SPSO decision report

Case: **201204447, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C, who is an advice worker, complained on behalf of Ms A about the care and treatment that her late father (Mr A) received during the last three days of his life, and about how her complaint about this was handled.

Mr A's GP referred him to a medical admissions ward. Mr A went straight to the ward, and was asked to wait in the day room. He remained there for four hours before he was seen by a doctor, given a bed, and treatment was started. Information on his referral showed he was very unwell, indicating that he had pneumonia and kidney failure. Mr A was treated with antibiotics, and was transferred to a different ward the next day.

For the next two days Mr A's condition remained stable and his vital signs (pulse, blood pressure, temperature and oxygen levels) were taken roughly every four hours. In the evening of the second day Mr A became increasingly unwell. This was noted by staff, who increased the frequency of checks on his condition to hourly. A doctor reviewed Mr A and identified that he needed more oxygen. He arranged for a special blood test to check oxygen levels in Mr A's blood, and asked for a repeat of this test two hours later. There are references to the results of both these tests in the clinical notes, but only the first test was noted in detail, and the second set of results were not identified by the board in their response to Ms C's first complaint. As a result, Ms C was mis-informed about these tests. This was because the test results were held on record electronically, and were not added to the clinical file. Despite further assistance with his breathing, Mr A died the following day.

We obtained independent advice on this complaint from one of our medical advisers. We upheld the complaint about the delay in getting a bed, as his advice indicated that Mr A should not have been kept waiting in the day room of the admissions ward for such a long time, and that this created risks for patient care. We did not uphold Ms C's complaints about vital sign checks and blood tests. Our adviser reviewed all the checks made on Mr A's vital signs and found them to be appropriate. He also reviewed blood test results from shortly before Mr A's death, and found that they were appropriate, but criticised the way in which the board held these records and reported them to Ms C. On complaints handling, Ms C had said that she did not get a final response until more than eight months after she first complained. While we found that further issues were raised at a meeting three months after the original complaint, we found there was still a substantial delay in providing a final response, and we upheld this complaint.

Recommendations

We recommended that the board:

- raise this case at the next meeting of its clinical directorate, specifically considering the risks involved in using day rooms as waiting rooms, and considers the introduction of mechanisms to avoid these risks;
- give careful consideration to the implementation of the early identification and treatment of sepsis (blood infection), using the 'Sepsis Six' initiative;
- remind doctors of the need to record all investigation results in the case notes immediately they are available, especially for tests such as arterial blood gases, where a formal laboratory result may not be

printed;

- ensure that all electronic records are reviewed during complaints handling and are passed to the SPSO on request; and
- apologise to Mr A’s family for the failures identified in our investigation.
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