SPSO decision report

Case: **201605478, Western Isles NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Decision: not upheld, recommendations

Summary

Ms C complained that there had been a delay in transferring her mother (Mrs A) from Uist and Barra Hospital to Western Isles Hospital. Mrs A had a stroke and after the emergency services were called, she was taken by ambulance to Uist and Barra Hospital. The Scottish Ambulance Service had been called prior to her admission, and a plane to transfer Mrs A to Western Isles Hospital then left the mainland. Because of adverse weather, the plane was unable to land at the nearby airport and as a result, the transfer could not take place that evening.

In response to Ms C's complaint, the board explained that there is a four and a half hour window to assess a patient who is suspected of having had a stroke and judge the potential benefit of thrombolysis (clot busting) treatment. The board said that the delay in transfer was caused by bad weather, which meant that the cut-off time for potential treatment with thrombolysis medication had passed.

We took independent advice from a specialist in emergency medicine. They did not find evidence of a delay in contacting the ambulance service regarding air transfer and said that the decision whether it was safe to fly or not, and the assessment of the likelihood of being able to land, rested with the aircraft captain. The adviser said that once it became apparent that the plane was unable to land, the opportunity to get Mrs A to Western Isles Hospital, complete a CT scan and consider the possibility of thrombolysis in under four and a half hours had passed. Whilst the adviser considered that the care surrounding the transfer was reasonable, they considered that the doctor's records should have been more detailed. We did not uphold this complaint, but we made a recommendation.

Ms C also raised concern about the communication during the transfer process. We found that the board had apologised for any upset and distress Ms C's family experienced. Having considered the evidence available, the adviser concluded that the communication was reasonable. We did not uphold this complaint.

Recommendations

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

- Medical staff should maintain sufficiently detailed medical records in accordance with General Medical Council Good Medical Practice guidance.

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.