SPSO decision report

Case: **201706000, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment her partner (Mr A) received during his admission to Queen Elizabeth University Hospital. After Mr A had been discharged he became unwell and was readmitted the following day. On the day of Mr A's readmission he was transferred to another hospital for specialist care where he died two days later.

Ms C raised concerns about the administration of an iron infusion which led to Mr A receiving an overdose of iron. Ms C questioned whether this may have contributed to Mr A's death and wondered if a blood transfusion would have been a more appropriate treatment. Ms C also questioned Mr A's discharge and whether, if he had been in hospital rather than at home when he became unwell, this would have affected his outcome.

The board had acknowledged that although the total dose of iron calculated for Mr A was accurate, he received a dose of iron higher that the recommended dose for a single infusion. They said that Mr A was monitored appropriately in case of an infusion reaction and his observations were stable on his discharge. The board also acknowledged there was an error in Mr A's medication on his discharge.

We took independent advice from a consultant in acute medicine. We found that all appropriate investigations and interventions were undertaken and it was reasonable to have discharged Mr A with the follow-up plans the board had set out. We also noted that Mr A was well enough for these to be arranged on an out-patient basis.

In relation to the iron infusion, we found that it was reasonable to have given this to Mr A to treat his anaemia and that this was more appropriate than a blood transfusion. While we could not exclude it absolutely, we considered that there was no evidence to suggest that the larger dose of iron that Mr A received had contributed to his death. We noted that Mr A's' sudden deterioration appeared to have been due to a rare cardiac problem that was unpredictable. However, Mr A did receive an overdose of iron and there was an error in his medication on discharge. Therefore, we upheld this aspect of Ms C's complaint and asked the board to provide evidence of action they said they had taken.

Ms C also complained about the nursing care Mr A received. We took independent advice from a nursing adviser. We found that the nursing care was reasonable and appropriate. Therefore, we did not uphold this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C and her family for Mr A having received too high a dose of intravenous iron and the error in Mr A's medication on his discharge. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.