

## SPSO decision report

**Case:** 201400857, A Practice in the Fife NHS Board area  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Outcome:** some upheld, recommendations

### Summary

Mrs C complained about the palliative care provided to her father (Mr A) after his dialysis treatment (a form of treatment that replicates many of the kidney's functions) was stopped. Although this decision was discussed with the family, the hospital did not tell Mr A's medical practice about this, so they only found out three weeks later during a visit to Mr A's care home. At this stage, the GP began palliative care, including prescribing fentanyl patches (a type of pain relief similar to morphine). However, another GP stopped the fentanyl patches a few days later, and did not prescribe any other pain relief. Mrs C was concerned about this, and contacted the hospital consultant. The consultant tried to contact the practice, but the practice did not call back until the next day. After speaking with the consultant, the practice arranged an infusion pump of a painkiller and sedative for Mr A.

After taking independent medical advice from one of our GP advisers, we upheld one of Mrs C's two complaints. We found the practice could not have known that Mr A required palliative care earlier (as the hospital was responsible for telling them), and when they did find out, their care was reasonable, based on Mr A's symptoms at the time. It was also reasonable for the practice to return the consultant's call the next day, as there was no evidence that the message was given as urgent. However, we were critical that the GP did not discuss the decision to stop the fentanyl patches with Mr A's welfare attorney (his wife). We were also critical that the practice gave Mrs C misleading information, as they told her that, if they had known the dialysis was stopped, they would have referred Mr A to the community palliative care team, but they later told us that this wasn't necessary in Mr A's case.

### Recommendations

We recommended that the practice:

- apologise to Mrs C for the failings our investigation found; and
- bring the findings of our investigation to the attention of the doctor involved for reflection as part of their next annual appraisal.