SPSO decision report

Case: **201802929, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained that the board failed to provide reasonable care and treatment to her friend (Mr A) at the Queen Elizabeth University Hospital, before his death. Mr A had been admitted to the hospital due to exacerbation of his asthma and flu. After a few days, his condition deteriorated. He died six days after being admitted to hospital.

We took independent advice from a consultant in acute medicine. We found that:

• more information about Mr A's alcohol intake should have been obtained;

• if the alcohol liaison nurse's entry had been read or actioned, his diazepam (a tranquillizingmuscle-relaxant drug used to relieve anxiety) prescription would probably have been cancelled;

• there was a failure to respond promptly to his deterioration;

• it was unreasonable that he was seen by a junior grade doctor when he was clearly very unwell;

• prescribing sedation and planning to review him four hours later was not an appropriate response to a patient who was deteriorating and showing evidence of lower oxygen levels than normal;

• he should have been seen more promptly after his initial deterioration by a more senior doctor;

• he should have had important investigations such as X-rays and blood tests as soon as he was settled enough to comply with them;

• it was unreasonable that he was not on a fluid balance chart daily from admission;

• he should have been assessed more thoroughly for potential sepsis (blood infection) when he deteriorated; and

• what was written down in the notes did not seem to be have been read by other members of the team.

Therefore, we upheld this aspect of Ms C's complaint.

Ms C also complained about the lack of communication from staff about Mr A's deterioration. We found that staff should have contacted her earlier than they did. The failure to do so substantiated the concern that staff did not recognise or respond to Mr A's deterioration appropriately and that they did not recognise how unwell he was. We upheld this aspect of the complaint.

Finally, Ms C complained that the board failed to accept that Mr A had sepsis. She considered that sepsis should have been recorded on his death certificate. We found that the tests that were carried out at that time showed

serious infection but did not indicate sepsis. Based on the information available, it was reasonable that sepsis was not recorded on Mr A’s death certificate. Therefore, we did not uphold this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

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

- Clinical entries in medical notes should be read and acted on. If a decision is taken not to act on the entry, this should be noted. Caution needs to be exercised when sedating patients with respiratory failure.
- Patients who have an elevated Early Warning score should be reviewed regularly, particularly if no definitive management plan has been established. The appropriate tests and investigations should also be carried out, including the tests for sepsis.
- Medical and nursing staff responsible for the care and treatment of a patient should ensure that they read the relevant notes.