge systems and processes in place, ensuring appropriate communication with patients and carers, and adequate detail in discharge documentation.
- Patients who are discharged with moderately low sodium levels, should be followed up to check that improvement is maintained. There should be clear guidance in place around this, to ensure it happens where indicated.
- The death certification process should be accurate and consistent with the clinical notes.

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.