SPSO decision report

Case: **202007782, NHS 24**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C's late partner (A) tested positive for COVID-19. A week after testing positive, A called 111 as they were still feeling very ill. They explained that they had had a fever for a few days and were having difficulty regulating their temperature. A was advised by a nurse practitioner to remain hydrated, continue taking paracetamol, and to continue to self-isolate until they had no fever for 48 hours. They were also advised to call back if they had any further concerns about their symptoms.

C called 111 again a few days later as they were concerned A's breathing was becoming laboured. C had to wait around 20 minutes before the call was answered. During the call, the call handler repeatedly asked to speak to A to take information directly from them, even though C kept answering for A as A was confused. The call lasted around 30 minutes. The call handler contacted Scottish Ambulance Service and requested an ambulance on an emergency basis, but by the time paramedics arrived A had stopped breathing and could not be resuscitated. C complained about the clinical assessments of A's condition on both instances.

We took advice from an advanced nurse practitioner with experience of assessing patients with similar presentations. We found the assessment on the first instance to be reasonable, and we therefore did not uphold this complaint.

We considered it unreasonable for the second call to have lasted 30 minutes before an ambulance was called. We noted that the call handler was following the protocol correctly, but were of the view that if the protocol took 30 minutes to establish that an emergency response was required, it was not fit for purpose. We considered that rigid following of the protocol led to a delay in obtaining medical attention for A. Therefore, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings we have 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:

- Protocol is reviewed so that in patients with shortness of breath as the primary presentation there is a clear escalation route to a medically trained clinician.

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.