SPSO decision report

Case: **201709017, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mr B) about the care and treatment provided to Mr B's late wife (Mrs A) when she was an in-patient at Queen Elizabeth University Hospital.

We took independent advice from a consultant physician. We found that, on one occasion, Mrs A was not given her dose of insulin, and that the reasons for this were not clear. We found that this resulted in Mrs A developing diabetic ketoacidosis (DKA – a potentially life threatening complication of diabetes, which happens when the body starts running out of insulin), and that there was a delay in the DKA protocol being commenced. We also found that there was a failure in communication between medical and nursing staff around the plan to measure Mrs A's blood pressure. There were also inconsistencies in recording Mrs A's intolerance to certain medication. We found that Mrs A was prescribed a medication which she had an intolerance to without the rationale for this decision being recorded.

We upheld Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr B for failing to provide reasonable care and treatment to Mrs A with regards to administration of insulin, the delay in DKA protocol being commenced and the poor management of medication. 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:

- Staff should be aware of the importance of insulin in patients with Type 1 diabetes. Diabetes medication should be given when required, and reasons for not doing this should be clearly documented.
- The DKA protocol should be commenced within the appropriate timeframe wherever possible.
- There should be one clear way for communicating tasks and results between staff groups. This should include a way for medical staff to remember what investigations and instructions they are awaiting the results of.
- Allergy/intolerance information should be recorded consistently.
- If medication is to be prescribed despite a recorded allergy/intolerance, the reasons for this should be documented.