Scottish Parliament Region: Glasgow

Case 201200306: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospitals – Oncology; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her late husband (Mr C) by Greater Glasgow and Clyde NHS Board – Acute Services Division (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff failed to provide Mr C with timely and adequate pain relief when he reported problems with his catheter (*upheld*);

(b) staff inappropriately discharged Mr C from hospital when he was suffering from a high temperature and wound infection (*not upheld*);

(c) staff failed to ensure that an adequate home care package was in place on discharge from hospital, including palliative care, or provide advice about agencies which could assist if required (*upheld*);

(d) the level of communication between staff and Mr C's family was inadequate (*upheld*); and

(e) on 15 and 16 July 2011, Out-of-Hours Service GPs failed to adequately assess Mr C (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) make Mrs C a formal apology for their shortcoming in this matter and for the distress she and her family have suffered;	25 February 2013
(i) emphasise to all the staff involved, the importance of keeping full and timely notes;	25 February 2013
(ii) review the circumstances of complaint (a) and demonstrate to the Ombudsman that they have a	25 February 2013

	programme in place to prevent such a situation occurring again;	
(iii)	make specific apology to Mrs C for failing to make proper arrangements for Mr C's care and support on his discharge from hospital;	25 February 2013
(iv)	in the wards concerned, review the procedures for patients' discharge to satisfy themselves that appropriate action is taken;	25 March 2013
(v)	make a specific apology for their failure to communicate adequately; and	25 February 2013
(vi)	taking into account the failures in communication, the Board should demonstrate to the Ombudsman the action to prevent such a situation occurring again.	25 March 2013

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 22 December 2011, Mrs C complained to Greater Glasgow and Clyde NHS Board (the Board) about the treatment provided to her late husband, Mr C, who died on 30 July 2011.

2. Mr C had suffered from prostate cancer for 11 years and was under the general care of the Beatson Oncology Centre (the Centre). Mrs C raised a number of concerns about Mr C's treatment during the period February 2011 to July 2011. She said that Mr C had been left in pain and in a wet bed at the General Surgery Ward at the Western Infirmary (Hospital 1) following the insertion of a catheter; he was discharged from Gartnavel General Hospital (Hospital 2) without a catheter or antibiotics on 1 March 2011 only to be readmitted to Accident and Emergency (A & E) the following day with a temperature and the inability to pass urine. Mr C was then readmitted to Hospital 2 on 3 March 2011 but Mrs C complained that on discharge he was not referred to the Home Care Support Team or given advice about how to claim Attendance Allowance.

3. On 29 June 2011, Mr C was readmitted to A & E at Hospital 1 with pain, discomfort and urine retention but, Mrs C alleged, there were some hours delay before a doctor inserted a catheter. He was then transferred to Hospital 2 and Mrs C said he was told that as he was sufficiently mobile he could call for nurses when he needed to use the lavatory. However, Mrs C said that her husband was frail and only able to walk with assistance. She said he had not been provided with any aids or auxiliary equipment. Mrs C alleged that nurses made inappropriate comments and said that if he wanted better treatment he should go to a private hospital. Mr C was later transferred to a bed without a buzzer.

4. Mr C had problems with the large catheter which was fitted and asked for an antispasmodic pill to help with the pain. This took about a day to be provided and when it was, it was ineffective. He asked for the catheter to be changed to a smaller one.

5. Mrs C said she had great difficulty in finding out from the medical staff what was happening with her husband.

6. Mr C was discharged from Hospital 2 on 15 July 2011 without antibiotics and as it was a holiday weekend, his GPs were on a four day break. He also had an infection at the venflon site which Mrs C said, a nurse burst at the time of the discharge and she was told she could dress the wound at home. Mrs C maintained that this was inappropriate as Mr C had a low white blood cell count and was at risk of infection. On arriving home, Mr C had a temperature and Out-of-Hours (OOH) doctors were called on three occasions over the weekend. Antibiotics were prescribed (once he was given penicillin, to which he had a known allergy). Mrs C believed that the OOH doctors did not realise that her husband was in the final, advanced stages of cancer and required palliative care.

7. The complaints from Mrs C which I have investigated are that:

(a) staff failed to provide Mr C with timely and adequate pain relief when he reported problems with his catheter;

(b) staff inappropriately discharged Mr C from hospital when he was suffering from a high temperature and wound infection;

(c) staff failed to ensure that an adequate home care package was in place on discharge from hospital, including palliative care, or provide advice about agencies which could assist if required;

(d) the level of communication between staff and Mr C's family was inadequate; and

(e) on 15 and 16 July 2011, Out-of-Hours Service GPs failed to adequately assess Mr C.

Investigation

8. As part of the investigation all the information provided by the complainant and the Board (including Mr C's relevant clinical records, complaints correspondence and their complaints policy) was given careful consideration. Independent specialist advice was also obtained from a consultant urologist (Adviser 1) and from nursing and general practice specialists (Adviser 2 and Adviser 3 respectively). The information they provided was taken into account.

9. This report does not include every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) Staff failed to provide Mr C with timely and adequate pain relief when he reported problems with his catheter

10. Mr C suffered from prostate cancer and had received treatment at the Centre for three years. During that time he had been taking part in a trial of the drug Abiraterone but the treatment was stopped in October 2010.

11. On 7 February 2011, Mrs C said that her husband had a Computerised Tomography (CT) scan and saw his consultant (the Consultant) at the Centre on 14 February 2011. He was told that his cancer was terminal and had spread. Regrettably, Mr C became ill and on 20 February 2012 required to be admitted to Hospital 1 with a urinary tract infection. He had a catheter inserted. This was removed and re-inserted on 22 February 2011. Mrs C said that he suffered immense pain after re-insertion and, as there was leakage, she said he was left lying in a wet bed. However, despite Mrs C bringing this to the attention of staff, Mr C was left in great pain for a number of hours. Mrs C maintained that it was only when new staff came onto the ward that a staff nurse removed the catheter and changed Mr C's bed. Mrs C was angry about this and said that this was no way to treat a patient who was terminally ill.

12. On another occasion, Mr C was bleeding from his prostate and the urologist tried to treat this by using a large catheter and washing out his bladder. Mrs C said this caused enormous pain and distress and Mr C requested an anti-spasmodic pill but that he had to wait a full day and night for this. Mrs C said that he got to the position where he just wanted the catheter removed as he could no longer bear it.

13. On 22 January 2012, Mrs C complained to the Board about these and other matters and on 9 March 2012, the Board replied. They confirmed that Mr C had been admitted to Hospital 1 with urinary retention and that he had ongoing issues with pain, discomfort and bypassing of his catheter after insertion. They said that the nursing notes indicated that on 26 February 2011, Mr C had been given two separate doses of painkillers and had been provided with a local anaesthetic gel to apply to the catheter site. After consultation, it was decided to remove the catheter but the Board were, they said, with the passage of time, unable to confirm what had happened with the removal of the catheter. However, they apologised for any delay that may have occurred. They also said they were sorry if Mrs C felt her husband had been left in a wet bed but said that as his catheter was bypassing, it would have been difficult to keep his skin and bed completely dry. Again, they said that with the passage of

time, it was difficult to confirm how often Mr C's bed had required to be changed but advised that, in the short term, it would have been normal practice to use incontinence pads until a decision was made on the removal of the catheter.

14. With regard to the three–way catheter which had been inserted after discussion with Mr C, the Board confirmed that he found it very uncomfortable despite regular analgesia. Because of this, it was changed to a smaller size the day after.

15. Advice was obtained on the care and treatment Mr C received and Adviser 1 told me that Mr C had three admissions: on 20 February; 3 March and 30 June 2011. On each occasion he was thought to be in urinary retention. On the first two occasions his bladder was impalpable (unable to be found by touch) and small volumes of urine were obtained on catheterisation but Adviser 1 said that on neither occasion was a bladder scan used to measure the residual volume to confirm whether Mr C was in retention or not. This being the case, he expressed the view that it was, therefore, probably inappropriate for him to have been catheterised on these occasions, as it appeared from the notes and an ultra sound that Mr C's renal function and kidneys were normal.

16. Adviser 1 went on to say that the decision to reinsert the catheter on 26 February 2011 was poorly documented as the medical records were poor, incomplete and at one point were contradictory (on 25 February 2011, one note indicated that the catheter had been removed but another, later entry said,' not re catheterised please insert long term catheter'). A catheter was reinserted on 26 February 2011 but Adviser 1 said the size of the catheter used, or whether there had been any difficulties, was not recorded. He added that when this catheter failed to drain properly and was associated with pain and by-passing this should have been dealt with as an emergency. Adviser 1 noted that local anaesthetic gel was applied to the external opening of the urethra around the catheter because of severe pain and a doctor was contacted who advised that the catheter should be removed but, Adviser 1 said, there were no further entries in the notes from 26 February until 1 March 2011 so it was very difficult for him to be specific about what happened to Mr C. He said there was also no Catheter Care Plan in the notes and, with regard to Mr C's admission on 3 March 2011, he commented that it was unclear under whose care Mr C was admitted, although it was noted that he saw various registrars. Adviser 1 said that this was despite the fact that a named consultant should have seen him within 24 hours. He further added that he would have expected that Mr C would

have been discussed at a Prostate Cancer Multi-Disciplinary Meeting (MDT) and to have been seen by a Clinical Nurse Specialist while he was an in-patient.

17. Mr C attended the A & E department at Hospital 1 on 29 June 2011 and Adviser 1 said that clinical records showed that he was catheterised and 500 millilitres residual of blood stained urine was obtained. Mr C was transferred to the urology ward of Hospital 2 the next day and, because of continuing haematuria (blood in urine), his catheter was exchanged for a size 18CH three way catheter. Mr C found this extremely uncomfortable. Despite regular and increasing doses of strong opiate based pain killers Mr C was unable to tolerate the catheter and it was reduced in size. Adviser 1 pointed out that no assessment of his intra venous (IV) cannula site was made so any infection here was not detected prior to Mr C's discharge. Adviser 1 added that subsequent pain associated with the stiffer three way catheter was almost certainly a result of the catheter irritating the progressively enlarging prostate cancer. Mr C received regular and appropriate analgesia but when pain levels increased, the correct treatment should have been to address the underlying cause of the pain rather than to administer stronger pain killers.

18. A nursing adviser (Adviser 2) also commented on the notes. She said that her impression from reading them was that there were a number of failings in Mr C's care. She said that it appeared fragmented and inconsistent and communication between the various members of the healthcare teams and specialists was below the standard she would have expected, particularly taking into account Mr C's poor prognosis and terminal illness. She agreed that no senior clinician appeared to take responsibility for the care plan.

19. Adviser 2 said that on 26 February 2011, it appeared to her from the available notes that Mr C required a catheter to be inserted. A nursing note on 25 February 2011 stated '…? Needs catheter'. A further note made at 13:45 on 26 February 2011 said, '… patient anxious that catheter was not inserted last night – inserted today at 13.30'. Adviser 2 said that, in her view, waiting this period of time was unacceptable.

20. Adviser 2 also commented on Mr C's notes. She said that in her opinion both the nursing and medical notes were poor and contradictory. She said that it was unclear from the records when each catheter was inserted, by whom and when it was removed.

21. She was critical of the Board's response that it would have been difficult to keep Mr C's skin and bed completely dry because, in her experience, whilst the problem of the catheter bypassing caused leakage, Mr C's skin should have been protected by the use of appropriate pads and frequent changing.

(a) Conclusion

22. This investigation has taken into account what Mrs C said on this matter and how the Board have replied. My complaints reviewer has obtained independent advice and this advice has expressed concern about the quality of note keeping and Adviser 1, in particular, commented on the difficulty he experienced in trying to establish clearly what had happened to Mr C. However, both advisers were able to determine that on occasion Mr C was left too long before his catheter was removed. Adviser 1 also questioned whether on the first of his two admissions Mr C should have been catheterised at all, given that there was no evidence that he was in retention and a bladder scan was not performed to confirm this. Adviser 1 further said that on the third occasion the appropriate action would have been to address the cause of the Mr C's pain (that is, the large catheter), rather than give him increasingly larger doses of pain killer.

23. In view of the circumstances described above, I uphold the complaint. The Board should make Mrs C a formal apology for their shortcomings in this matter and for the distress she and her family have suffered. They should also emphasise to all the staff involved, the importance of keeping full and timely notes. They should review the circumstances of this aspect of the complaint and demonstrate to me that they have a programme in place to prevent such a situation occurring again.

(a) Recommendations

24. I recommend that the Board:	*Completion date*
(i) make Mrs C a formal apology for their shortcomings in this matter and for the distress she and her family have suffered;	25 February 2013
(ii) emphasise to all the staff involved, the importance of keeping full and timely notes; and	25 February 2013
(iii) review the circumstances of this aspect of the complaint and demonstrate to me that they have a programme in place to prevent such a situation	25 March 2013

occurring again.

(b) Staff inappropriately discharged Mr C from hospital when he was suffering from a high temperature and wound infection

25. Mrs C said her husband was admitted to Hospital 2 on 27 February 2011 and was discharged on 1 March 2011 without a catheter. On 2 March 2011, he had a temperature and difficulty passing urine but he was told he could not be readmitted there but would have to go the A & E department at Hospital 1. He was, however, admitted to Hospital 2 again on 3 March 2011. Later, after his third admission in June 2011, Mrs C said that Mr C was discharged at the very beginning of the Glasgow holiday without any further treatment, although he had been on antibiotics for the previous two weeks. She also said that his venflon site was infected and the nurse cleaned and dressed the site. Mrs C said she was told to repeat this at home.

26. In response to this complaint the Board said that when Mr C was discharged home on 1 March 2011, he was, '…voiding good volumes of urine with control and his post-voiding residual scans were within acceptable volumes'. Thereafter, on 15 July 2011, after his third admission, Mr C was discharged home to the care of his GP and referred to the community nursing team for support with his catheter. A discharge letter for Mr C's GP and discharge prescription were provided. The Board said that antibiotics were not prescribed as part of the discharge prescription as these had been discontinued as Mr C had completed his course. In commenting on a draft of this report Mrs C said that this was despite the fact that Mr C had been prescribed with a low dose of antibiotic as prophylaxis (a preventative) by his GP prior to his hospital admission.

27. Adviser 1 reviewed Mr C's clinical notes. He said that when Mr C was seen by the Consultant at the Centre on the 14 February 2011 there was clear evidence that he had progressive prostate cancer with lymph node and bone metastases (a spread of cancers cells from the primary tumour to the bone). Adviser 1 said he should have been discussed at a MDT (see paragraph 16 above) and the palliative care team involved. The Consultant suggested this when he saw Mr C on 29 March 2011, following the first two of Mr C's admissions. Following the catheter removal on the first admission, Mr C was monitored with bladder scans to ensure that he was not in retention and had follow-up plans to be seen in both the urology and oncology clinics. In Adviser 1's view, Mr C was fit for discharge and had appropriate plans in place.

During the second admission, Adviser 1 said that Mr C should have seen a clinical nurse specialist who would have identified his needs and co-ordinated services, including the Community Palliative Care team, once he was discharged. Thus, although he said Mr C was fit for discharge (although, he said, low dose antibiotics should probably have been continued to minimise the risks of infection associated with his long term catheter) and had an oncology out- patient appointment, co-ordination with community support was lacking.

28. On Mr C's final discharge, Adviser 1 said that he left Hospital 2 with a catheter in situ but, he said, it would appear that no assessment was made of the cannula (a thin, flexible tube inserted into the body) site prior to discharge so any infection would not have been detected. Arrangements were in place for the District Nurses to attend four times daily to care for this. He said this was entirely appropriate. However, he said and there was no evidence that the Clinical Nurse specialists had been involved during his in-patient stay and, although Mr C had been referred to the MacMillan palliative care team following his admission for a blood transfusion in April 2011 under the care of the oncologists, there was no evidence that they had been informed of his admission or discharge on this occasion. He said if they had been informed, his care (including pain management) could have been co-ordinated and input from his GP over a holiday weekend would probably not have been required.

29. It was Adviser 2's view that on Mr C's final discharge, the nursing care plan was sparse and contained very limited information that would be helpful for staff or his family.

(b) Conclusion

30. From the information and advice available to me, I cannot conclude that Mr C was discharged inappropriately in so far as he was unfit. Although Mrs C maintained that on his third discharge he had a wound infection, this was not confirmed in the available notes (see paragraph 28 above). My decision must be made on the evidence available to me and, accordingly, I do not uphold this complaint. Neither Adviser 1 nor Adviser 2 expressed concerns about Mr C being unfit for discharge (see paragraph 27). They have, however, commented on the sparse information contained in the notes and the fact that there was poor planning for Mr C's discharge and these matters are dealt with in complaint (c) below.

(c) Staff failed to ensure that an adequate home care package was in place on discharge from hospital, including palliative care, or provide advice about agencies which could assist if required

31. After Mr C's second discharge, Mrs C said that he was not referred to the Home Support team or given any support. Nor was he given any advice about the resources available to the terminally ill. The complainant said that it was only two days before he died when Mr C was taken into a hospice where he was provided with a high standard of care, attention and adequate pain relief.

32. After Mrs C pursued her complaint with the Board, in their reply of 9 March 2012, they said that before his second discharge Mr C had a long conversation about his condition with a Specialist Registrar in Urology. However, they confirmed that there was no record of Mr C being referred to the social work team or of this being requested. They apologised if there had been a breakdown in communication and said that nursing staff would have facilitated this if they felt that it had been needed or if it had been brought to their attention.

33. As outlined above (in complaint (b)), Adviser 1 said that once it was clear Mr C had progressive cancer he should have been discussed at a MDT Meeting and seen by a Clinical Nurse specialist, who would then have liaised with the Community Palliative Care team. This did not happen and, even after the oncologists made referral to the MacMillan West Glasgow Palliative Care service in April 2011, it was not clear from the notes whether this had been followed through. After Mr C's final discharge in July 2011, he was referred to district nurses for catheter care but there was no mention of the Palliative Care team. Adviser 1 said that in his opinion, overall, it appeared that the involvement of the Palliative Care services was lacking.

34. Adviser 2 also gave her view that the nurse in charge of the ward (the Senior Charge Nurse) was responsible for making arrangements for discharge. She added that in terms of outside agencies this was often arranged by a social worker who would set up a care package. Adviser 2 noted that on 15 April 2011, nursing notes mentioned referral to McMillan and on 18 April 2011 the notes said 'Contacted IRIS team [a service for people discharged home who require support] – they will come tomorrow to assess [Mr C's] needs on discharge and will arrange any services required'. This review took place on 19 April 2011 and this arrangement was communicated to Mrs C later that day. Adviser 2 said that at this point it appeared that the

arrangements for discharge were reasonable and communicated to Mr and Mrs C.

(c) Conclusion

35. Notwithstanding the Board's response on this complaint, Adviser 2 told me that it was the responsibility of the Senior Charge Nurse to make arrangements for discharge. Accordingly, it should not have been for Mrs C to alert them to the fact that her husband may need further support on discharge. Adviser 1 also pointed out that the situation was unclear concerning the Palliative Care team. Mr C was terminally ill and towards the end of his life. This support should have been made available to him. I uphold the complaint.

36. The Board should make specific apology to Mrs C for failing to make proper arrangements for Mr C's care and support on his discharge from hospital. In the wards concerned, they should also review the procedures for patients' discharge to satisfy themselves that appropriate action is taken.

(c) Recommendations

37. I recommend that the Board:	*Completion date*
(i) make specific apology to Mrs C for failing to make proper arrangements for Mr C's care and support on his discharge from Hospital 2; and	25 February 2013
(ii) in the wards concerned, review the procedures for patients' discharge to satisfy themselves that appropriate action is taken;.	25 March 2013

(d) The level of communication between staff and Mr C's family was inadequate

38. Mrs C's letter of complaint to the Board, dated 22 January 2012, also referred to her concerns about the level of communication both with her and between those dealing with Mr C's care. For example, Mrs C said that there appeared to be no communication between the Centre and Hospital 2. Mrs C also said that towards the end of his life Mr C was subject to many blood tests and so it must have been known that he was deteriorating rapidly but that neither she nor his GP knew what was going on.

39. In their response letter of 9 March 2012, the Board acknowledged that there may have been a breakdown in communication about requesting help from social services (see complaint (c) above). They also acknowledged that

information about summoning assistance (the availability of a buzzer) was not appropriately communicated to Mrs C. They said, however, that Mr C's ongoing care was discussed with Mrs C before his discharge in July 2011 and it was suggested that a meeting could be arranged with Mrs C and one of Mr C's registrars (although Mrs C denied this).

40. It would appear, therefore, that in some circumstances communication was less than what could have been expected. This was confirmed by Adviser 1, who told me that Mr C's care in the terminal phase of his illness appeared to be fragmented between the Centre and Hospital 1 and Hospital 2. Although clinicians communicated following out-patient appointments and after discharge, there was often considerable delay in clinical letters being typed. In Adviser 1's view, an MDT meeting was the best method of clinical decision making and there was no evidence that this took place. He said that there was also little evidence that discussion took place between senior clinicians and the family, to explain the terminal nature of Mr C's condition. Adviser 1 believed that these problems could have been resolved by the involvement of cancer care specialist nurses.

41. Adviser 2 said that there was a record of Mrs C raising concerns with the nursing staff about 'not being given full information on her husband's management. Explanations given and advised to contact [a named consultant]'s secretary to make appointment. Appeared satisfied'. However, in terms of full information about care and treatment and end of life care, she said there was no evidence to suggest that Mr C and his family received any information in hospital; there was no communication sheet and no involvement of a specialist nurse. She added that due to the numerous specialists involved, there seemed to be a gap in the consideration of Mr C's overall plan of care and said that this role was usually performed by the cancer nurse specialist.

(d) Conclusion

42. The Board have agreed that there may have been a breakdown in communication with Mrs C. This failure in communication has been confirmed by both Adviser 1 and Adviser 2. I uphold the complaint. In the circumstances, the Board's apology (see complaint (a)) should make reference to this. Taking into account the failures identified above, the Board should demonstrate to me the action they have taken to prevent such a situation occurring again.

(d) Recommendations

43. I recommend that the Board	*Completion date*
(i) apologise, making reference to their failure to communicate adequately; and	25 February 2013
(ii) take into account the failures in communication and demonstrate to me the action taken to prevent such a situation occurring again.	25 March 2013

(e) On 15 and 16 July 2011, Out-of-Hours Service GPs failed to adequately assess Mr C

44. On being discharged from Hospital 2 on 15 July 2011, Mrs C said that Mr C had a high temperature and she had to call NHS 24 three times. She said each time, a different OOH doctor visited and recommended a different antibiotic. Mrs C said on the first call out, OOH Doctor 1 gave Mr C an antibiotic for a skin infection which contained penicillin. Her husband was allergic to penicillin. Mrs C alleged that none of the treatments offered to Mr C were appropriate as his cancer was so advanced. She complained that the OOH doctors failed to have a proper understanding of Mr C's condition or his requirement for palliative care.

45. In responding to these concerns, the Board said in their letter of 9 March 2012 that the first doctor (OOH Doctor 1) to see Mr C on the evening of 15 July 2011 documented a full and detailed history. He noted that Mr C was fevered and had an infection at the site of his venflon, also haematuria (blood in urine). They said that he concluded that Mr C had a skin infection and treated this with an appropriate antibiotic. However, Mr C was allergic to penicillin. The Board offered you their sincere apologies that this happened, as did the doctor concerned.

46. The Board said Mrs C made another call to NHS 24 the following morning (16 July 2011) and she had a telephone consultation with OOH Doctor 2, who prescribed an alternative antibiotic. Later that day, a third call was made and the doctor (OOH Doctor 3) who attended to see Mr C, after making himself aware of his recent history and diagnosis, prescribed an antibiotic for a urinary tract infection. The Board said that neither OOH Doctor 1 or 3 who came to see Mr C felt that his condition was such as to require palliative care.

47. Specialist GP advice (from Adviser 3) was obtained on this aspect of the complaint. Adviser 3 commented that when Mr C was discharged on

15 July 2011, there was no mention of the need for palliative care. He said there were no notes from the district nurses and that this could have been important as, in many places, palliative care was provided by district nurses in the community with or without input from specialist cancer or palliative care nurses.

48. On the evening of Mr C's discharge, a request for a house call was made, as he had restarted having haematuria and had a fever. Adviser 3 said that an appropriate assessment was made but Mr C was prescribed flucloxacillin (a penicillin) despite his being allergic to penicillins. Adviser 3 noted that the Board and the OOH Doctor 1 had admitted this mistake and apologised.

49. Adviser 3 said that the second Out-of-Hours contact (details of which were only provided by the Board at the draft stage of this report) noted that Mrs C telephoned the OOH service as she had realised her husband was reacting to the penicillin he had been given. An alternative prescription was then arranged with the pharmacy. The third contact was on the following day when Mr C had a fever with associated symptoms and haematuria. Another antibiotic was given specifically in case of a urine infection suggested by the increased blood in the urine. Re-admission was considered by OOH Doctor 3 but Adviser 3 said it was not known whether this was discussed with either Mr or Mrs C.

50. It was Adviser 3's view that other than being given antibiotics to which he was allergic, the care given by the OOH doctors was reasonable. The records suggested that both doctors (OOH Doctors 1 and 3) attending Mr C knew of the seriousness of his condition and the importance of follow-up or re-admission was considered and noted. However, he said some notes on the discussions with the patient and family would have been helpful.

(e) Conclusion

51. Adviser 3 concluded that, other than the prescription of an antibiotic to which Mr C was allergic, his care was reasonable and that he had been properly assessed, but, such a mistake should not have happened. On balance, therefore, I uphold the complaint. I note, however, the Board's and the doctor concerned's sincere apology and I do not recommend further action.

52. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
Mr C	The complainant's late husband
The Centre	The Beatson Oncology Centre
Hospital 1	The Western Infirmary
Hospital 2	Gartnavel General Hospital
A & E	Accident and Emergency
OOH	Out-of-Hours
Adviser 1	Consultant urologist adviser
Adviser 2	Nursing adviser
Adviser 3	GP adviser
CT scan	Computerised tomography scan
The Consultant	Mr C's consultant at the Beatson Oncology Centre
MDT	Multi-Disciplinary Team
OOH Doctor 1	The first Out-of-Hours doctor
OOH Doctor 2	The second Out-of-Hours doctor
OOH Doctor 3	The third Out-of-Hours doctor

Annex 2

Glossary of terms

Bone metastases	A spread of cancer cells from the primary tumour to the bone
Cannula	A thin flexible tube inserted into the body
Haematuria	Blood in urine
Venflon site	Site where the catheter is inserted