SPSO decision report

Case: **201608139, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care that his late wife (Mrs A) received from the board's out-of-hours GP service and the care she received from Victoria Hospital after she was admitted with symptoms of ongoing diarrhoea. Mr C was concerned that Mrs A's bowel cancer, which was at an advanced stage, would have been identified sooner had a CT scan been carried out sooner. He also raised concerns that there was a delay in pain relief medication being provided and that the board's response to his complaint was poor.

We took independent advice from a general practitioner and from a consultant in acute medicine. We found that the care provided by the out-of-hours GP service was of a reasonable standard because Mrs A's symptoms, and their duration, were in keeping with a working diagnosis of infective diarrhoea. We found that there was no evidence of an abdominal mass and that her vital observations (pulse rate, blood pressure and oxygen saturates) were stable with no indication of an acute emergency. We also considered that there were appropriate reasons for not carrying out the CT scan earlier. These reasons included the initial working diagnosis of infection, Mrs A's fluctuating kidney function, her warfarin (blood thinning) levels and Mrs A's preference to avoid further investigations. We did not uphold these aspects of Mr C's complaint.

We were critical that there was a delay in providing Mrs A with pain relief and we upheld this aspect of Mr C's complaint. The board have acknowledged and apologised for this. Whilst the board have taken some action, which we have asked them to provide evidence of, we made a recommendation for them to address the lack of available anticipatory medications (medicines that might be required at any time of the day or night in end of life care).

With regards to complaints handling, we found that the board's letter of response lacked clarity and should have been more accurate. We also found that some of their comments in the response letter were unneccesary. The board accepted that some of the information contained within their letter was conveyed inadequately and have taken action to ensure learning from this case. We upheld this part of Mr C's complaint. We have asked the board to provide evidence of the action they have taken and to apologise to Mr C.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the complaints handling failings. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Staff should ensure that appropriate anticipatory medications are prescribed and administered for relevant patients in line with NHS Scotland's palliative care guidelines.

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.