SPSO decision report

Case: **201405987, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained to us on behalf of her husband (Mr C), following surgery he had at Victoria Hospital. Mr C was given morphine for post-operative pain, administered through a Patient Controlled Analgesia device (PCA - a special syringe allowing pain relief on demand). Over the subsequent 18 hours Mr C administered his own morphine, within limited doses, via the PCA. Nursing staff contacted the Hospital at Night team when they were concerned about the amount of morphine he had received, but he was not seen by a doctor until ward rounds the next morning. Concern over his pain relief led to a referral to the pain team. Mr C was seen by a pain nurse, who stopped his PCA and prescribed alternative, morphine based pain relief. Three hours after his PCA was stopped Mr C started to show clear signs of opiate toxicity (overdose). A doctor was called and he was given medication to reverse the overdose.

We sought independent advice from nursing, anaesthetic and general medical advisers. The nursing adviser was satisfied that nursing staff had appropriately monitored Mr C's condition. The anaesthetic adviser noted that Mr C had shown signs of mild opiate toxicity before his overdose, and that a review by an anaesthetist should have been requested either at those times or when he was seen by the pain nurse. The general medical adviser agreed with this assessment.

The signs of opiate toxicity which Mr C displayed in the hours after his surgery were short-lived, and his observations on charts remained reasonable. While nursing staff monitored him appropriately, and it was reasonable to refer him to the pain team, we decided he should have been reviewed by an anaesthetist to identify whether alternative medication was more appropriate. We found that this could have eliminated the risk of an overdose. We upheld Mrs C's complaint.

Recommendations

We recommended that the board:

- discuss this case in an appropriate multi-disciplinary setting, to identify alterations to current procedures to assist staff in identifying when they should seek an anaesthetic review; and
- apologise to Mr and Mrs C for the failings identified and the distress caused as a result.