SPSO decision report

Case: **201303576, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C raised a number of concerns regarding the care his father (Mr A) received in Ninewells Hospital. Mr A had existing diagnoses of lung cancer and diabetes when he was admitted to the hospital with an infection. Mr C said that his father's initial treatment was excellent, but when he was later transferred to another ward, the standard of care dropped. Mr C raised a number of concerns regarding the standard of clinical and nursing care on that ward, where Mr A died three days after his admission. Mr C complained that family members were not made aware of Mr A's deterioration. He also complained that staff failed to adequately manage Mr A's diabetes and food and fluid intake. Mr C believed his father's death was caused by a failure to identify and treat hypoglycaemic shock (severely diminished blood sugar levels), rather than as a result of his underlying cancer and infection as the board suggested.

After taking independent advice from a nursing adviser and a medical adviser, we upheld Mr C's complaints. We were satisfied that Mr A's condition was appropriately assessed upon admission and that the proposed treatment with intravenous antibiotics was appropriate. That said, we were concerned by the ward staff's management of his blood glucose levels. Mr A's diabetes was clearly recorded when he was admitted to hospital, but we found evidence to suggest that the ward was not equipped to react to significant changes to his blood glucose levels, and the board's own procedure for managing hypoglycaemia was not followed. We also found that medication was omitted from the list of existing medications for Mr A and that this likely contributed to his hypoglycaemic episode. However, we accepted medical advice that the hypoglycaemic episode was ultimately dealt with appropriately and that there was no evidence to suggest that this contributed to the decline in Mr A's condition, or to his death. We were, however, critical of the board for failing to contact the family when Mr A deteriorated, and for their poor handling of Mr C's complaint.

Recommendations

We recommended that the board:

- provide us with an update on their plans for electronic palliative care summaries;
- conduct an audit of the ward staff's compliance with their obligations in terms of maintaining full, accurate medical records;
- provide us with an update on all of the actions taken to improve their performance as a result of Mr C's complaint;
- conduct a review of their approach to catering for in-patients with diabetes;
- share our decision with the clinical staff involved in Mr A's care; and
- apologise to Mr C and his family for the issues our investigation highlighted.