SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201305720, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his father (Mr A) by the board.

Mr A, who had a previous medical history which included Type II Diabetes, was admitted to Wishaw General Hospital as a day-patient for a gastroscopy (internal inspection of the stomach by way of a tube fitted with a camera). On admission Mr A's blood glucose level (a measure of how the body is able to process sugars in food and drink) was very low and staff gave him medication to increase it. Two subsequent readings were also low and Mr A was given a further dose of medication, followed by insulin (a drug used by diabetics to help them process sugars) delivered intravenously (directly into the vein). His blood glucose level eventually reached a reading considered to be within an acceptable range and the procedure went ahead. Following the procedure, Mr A was discharged home.

Three days after his discharge, Mr A collapsed at home and his blood glucose level was again very low. Mr A was taken by ambulance to Monklands Hospital where he was admitted to the Emergency Receiving Unit and in the early hours of the next day, which was a Friday, transferred to a ward. He then underwent some tests and investigations and his family were told that the team caring for Mr A were considering operating on him for abdominal problems. Later that day, the family were told that the surgeon was not going to operate as he did not work weekends; they were told that the surgeon would review Mr A again on the Monday and decide if he would operate. Over the weekend Mr A's condition deteriorated and his family found it difficult to obtain information from staff about Mr A's condition and treatment. Mr A died on the Monday morning without having had surgery.

Our investigation included taking independent advice from two of our advisers, a consultant geriatrician (specialising in the care of older people), and a nurse. In relation to Mr A's first admission to hospital, we found that although the board had stated in their responses to Mr C and to us that their guidelines on diabetic patients undergoing surgical procedures had been followed, this was not evidenced in Mr A's medical notes. We also found that despite the guideline stating that a patient's blood glucose level should be checked one or two times an hour, only one reading was taken after the procedure and before Mr A was discharged.

We also found that although Mr A had been advised to speak to his GP about his low blood glucose level, no advice on how to manage his condition for the rest of the day, or who to contact for advice, was given. We also found that although the Board's guideline gave advice on how to treat patients before a surgical procedure, it did not give guidance on how to treat patients after a procedure. Mr A was also not given anything to eat or drink before he was discharged to ensure that he was able to eat and drink normally, which is recommended by the Diabetes Association (a UK-wide organisation who provide advice to patients and carers and are often involved in preparing NHS guidance). Both advisers agreed that Mr A should have been kept in hospital until his blood glucose level stabilised and he was able to eat and drink normally.

In relation to the second admission to hospital, we found no evidence to link Mr A's earlier discharge from Wishaw General Hospital directly with his subsequent collapse and death. Our geriatrician adviser said that the

assessment, investigation and treatment of Mr A's condition was reasonable and that contrary to what the family were apparently told, surgical intervention, although an option considered by the team, was never thought to be realistic. This was because it had been clear to the team caring for Mr A at an early stage that he was very frail and surgery would have been likely to cause his deterioration and death. However, we found that the team failed to convey this information to the family. Our nursing adviser also agreed that communication was poor and that there was only one record in the nursing notes that a staff nurse intended to speak with Mr A's daughter when she came to visit the day before Mr A died, but there was no record of this discussion ever having taken place.

We were also critical of the Board's response to Mr C's complaint. Although the board offered apologies for failings identified during the internal investigation, it was done in such a way as to devalue the apology.

Recommendations

We recommended that the board:

- review their guideline on diabetic patients undergoing elective procedures to ensure that it provides appropriate support and guidance to staff in both pre-operative and post-operative situations;
- ensure that staff involved in this complaint are made aware of the findings of our investigation;
- ensure that staff involved in this complaint are reminded of the importance of accurate and appropriate record-keeping;
- remind staff involved in this complaint about the importance of good communication with patients and their loved ones, in particular where the prognosis is poor;
- ensure that staff involved in complaints handling are made aware of the importance of making appropriate apologies for failings identified during internal investigations; and
- issue a written apology for the failings identified during this investigation.