SPSO decision report

Case: **201300540, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C's daughter (Ms A) was admitted to Forth Valley Royal Hospital after taking an overdose of a mixture of medications, including venlafaxine (an anti-depressant) and propanolol (a beta blocker, used to treat conditions such as heart problems, blood pressure and anxiety), which are absorbed into the system slowly. She had called an ambulance herself and was taken to the emergency department, where she was seen immediately by a staff nurse. She was assessed before being seen by a trainee doctor. Ms A was groggy and her blood pressure was low. She was treated with intravenous fluids (fluids put directly into a vein). Blood tests and an electrocardiograph (a test that records the electrical activity of the heart) were also arranged. Over the following hours, Ms A's blood pressure remained low. Around seven hours after being admitted she began to have seizures and breathing difficulties. Her condition deteriorated further and the intensive care unit was asked to review her. Shortly afterwards, Ms A's heart stopped. Attempts were made to resuscitate her and she was treated with glucagon (medication used to increase blood sugar levels, which can be used in the treatment of propanolol overdose). This failed to improve her condition, however, and she died.

Mrs C complained that staff did not provide glucagon until it was too late. She considered that, had this medication been provided earlier, Ms A might have survived. She also complained about the board's record-keeping. The board said in response to her complaint that glucagon is not the first line of treatment for propanolol overdose and, as Ms A had been responding to intravenous fluids, it was not considered a necessary treatment for her at the time.

After taking advice on this complaint from one of our medical advisers, who is a consultant in emergency medicine, we upheld both of Mrs C's complaints. The adviser reviewed Ms A's medical records, and said that she had not been responding adequately to the intravenous fluids and that glucagon should have been considered far sooner. Although we found evidence that clinical staff consulted TOXBASE (the national poisons information database) we were critical that there was a delay in doing so. We found that Ms A's overdose would have been treated differently had the guidance been consulted and followed earlier in her admission. We were also critical of the board's record-keeping. Important information about medication had been lost from Ms A's records and there was no documented record there of staff having consulted TOXBASE.

Recommendations

We recommended that the board:

- provide a copy of our decision letter to the doctor to ensure that he is fully aware of the outcome of our investigation and discuss any learning points with him at his next appraisal;
- apologise for the lack of appropriate record-keeping in this case; and
- remind all nursing and medical staff of the importance of maintaining accurate contemporaneous records.