SPSO decision report

Case: **201103340, Highland NHS Board**
Sector: health
Subject: communication, staff attitude, dignity, confidentiality
Outcome: not upheld, no recommendations

Summary

Mrs C's late mother (Mrs A) was diagnosed with cancer in 2011. Mrs C complained that when blood test results were found to be abnormal, a GP from her mother's medical practice (GP 1) failed to tell Mrs A about these when he was the on-call doctor. Mrs C was unhappy that her mother did not find out the results until nine days later when she attended the local community hospital's accident and emergency department (A&E) and GP 1 (who was the on-call GP in the hospital at the time) accessed the results.

The background to this is that another GP at the practice (GP 2) had arranged for Mrs A to attend the surgery in late December 2010 to have non-urgent blood samples taken. These were sent to the laboratory the following day where they were immediately identified as abnormal. At the time, the laboratory's procedures set out that they must communicate abnormal test results to medical staff quickly, and make a computer entry showing when the call took place and to whom. The procedure also included an out-of-hours number for laboratory staff to call if it concerned an out-of-hours GP.

In their response to Mrs C's complaint, the board apologised for a failure in the timely reporting of the abnormal blood results. However, the board advised us that it was unclear to them whether the laboratory had failed to follow procedure. When we investigated, we found that it was difficult for us to be certain whether the laboratory had telephoned and told the practice the results. There was an entry on the computer system suggesting that a call had been made to GP 2. However, the surgery had closed an hour before the laboratory had apparently made the call. In addition, GP 2 saw his last patient in the surgery at 12:45 and was not the on-call doctor that particular day. There was also no entry in Mrs A's medical records to indicate that the surgery had received a call from the laboratory. There was, therefore, no conclusive evidence that confirmed that the practice were aware of the test results.

The medical records showed that GP 1 accessed the results in early January 2011 when Mrs C's mother attended A&E. We did not uphold the complaint, as we considered that GP1 had taken appropriate action to have Mrs A further assessed at that time, and there was no evidence to support that he was aware of the blood test results before he accessed them in January 2011.