SPSO decision report

Case: **201603660, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C, who works for an advocacy and support agency, complained on behalf of his client (Mr A) about the care and treatment that was provided to his late wife (Mrs A) at Queen Elizabeth University Hospital. Mrs A had been referred to the board by her GP after she was diagnosed with Cushing's syndrome (a collection of symptoms caused by high levels of the cortisol hormone in the body). Mrs A attended the hospital and remained there until she died two months later.

In investigating Mr C's complaints, we took independent advice from a consultant in acute medicine. On the basis of the advice we received, we upheld Mr C's complaint that the board failed to provide reasonable care and treatment for Mrs A during her admission to the hospital. The advice we received was that when Mrs A's condition deteriorated, this was recognised and responded to in an appropriate manner. However, there were aspects of her care that were unreasonable. In particular, she had recurrent bouts of sepsis which were not adequately investigated and her elevated blood glucose and low potassium levels were not investigated. Mrs A also had a fever of unknown origin and this was not recognised or investigated promptly. In addition, the advice we received was that Mrs A was moved unreasonably on multiple occasions between wards and hospitals. We found that, despite an elevated national early warning score (a system that determines the degree of illness of a patient), Mrs A was transferred to a hospital that was unable to look after a patient who required oxygen, and so she was subsequently transferred back to the Queen Elizabeth University Hospital.

We also upheld Mr C's complaint that the board had failed to communicate with Mr A about his wife's condition during her admission. The advice we received was that there was little evidence in the medical records to demonstrate that Mr A was informed of Mrs A's multiple transfers, or the rationale for these transfers. We considered that the level of communication was unreasonable.

We did not uphold Mr C's complaint that the board had failed to respond fully to Mr A's complaint. We were satisfied that the board had reasonably responded to the issues raised by him in his letter of complaint to them.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for failing to provide Mrs A with appropriate care and treatment. This apology should comply with SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance.
- Apologise for failing to communicate adequately with Mr A. This apology should comply with SPSO guidelines on making an apology, available at www.spso.org.uk/leaflets-and-guidance.

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

- Where possible, moving a patient multiple times should be avoided. The rationale for necessary moves should be clearly recorded in the medical records.

- Patients with elevated national early warning scores should not be transferred without further medical review and adequate handover.
- Communication between 'giving' and 'receiving' units regarding a patients needs should include national early earning scores and any requirement for oxygen.
- The handover process should ensure that events that happen overnight, even those perceived as small, are relayed to the day team for action. Abnormal blood results should be appropriately flagged and consideration given to an alert if the same patient has
- Patients with ongoing low potassium levels should be reviewed by appropriate specialist teams.
- Microbiology input and review should be sought for patients with recurrent sepsis.
- Families should be given sufficient opportunities to discuss their concerns and raise questions with clinical staff; especially in situations where the admission is prolonged and complex.

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.