SPSO decision report

Case: **201904254, Forth Valley NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained on behalf of her husband (Mr A) about the treatment he received when he attended A&E of Forth Valley Royal Hospital due to experiencing pain that had started in his neck and had travelled to his hands. In particular, Mrs C was concerned that there was a delay in diagnosing Mr A with sepsis (blood infection).

Mr A had been examined and then discharged to the care of his GP on the same day. We found that there was no evidence that Mr A had sepsis at that time. A diagnosis of sepsis requires a source of infection and evidence of abnormal physiology; however, the urinalysis showed no signs of infection. Therefore, there was no failure to identify sepsis at this stage. The following morning Mr A was taken by ambulance to hospital and was admitted again. Mr A was diagnosed with a urinary tract infection and then developed sepsis. While we did not consider there to be a failure to diagnose sepsis, Mr A is a diabetic and we found that there was a failure to carry out a bedside blood glucose finger prick test during his first attendence at hospital given glucose was found in Mr A's urine following the urinalysis. On this basis, we considered that the board failed to provide Mr A with reasonable care and treatment. Therefore, we upheld this complaint.

Mrs C also complained about the response she received to her complaint regarding the content of the discharge letter to Mr A. The response to the complaint correctly stated what was in A&E notes (the GP was to consider referring Mr A to neurology (the branch of medicine concerned with the diagnosis and treatment of disorders of the nervous system)), but the discharge letter to Mr A's GP did not mention this. We upheld the complaint on the basis that the discharge letter should have contained this information and the complaint response should have identified this discrepancy. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for (a) an unreasonable failure to carry out a bedside finger prick blood glucose test; (b) an unreasonable failure to include within the discharge letter to Mr A's GP information about a possible GP referral to neurology; and (c) a failure to ensure the response to the complaint correctly reflected what was in the discharge letter to the GP regarding a neurology referral. 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:

- To ensure clinical staff are aware of the circumstances in which a bedside fingerprick blood glucose test should be carried out.
- To ensure clinical staff include relevant information in discharge correspondence to GPs.

In relation to complaints handling, we recommended:

- To ensure the facts of an investigation are correctly reported to a complainant.

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.