SPSO decision report

Case: **201402395, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained to us about the care and treatment his father (Mr A) received at the Southern General Hospital. Mr A was admitted to hospital following a failed catheter change with a medical history including angina, heart attack and chronic kidney disease. A urinary tract infection was suspected and Mr A's kidneys were also found to be working abnormally. Treatment with intravenous (IV) fluids (administered directly into the veins) and antibiotics was started. Due to Mr A's cardiac history, he was prescribed IV fluids at a reduced rate. Mr A became breathless and was treated for fluid overload. Mr A's condition deteriorated and after some delay he was transferred to the Coronary Care Unit (CCU). Mr A died some weeks later.

Mr C complained about Mr A's fluid intake and that there was an unreasonable delay in transferring him to the CCU. The board advised that both Mr A's heart and kidney conditions had been considered but that it can be difficult to balance treatment in these situations. They provided an apology that no parameters or guidance had been given around oral fluid intake. In relation to delay, the board advised that there had been a breakdown in communication between staff. They assured Mr C that their processes had been reviewed to ensure that this would not happen in future.

After taking independent advice from one of our medical advisers, who is a consultant physician, we found that Mr A's treatment in relation to fluids was consistent with established good practice and we did not uphold this part of the complaint. However, the second element of Mr C's complaint was upheld as our adviser was critical of the delays in referring Mr A to the CCU and we found that this should have taken place at an earlier stage than the board identified.

Recommendations

We recommended that the board:

- make staff aware of the need to consider whether parameters and guidance for oral fluid intake may be required in specific cases;
- apologise to Mr C for the delay in referring Mr A for a cardiology assessment;
- draw the findings of this investigation to the attention of appropriate staff; and
- provide full details of their referral escalation process and confirm how awareness of this has been raised with staff.