SPSO decision report

Case: **202107872, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, no recommendations

Due to a technical error, only half of the intended decision summary was published on the 24 May 2023. The paragraph in italics below was added on 8 January 2024 once the error was identified.

Summary

C complained about the care and treatment provided to their late parent (A). A felt unwell whilst residing in a care home. They were coughing up blood associated with green phlegm and had chest and abdominal pain. Staff at the care home contacted NHS 24 and were advised that a home visit would be conducted. However, the GP subsequently carried out a telephone consultation due to concerns around the transmission of COVID-19. They diagnosed A with a chest infection. A second GP visited 48 hours later and suspected A had pulmonary embolism (a blocked blood vessel in the lungs) and deep vein thrombosis (a blood clot in a vein). A was admitted to hospital where this was confirmed. A died a few months later and C said that pulmonary embolism was described as a contributing factor on their death certificate. C was concerned that the GP did not conduct a home visit and subsequently failed to correctly diagnose A's condition and instead focused on the transmission of COVID-19 and associated risks. C believes that if a home visit had been conducted, A would have been correctly diagnosed 48 hours earlier and could have received treatment.

The board responded and identified some issues in the medical history and documentation taken. C remained dissatisfied with the board's response and brought their complaint to us.

We took independent advice from a GP. We found that it was reasonable that no home visit was offered in the context of COVID-19. However, the medical history and particularly the documentation taken by the GP was unreasonable. In particular, there was no documentation to support the consideration of respiratory rate/ breathlessness, leg pain/swelling and pulmonary embolism. In view of these failings, we upheld C's complaint that the board failed to provide A with reasonable care and treatment. The board had already apologised for the failings and had highlighted them to relevant staff as a learning point. However, we provided some further feedback to the board.