SPSO decision report

Case: **202005176, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their spouse (A) when they became unwell with severe lower abdominal pain and vomiting. A was visited and examined by an out-of-hours (OOH) GP, who administered an injection for vomiting and left some medication for A. A's condition worsened and a different OOH GP attended the same evening. A was taken to hospital by ambulance and was found to have a perforated bowel (hole in the large intestine) and kidney failure. Medical intervention was not considered appropriate and A's care was redirected to palliative care. A died in hospital two days later.

C complained that the first OOH GP missed important aspects of A's condition during their home visit. C further complained that when A was admitted to hospital, A was left in pain and discomfort for many hours and it was only when C raised concerns that A was given stronger pain relief.

We took independent advice from a GP adviser, as well as a registered nurse and a general physician in acute medicine.

We found that overall, the assessment and examination carried out by the first OOH GP was reasonable and appropriate. It was determined that there was nothing suggestive of an acute abdomen (sudden, severe abdominal pain) which would have necessitated admission to hospital. We did not uphold this aspect of C's complaint.

C also complained that A was given unreasonable care and treatment in the hospital, in relation to managing A's pain. We considered that overall, the approach to A's pain management by nursing staff was reasonable. Nursing staff identified A's level of pain from first admission and throughout and took appropriate action to try and address this.

However, we found that given the very high doses of morphine administered, medical staff should have checked the medication prescribed to see if it was working, and review or prescribe something else. Furthermore, given that the medical team would have been aware that A was on the ward round for comfort care, a palliative care referral could have been made earlier. We considered that an earlier referral may have supported better comfort care for A in the final stages of life. As such, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Pain medication prescribed for patients should be appropriately checked by medical staff to see if it is adequately working. Referrals to palliative care should be made in a timely way without 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.