SPSO decision report

Case: **201608368, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Miss C complained that staff at Queen Elizabeth University Hospital failed to provide her late mother (Mrs A) with appropriate medical treatment in view of her presenting symptoms. Miss C raised a number of concerns about Mrs A's treatment following her arrival at hospital, when she was thought to have new onset confusion due to a possible urinary tract infection or a stroke. Mrs A died six days later.

We took independent medical advice from a consultant in emergency medicine and a consultant neurosurgeon. We found that the emergency department staff failed to consider Mrs A's current medication during their assessment of her and failed to record her Glasgow coma score (detailing the level of consciousness in a patient), pupil response and blood sugar level. They also failed to record their decision and actions following receipt of Mrs A's blood clotting test and did not carry out a scan as part of the emergency department's assessment and evaluation of Mrs A. We found that there was a delay in the administration of Mrs A's Beriplex (a drug to help blood clot) and in a second scan being carried out. We also noted that there were discrepancies between the findings of the board's internal report on Miss C's complaint and the board's response to Miss C, resulting in her not receiving adequate explanations of what happened in Mrs A's case. Therefore, we upheld Miss C's complaint. However, we noted that the outcome in Mrs A's case was unavoidable.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C and her family for failing to carry out an appropriate assessment of Mrs A; failing to note relevant decisions and actions; the delay in administering Beriplex; the delay in carrying out scans; and failing to provide Miss C with an adequate response to her complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- In cases such as this, patient's existing medications should be considered in the emergency department; doctors in the emergency department should record key decisions/actions; an assessment and record should be made of patient's Glasgow coma score, pupil response and blood sufar level; and consideration given to carrying out a scan as part of the emergency department's assessment and evaluation of the patient.
- Medications should be administered in a timely manner.
- Patient deterioration should be appropriately recognised in circumstances such as this, and scans carried out in a timely manner.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.