SPSO decision report

Case: **201801842, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained that the board did not provide reasonable care and treatment to her late brother (Mr A) at Inverclyde Royal Hospital and that the board's staff had failed to communicate adequately with her about Mr A. Mr A, who was terminally ill, died in the hospital days after his admission.

We took independent advice from a consultant in acute medicine and from a senior nurse. We found that there were failings in the care provided to Mr A when he was in A&E. There were failures to recognise and respond to Mr A's high blood glucose levels, to perform an electrocardiogram (ECG) as part of initial investigations on admission and to address his pain. We noted the board has acknowledged the failing to address Mr A's pain needs and has taken appropriate steps to improve this area of care.

We found that when Mr A was transferred to another ward, there was a failure to recognise and treat sepsis (blood infection) early enough or adequately for Mr A as a patient with an impaired immune system. We noted, in particular, that Mr A's profound and rapid deterioration may have been avoided with earlier, more aggressive input. Finally, there were a number of record-keeping failures, which meant it was unclear to know exactly what had happened with respect to Mr A's deterioration and the ward move. Therefore, we considered that the board did not provide reasonable clinical treatment to Mr A and upheld this aspect of the complaint.

In relation to Mr A's nursing care during his assessment in A&E, we identified failures to check Mr A's blood glucose levels and to address his pain relief while he was there. The nursing care received after Mr A's ward move was found to be of a reasonable standard. In view of the failings in relation to the nursing assessment in A&E, on balance, we considered that the board did not provide reasonable nursing care to Mr A and upheld this aspect of the complaint.

We noted that the board acknowledged that there were shortcomings in communication, and have offered an apology to Mrs C.

The principal issue our investigation identified was that there was a failure by haematologists (medical specialists of blood and its disorders) to discuss the rapid progression of Mr A's leukaemia with him and his family and that he would be for palliation (care to make you more comfortable, not cure) only. This contributed to the shock Mr A's deterioration had on his family. Therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C and her family for a failure to check blood glucose and carry out an electrocardiogram test; a failure to recognise and treat sepsis; failures in record-keeping; and a failure to discuss the rapid progression of the leukaemia. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets .

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

- Patients with diabetes should have their blood glucose checked on admission and regularly during their in-patient stay. Patients presenting with an abnormal heart rate should have an ECG on admission (as part of initial investigations). Patients who are in pain should have their pain needs addressed prior to transfer out of A&E. Patients who are immunosuppressed should be reviewed for sepsis early and frequently and have appropriate therapy commenced. Deteriorating patients should not be transferred between wards unless the move is intended to improve the management of that patient's deterioration/underlying condition. Staff should maintain reasonable medical records, consistent with General Medical Council guidance. Time and the band of nurse should be documented in the patient's records. Staff should communicate with a patient and relatives where it is clear that the patient is deteriorating and only palliative care is to be provided.

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.