SPSO decision report

Case: **201507538, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr A was referred to hospital by an out-of-hours GP after feeling increasingly unwell. On admission to Vale of Leven Hospital, Mr A was diagnosed as suffering from sepsis (a blood infection) and received treatment for this. Mr A's condition deteriorated over the following days and he was transferred to Royal Alexandra Hospital. Mr A's wife (Mrs C) complained that staff at Vale of Leven Hospital did not identify sepsis quickly enough and that Mr A was not transferred to Royal Alexandra Hospital soon enough.

We took independent advice from a consultant in respiratory medicine. The adviser confirmed that sepsis was identified immediately and noted that Mr A was treated appropriately, in line with the board's sepsis protocol. While the adviser noted that medical records should have shown greater detail about plans to transfer Mr A, they were satisfied that there was no inappropriate delay in transferring him. However, the adviser noted that the board should consider introducing a more robust set of criteria for the transfer of seriously ill patients.

After Mr A was transferred to Royal Alexandra Hospital, he was treated in the high dependency unit, where he died. Mrs C expressed concern that her husband did not receive treatment in the intensive therapy unit (ITU) and was not referred for dialysis. The adviser considered that Mr A received appropriate treatment and noted that the medical staff involved in Mr A's care decided that he was not suitable for escalation to ITU or referral for dialysis because of his multiple health conditions and deteriorating health.

While we did not uphold Mrs C's complaints, we made a recommendation to take into account the adviser's comments about the transfer between hospitals. We also noted that the board had acknowledged communication failings and had advised Mrs C that a new standard process template would be introduced for staff to record communication with families of patients. We accordingly made a further recommendation to confirm that this learning had been implemented.

Recommendations

We recommended that the board:

- feed back to relevant staff the adviser's comments regarding record-keeping and introducing more robust criteria for transferring seriously ill patients; and
- provide us with a copy of the new process template.