SPSO decision report

Case: **201302345, A Medical Practice in the Lothian NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained that a consultation that her late husband (Mr A) had at his medical practice was unreasonable, and was unhappy with their handling of her subsequent complaint. Mr A had been suffering from a cough and loss of appetite, and was due to see his GP but as his condition had worsened he arranged an earlier emergency appointment. The GP examined him and diagnosed pneumonia. He prescribed an antibiotic (a drug used to fight bacterial infections), took blood samples for testing, completed a referral form for Mr A to take to his local hospital for a chest x-ray later that day and planned to review Mr A again in one week, or earlier if his condition deteriorated. Mr A returned home, and, sadly, his teenage son found him dead there some three hours later. Ms C complained to the practice in July and September 2013 and the GP responded in July and October 2013. Ms C was dissatisfied with the responses and asked us to look at her complaint.

Our investigation, which included taking independent advice from one of our medical advisers, found that there were some failings in the GP's actions and his recording of the consultation and we upheld this part of Ms C's complaint. The adviser said that although the GP had noted some observations, other key observations (such as blood pressure, temperature, and respiratory rate) were not recorded. The adviser said that, although there was no indication that Mr A needed to be immediately admitted to hospital, the lack of these recordings were of concern where a patient had been diagnosed with pneumonia.

The adviser also noted that guidance on the management of lower respiratory tract infections (SIGN 59), issued by the Scottish Intercollegiate Guidance Network (SIGN) recommended that two different, but complementary, types of antibiotic should be prescribed for patients with suspected pneumonia. SIGN 59 also recommended review in 48 hours rather than the one week planned by the GP. Overall, the adviser was of the view that immediate hospitalisation might not have changed the outcome for Mr A. He said that bronchopneumonia (acute inflammation of the lungs) - which was identified as the cause of Mr A's death - can progress rapidly and aggressively. Because of the failings in the records of the consultation, however, it was impossible to say this for certain. We noted that the practice had conducted a significant events analysis (a process of examining what happened and identifying what, if anything, went wrong and what, if any, remedial action is needed). The adviser said that this had picked up some, but not all, of the learning points from this complaint.

Our investigation found that the practice acknowledged and responded to Ms C's complaint within the timescales in their complaints process, which mirrored the national guidance on complaints handling. The first acknowledgement was incorrectly dated but the practice manager had apologised for this in a later letter. Although we appreciated that Ms C was not happy with the practice's handling of her complaint, we considered that the timescales had been met and all the issues she raised were addressed - albeit not to her satisfaction. Because of this we did not uphold this part of her complaint.

Recommendations

We recommended that the practice:

- ensure that the GP reflects on his practice in relation to these events, in particular in relation to SIGN 59 and clinical note-taking, and discusses any learning points at his next appraisal;
- review their procedure for conducting a significant event analysis to ensure that all learning points are recorded and addressed; and
- issue a written apology for the failings our investigation identified.