SPSO decision report

Case: **201301736, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mrs C's late father (Mr A) had a rare type of lung cancer and was admitted regularly to the Victoria Infirmary for problems related to this, particularly chest infections. In early 2013, he was admitted there and started on antibiotics to cover the possibility of another chest infection. A few days later, a doctor described him as being frail and it became apparent, as Mr A deteriorated further, that he was at the end of his life. He received palliative care (care provided solely to prevent or relieve suffering), and he was reviewed by several doctors and prescribed pain relief for agitation. Mr A died two weeks after being admitted to hospital.

Mrs C complained about the end of life care her father received, saying that he was not given reasonable pain relief or antibiotic treatment and that there was a lack of senior clinical input. She also said that nursing staff failed to assess his pain and keep comprehensive records. Mrs C said that her father was screaming out in pain during the latter stages of his illness, and she was extremely concerned that staff failed to respond to this appropriately.

We took independent medical advice on the case from two of our medical advisers, one of whom is a doctor specialising in care for the elderly, and the other a nurse, after which we did not uphold Mrs C's complaint. We found that we were unable to reconcile the different accounts of the level of pain that Mr A experienced, and the advice we received was that Mr A had symptoms of breathlessness, anxiety and agitation, which were treated adequately. There was no evidence in the medical records or statements from staff of Mr A screaming in pain. We noted that a delay in providing antibiotics and failure by senior staff to review Mr A had been raised with the staff concerned, but our medical adviser (a doctor specialising in care for the elderly) said that these did not affect what happened or the management of Mr A's condition. Our nursing adviser also noted a lack of documentation in relation to pain assessment and end of life care, and we made a recommendation about this. However, again these did not impact on the care Mr A received, which she said was of a reasonable standard.

Recommendations

We recommended that the board:

- ensure the failures in record-keeping, in particular completion of SEWS (Scottish early warning system - a set of patient observations) are raised with relevant staff.