SPSO decision report

Case: **201505989, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the care and treatment her late father (Mr A) received from the board's out-of-hours service shortly before his death. Mr A had been diagnosed with bladder cancer and was receiving palliative care. On the day Mr A died he was in severe pain in the early hours of the morning and Ms C's mother (Mrs A) contacted NHS 24. Mr A was seen by a doctor from the out-of-hours service and was given morphine for the pain. He remained in pain and another out-of-hours doctor was asked to attend but they felt they would not be able to attend before their shift ended, so asked that Mr A's GP attend instead. Mr A was told the GP would attend at 08:00 however the GP was not contacted until 08:05 and did not attend until 08:45. Mr A died in the early afternoon. Ms C complained that the actions of the out-of-hours doctors prolonged Mr A's severe pain during the final hours of his life.

We took independent advice on Ms C's complaint from a GP adviser. We found that the first out-of-hours doctor attended in good time but provided a dosage of morphine that was too low to improve Mr A's pain and did not take into account the medication he had already been taking which had little effect. We found there was a similar failure to look into Mr A's recent history by the second out-of-hours doctor as there was no evidence of this second doctor speaking to either Mr or Mrs A to assess Mr A's condition at that time nor of them making their decision with reference to the earlier out-of-hours attendance. We were critical that the decision to refer Mr A to his GP practice was taken without taking into account his needs. The second call to the out-of-hours doctor was given a one hour priority, but passing the call on to Mr A's GP practice (which had not yet opened at the time of the call being passed on) meant it was not possible for the one hour timescale to be met. We noted that the board's out-of-hours policy recognised situations like this and provided scope for the out-of-hours doctor to act if the presenting condition and treatment fell outwith the time-frame. In this case, however, this did not occur. At the time of the second call Mr A was in severe pain which had not improved following an earlier visit. We found that had the second out-of-hours doctor responded to the call and visited Mr A the pain, discomfort and distress he and his family endured may have been avoided.

Recommendations

We recommended that the board:

- apologise to Mr C's family for the poor standard of care and treatment that Mr A received;
- share our findings with the staff involved in Mr A's care and treatment with a view to identifying any areas where their clinical decision-making may be improved; and
- ensure clinicians have regard to the out-of-hours policy, in particular in relation to exceptional circumstances, when providing out-of-hours care and treatment.