SPSO decision report

Case: **201507623, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained that the practice failed to provide appropriate medical care to her husband (Mr A).

Mr A suffered from ischaemia (inadequate blood supply), which had previously resulted in the amputation of his right leg below the knee. He was admitted to hospital with ischaemia of his left foot and an ulcer. There was no surgical option available to address this issue and the plan was to delay amputation as long as possible. Mr A was being seen twice a week by district nurses following discharge from hospital.

Some months after discharge, the practice was contacted by the board's district nurse who had identified deterioration in Mr A's foot. A GP at the practice did not consider a visit was necessary at that time, and instead prescribed antibiotics for Mr A. On the fourth day after the visit, Mrs C further contacted the practice when she received no subsequent visit from the board's district nurses. A second GP from the practice attended Mr A at home. The GP did not examine the wound, but prescribed further antibiotics. Two days later, the practice was further contacted as a district nurse had attended and discovered a maggot infestation in Mr A's wound. A GP attended and Mr A was taken to hospital. Mr A subsequently received an above-knee amputation of his left leg.

Mrs C complained about the actions of the two GPs. She also complained about the practice's communication with the board. The practice acknowledged communication failings had occurred, and apologised to Mrs C.

After receiving independent advice from a GP, we upheld Mrs C's complaint. While we found the first GP acted appropriately in prescribing antibiotics, we found the second GP should have examined the wound given Mr A had previously received antibiotics and his symptoms were worsening. We also found that the practice's communication with the board fell below a reasonable standard.

Recommendations

We recommended that the practice:

- ensure the relevant GP is made aware of the findings of the investigation for reflection and learning;
- issue an apology for the identified failings in care.