SPSO decision report

Case: **202101442, A Medical Practice in the Grampian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to the practice about the care and treatment provided to their relative (A). A began to experience abdominal pain and was reviewed by doctors at the practice a number of times before being admitted to hospital as an emergency. Following discharge, A was seen at the practice again with continuing symptoms and unintended weight loss. They were referred to hospital and again discharged. A colonoscopy performed suggested acute diverticulitis (where small pouches from the wall of the gut become inflamed or infected). A attended the practice again with worsening symptoms and was admitted to the hospital after an urgent request was submitted. A died in hospital a few weeks after.

C was concerned about the standard of care provided to A by the practice. The practice met with A's family. The practice carried out a Significant Event Analysis (SEA). The practice responded to C's complaint and noted their frustration that A had been discharged from the hospital without progress in the management of their condition. However, they did not find that they should or could have done anything differently in A's care.

C submitted a further complaint to the practice after they received a response from the health board regarding the care provided at the hospital. The practice responded confirming that an SEA had been carried out. The doctor who had seen A had discussed the case with colleagues in the practice and with their Educational Supervisor. These discussions had been informal and had not been documented in A's notes.

C was dissatisfied with the complaint responses and brought the complaint to our office. We took independent advice from a GP. We found that most of A's care was of a reasonable standard. However, there was a delay in acting on concerns about A's condition following their second discharge from hospital. Given the significance of the failures identified, we considered that A's care fell below a reasonable standard and upheld this part of C's complaint.

C also complained that the practice failed to reasonably respond to C's concerns. We found that the identified failure should have been communicated to the family, by the practice, during their investigation of the family's complaints. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the failure to act with sufficient urgency following A's discharge. The apology should meet the standards set out in the SPSO guidelines on apology. available at www.spso.org.uk/information-leaflets.
- Apologise to A's family for the complaint investigation's failure to identify a failing in A's care. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients requiring urgent care should be referred to specialists within a reasonable timeframe.
- The practice should ensure relevant staff are aware of the need to document discussions about patient care appropriately, in this case discussions between a trainee doctor and their Educational Supervisor, concerning a patient's care.
- Complaint investigations by the practice should address all relevant issues and should clearly identify and address any failings.

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.