SPSO decision report

Case: **201401410, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the care and treatment her late mother (Mrs A) had received from the board. Mrs A had taken lithium medication for many years for her bipolar disorder. This medication was changed in November 2012 and then changed back to lithium around six months later. Ms C was unhappy with these decisions as she felt they caused her mother to suffer from lithium poisoning, which caused Mrs A to attend Lorn and Islands Hospital. She was transferred to Argyll and Bute Hospital and then was moved between the hospitals again. Mrs A died within two months of her initial admission and Ms C was unhappy with the care her mother had received throughout this period.

We considered whether Mrs A's treatment was reasonable in the circumstances at the time. We did not use the benefit of hindsight in making that decision and we took independent medical advice from a psychiatrist and a geriatrician (a doctor specialising in medical care for the elderly). Their advice confirmed that the original decision to change Mrs A's medication was reasonable in the circumstances, as was deciding to reintroduce lithium. In light of this clear advice, we did not uphold Ms C's first two complaints.

Our medical advice was that Mrs A appeared to have been suffering from lithium toxicity when she first attended Lorn & Islands Hospital, and that it was unreasonable to have transferred her to Argyll and Bute Hospital at that time. Mrs A was then transferred back to Lorn and Islands Hospital for a time before returning to Argyll and Bute Hospital. Our medical advice was that the potential severity of Mrs A's lithium toxicity appeared not to have been recognised during this time and her condition was not investigated sufficiently. We upheld Ms C's complaints about these admissions. However, in terms of Mrs A's final admission to Lorn and Islands Hospital, our medical advice was that care and treatment was by that point reasonable, so we did not uphold Ms C's complaint about that.

Recommendations

We recommended that the board:

- apologise to Ms C for the failings identified in our investigation;
- remind relevant staff (including in A&E) of the possibility for lithium toxicity to occur in older patients at levels within the standard range of prescribed dosage;
- consider whether a shared protocol between Lorn and Islands Hospital and Argyll and Bute Hospital would be appropriate for management of lithium toxicity; and
- raise the medical advice we received about restarting lithium medication at the relevant psychiatrist's appraisal for reflection.