SPSO decision report

Case: **202104299, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A). A underwent surgery to treat hypertension (high blood pressure). A few days later, A's condition deteriorated with the cause thought to be sepsis (a life-threatening reaction to an infection). A's condition worsened further and they were transferred to the High Dependency Unit (HDU). A died later that day.

C complained that there had been a failure to administer antibiotics that A had required and that there had been unreasonable delays in transferring A to the HDU, which resulted in A being left in a state of distress. C also complained about the conclusions that the board had reached about A's care following a Significant Clinical Investigation (SCI).

The board stated that A had been monitored every 30 minutes and that there had been no delay in providing antibiotics to A. The board accepted that there had been a failure in communication between nursing and porter staff which had led to a delay in A being transferred to HDU. However, the board considered that this would not have resulted in a different outcome although it was acknowledged that this would have reduced A's family's distress.

We took independent clinical advice from an acute medicine and nursing adviser. We found that there were a number of failings in the care provided to A following the initial deterioration in their condition. This included failure to initiate tests to identify sepsis, failure to commence intravenous fluids (medical technique that administers fluids, medications and nutrients directly into a person's vein) and failure to perform necessary blood tests, as had been outlined by A's consultant. There was also no evidence that A had received antibiotics nor had been monitored with the frequency stated by the board. We also found that nursing staff failed to escalate a further deterioration in A's deterioration and that there had been an unreasonable delay of around two hours in transferring A to HDU. In addition, we found that several aspects of the nursing records fell below the professional standards required by the Nursing and Midwifery Council and that the board's SCI had failed to identify areas of learning arising from this case. For these reasons, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Significant Clinical Incident reports should:
- (i) be reflective and learning processes that consider events against relevant standards and guidelines,
- (ii) ensure failings are identified and any appropriate learning and practice improvements are made and,

- (iii) be in line with Learning from adverse events through reporting and review - A national framework for Scotland: December 2019 (healthcareimprovementscotland.org)
- Treatment plans should be comprehensive and document the working diagnosis. Patients should receive the treatment plan recorded in the medical records following consultant review unless there is a change of plan. If this happens this should be clearly recorded.
- Where the cause of a patient’s deterioration is suspected to be due to sepsis, the sepsis bundle should be initiated.
- Patients should be assessed, in accordance with the NEWS guidance relative to the patient's NEWS score. Where there is deviation from this, this should be recorded. In addition, patients who are assessed to have a NEWS score of five or greater should be escalated urgently for further assessment in line with NEWS guidance. NEWS scoring documentation should be fully completed and recorded.
- For patients where there is the presence of red flags indicating an ECG, this should be acted on without delay.
- Where blood tests are requested in order to investigate a deterioration in patient's condition they should be processed and reviewed as soon as possible. Patients should receive the appropriate blood tests to adequately assess the cause of deterioration and any tests that have been specifically requested by clinicians.
- Where a deteriorating patient requires to be transferred from the ward for more intensive treatment, the transfer should take place as soon as possible and without undue delay. A record should also be made showing which member of staff has requested the transfer, the time at which the transfer was requested and to whom the request was made.
- Nursing records should be documented in real time, as far as it is reasonably practicable to do so. They should also include a clear timeline of events, the actions taken by nursing staff (including in what order) and details of all communication with relatives and other healthcare professionals.

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.