SPSO decision report

Case: **202208173, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) during two admissions to hospital. C complained that during their first admission A was given insulin that was for another patient and C was not timeously informed. C complained that during the second admission, A was initially diagnosed and treated for sepsis but when a CT scan was later performed a major stroke was discovered. C considered that stroke should have been considered and a CT scan should have been carried out earlier. A was given an infusion of both insulin and glucose to manage diabetes. C complained that A was inappropriately given intravenous (IV) glucose for 38 hours after IV insulin had stopped, noting that A became hyperglycaemic (when the level of sugar in the blood is too high) and then developed seizures. C also complained that nursing records were incomplete and that the board's incident management and review process did not go far enough to recognise or rectify failings.

We took independent advice from a registered nurse and a consultant specialising in medicine of the elderly. We found that the insulin error should not have happened. In relation to sepsis treatment, it was reasonable to treat the infection in the first instance but when C informed medical staff of A slumping to one side a medical assessment for stroke should have been carried out and a CT scan should have been booked. We also found that it was unreasonable to continue IV glucose after insulin had been stopped, record keeping was inconsistent and incomplete such that it could not be said that nursing care was reasonable and that incident management and review was also unreasonable. Therefore, we upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable care and treatment provided to A. In particular in relation to the treatment of A's constipation, the incorrect administration of insulin, the failure to undertake a detailed stroke assessment and book a CT scan, and the fact that fluids were not reviewed or considered on after A's insulin infusion was stopped and their blood glucose increased. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for the unreasonable incident management of the insulin error, for not recording a Datix incident for the glucose error, that the SAER report was not sufficiently detailed to provide reassurance in regards to the quality of incident management and review and that learning and action in relation to medical care during the second admission was not appropriately considered in the SAER. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for unreasonable record keeping. 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:

- Errors in relation to the management of a patient's care should be appropriately recorded e.g. using Datix.

Adverse event reviews should be thorough and should appropriately identify the failings, learning and improvement from the event.

- Patients should receive appropriate treatment including any relevant checks and scans booked in accordance with their symptoms.

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.