SPSO decision report

Case: **202005520, A Medical Practice in the Forth Valley NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the treatment provided to their late parent (A) by their GP practice. A had prostate cancer for a number of years which later spread to their liver.

C complained that the practice failed to reasonably monitor A's blood sugar levels (HbA1c) after prescribing medication. We took independent advice from a GP. We found that the decision to commence medication for A's raised HbA1c was reasonable and appeared to be made with the input of a specialist medical consultant. However, there was no record to indicate that the practice discussed the risks of hypoglycaemia (low blood sugar) with A or took steps to allow A to monitor their blood sugar levels. We considered that the responsibility of monitoring any risks from the medication fell to the practice. Therefore, we upheld this aspect of C's complaint.

C complained that the practice failed to reasonably respond to A's reduced haemoglobin (Hb) levels. We found that, while the actions taken after the blood test results reported two weeks prior to A's death were reasonable, there was an opportunity prior to that to act on A's falling Hb levels. We noted that given the trend of A's falling Hb levels and their overall clinical picture, there was a fair to good chance that A's condition would deteriorate prior to a scheduled admission for a blood transfusion. We considered that the decision not to admit A prior to the scheduled admission, was a doctor-led decision rather than one made in conjunction with A and their family's wishes. As such, we upheld this aspect of C's complaint.

Finally, C complained that the practice failed to reasonably manage A's pain and comfort. We found that the pain management was reasonable and that the practice provided a high standard of palliative care. The medications administered, the timing of them and the increases in dosage were in keeping with the recommended standards of care, and in keeping with A's needs. Therefore, we did not uphold this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to reasonably manage A's blood sugar levels after prescribing medication and the delay in responding to A's falling Hb levels. 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:

- Decisions about admission for treatment should be made in conjunction with the patient's and family's wishes.
- The practice should discuss with patients the risk of hypoglycaemia, or the institution of finger prick monitoring when instigating medication affecting HbA1c. The patient should be counselled about the risk and this should be recorded.
- Trends towards falling Hb in a patient with cancer should be noted and acted on timeously.

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.