SPSO decision report

Case: **201704020, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained to us about the care and treatment that her late father (Mr A) had received from the practice. Mr A had attended the practice as he was feeling some discomfort in his chest after exertion and increasing fatigue. He was referred to hospital urgently for a chest x-ray. The GP also increased the dose of Verapamil (a medication used for high blood pressure and angina) Mr A was receiving. Mr A had a scan of his heart at the hospital approximately ten days later This showed valve disease in Mr A's heart, which can lead to heart failure. An appointment was made for him to see a consultant cardiologist (a doctor who specialises in finding, treating and preventing diseases of the heart and blood vessels) and the Verapamil was stopped and his medication changed. Mr A's condition deteriorated and he returned to the practice several days after the hospital appointment. He complained of chest pain radiating to his back and said that he was no better with the new heart medication. The GP thought that this might be caused by gastric irritation and increased his medication for stomach acid. Mr A died from heart failure the following morning.

Ms C complained about the practice's decision to increase her father's Verapamil. We took independent advice from a GP adviser. We found that Mr A had been referred to hospital because it was considered that he had worsening angina. The GP had consequently increased Mr A's Verapamil, which is a recognised and common treatment for angina. The GP could not have foreseen the echocardiogram result at that time and, therefore, could not have foreseen that increasing the Verapamil was not the best treatment. Mr A's valve disease had not been caused by Verapamil, but is a condition that deteriorates over many years. We did not uphold this aspect of Ms C's complaint.

Ms C also complained that the GP did not examine Mr A's chest at the appointment after his hospital visit. We found that the GP should have examined Mr A, as he was complaining of persistent chest pains and had no improvement with cardiac medication, despite recent cardiology confirmation that he had developed new heart failure. We upheld this aspect of Ms C's complaint, although we were unable to say if an examination by the GP would have changed the overall outcome for Mr A.

Finally, Ms C complained that the practice had delayed in processing a medication request for Mr A. The practice had accepted that there had been failings in relation to processing this request and had apologised to Ms A for this. We also, therefore, upheld this aspect of her complaint. We made no further recommendations regarding this, but we asked the practice for evidence of the action they said they had taken.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to carry out an examination of Mr A. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Staff should be aware of the symptoms, signs and management of unstable angina and should carry out and record an adequate clinical assessment in appropriate cases in line with General Medical Council guidance.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.