SPSO decision report

Case: **201903499, Dumfries and Galloway NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C was concerned about the care and treatment that his late wife (Ms A) received at Dumfries and Galloway Royal Infirmary.

Mr C complained that his wife was misdiagnosed with pneumonia when she initially attended the Clinical Assessment Unit. We received independent advice from a consultant in acute medicine. We found that the investigations carried out during this attendance were reasonable. We also found it was reasonable to treat Ms A for a suspected infection based on the history, examination and investigations, while arranging a CT scan on an out-patient basis to investigate Ms A's symptoms further. We did not uphold Mr C's complaint regarding this point.

Mr C complained about the delay in reporting an x-ray carried out during this attendance at the Clinical Assessment Unit. We took independent advice from a radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans). We found an unreasonable delay in reporting a chest x-ray and we upheld Mr C's complaint in this regard.

Ms A was subsequently diagnosed with lung cancer and a few months later was admitted to the hospital with worsening shortness of breath. Mr C complained about the care and treatment that his wife received during this third attendance at the Clinical Assessment Unit. We received independent advice from a consultant in acute medicine. We found that there should have been earlier consideration to administering IV fluids and IV antibiotics to Ms A given that her low blood pressure and high heart rate were indicative of sepsis (blood infection). We upheld Mr C's complaint about the care and treatment provided in the Clinical Assessment Unit on Ms A's third attendance.

Mr C also complained about the care and treatment that Ms A received on the respiratory ward at Dumfries and Galloway Royal Infirmary. We took independent advice from a consultant physician in respiratory and general medicine We found that the medical care and treatment was reasonable and did not uphold this aspect of Mr C's complaint.

Finally, Mr C complained about the nursing care provided to Ms A. We took independent advice from a nursing adviser. We found that Ms A's catheter bag was not emptied regularly, there was a delay in Ms A receiving a pressure mattress and the syringe driver was not checked every four hours which was contrary to the guidance that a minimum of four-hourly checks should be carried out within in-patient settings. We upheld Mr C's complaint about the nursing care that Ms A received.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the delay in reporting the chest x-ray and for not giving earlier consideration to administering IV fluids and IV antibiotics to Ms A given that her low blood pressure and high heart rate

were indicative of sepsis. 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:

- Checks on syringe drivers should be carried out four hourly as a minimum within in-patient settings in accordance with the relevant guidelines.
- Consideration should be given to administering IV fluids and IV antibiotics to patients who have low blood pressure and high heart rates.
- X-rays should be reported without undue delay.

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.