SPSO decision report

Case: **201100005, A Medical Practice, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, action taken by body to remedy, recommendations

Summary

Ms C took her son to see her GP. The GP diagnosed tonsillitis and prescribed penicillin. When Ms C read the patient information leaflet that came with the penicillin, it said that the dosage for a child aged five or under was less than that prescribed by the doctor. The following morning at 08:00, Ms C telephoned the surgery to explain her concerns about the dosage. She said she was told that her GP would call her back at midday. Ms C said that at 17:00, having had no response, she telephoned again. Ms C said her GP eventually called her back at 18:00, apologised for the delay and advised her to amend the dosage. It was clear from the complaint correspondence that the GP accepted that he made an error in this case, and that he had reflected on and apologised for his mistake. In order to try to provide Ms C with some reassurance on the effects of the over prescription on her son, the GP also discussed the prescribing error with a consultant paediatrician. In investigating the complaint, we took advice from one of our medical advisers about the mistake. They said that although the dose was higher than recommended it was unlikely that the prescribing error would result in any lasting harm to Ms C's son. They did, however, suggest that we made recommendations about this.

Recommendations

We recommend that the medical practice conduct a Significant Event Audit around the prescribing error.
We recommend that the GP discusses the complaint and management of paediatric problems at his next appraisal.