# SPSO decision report

**Case:** **202104751, A Medical Practice in the Lanarkshire NHS Board area**
**Sector:** Health
**Subject:** Clinical treatment / diagnosis
**Decision:** upheld, recommendations

## Summary

C complained on behalf of their partner (A) about the care and treatment they received from the practice. A was prescribed an anti-inflammatory drug by a rheumatology consultant (specialists in diagnosing and managing chronic inflammatory conditions). The medication was issued on repeat prescription by the practice. C told us that the medication had risks and the practice failed to carry out appropriate medication reviews or update A about the risks. C said A was not aware of the risks of the medication and trusted that it was safe to use long-term. They felt it was unreasonable for the practice to assume A would have read the leaflet with the medication to identify any changes or to know to ask for a medication review.

The practice said that the medication was prescribed by the rheumatology service and would have been monitored by them. The practice highlighted that at the time the medication was prescribed, it was not considered high risk, and that the risks only became known after A had been prescribed the medication for a number of years. The practice noted that A did not proactively contact the practice to review their medication periodically but acknowledged that they did not contact A either.

We took independent advice from a GP. We found that national guidance states that patients should have annual checks when taking medication of this sort. The responsibility for carrying out these checks lies with whoever is issuing the prescription. When discharged from the rheumatology service, the practice should have invited A for a review and arranged appropriate follow-up. The practice should have carried out medication reviews and informed A about the change of risks associated with the medication.

We found that it was unreasonable for the practice not to have carried out medication reviews or informed A about the change in risks. Therefore, we upheld C's complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to A for failingto alert them to the changes in risks associated with the medication, having a discussion about the risks, and allowing them to make an informed choice on whether or not to continue with the medication; failing to carry out medication reviews annually as they should have done; and failing to invite A to a review of their health when the practice became aware they were discharged from the rheumatology service. 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:

- GPs should recognise that as the prescriber of the medication it is their responsibility to carry out medication reviews on medications provided via repeat prescription. When a GP is alerted to the fact a patient is discharged from a secondary care service due to non-attendance, they should contact the

patient to arrange a review and consider appropriate follow-up. Medication reviews should be carried out annually.

- When medication alerts are issued nationally, the practice should identify and review any of their patients to whom such an alert might apply.

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.