SPSO decision report

Case: **202203063, A Medical Practice in the Tayside NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late sibling (A) received from the practice. A attended the practice with back pain and was given painkillers. Clinical staff noted comments on A's appearance and demeanour during the appointment. They also noted that they considered A to be drug seeking. A died a few days later.

C complained that the examination was not thorough enough and that clinicians missed the fact that a lung infection was the cause of A's symptoms. The practice said that they considered the examination to be reasonable, that they felt that A did not present with typical signs of respiratory concern and so auscultation (listening to the lungs) was not indicated. They did not identify anything that could have been done differently.

We took independent clinical advice from an advanced nurse practitioner. We considered that there were enough complicating factors in A's history and presentation to warrant a more thorough examination of A. Therefore, the examination carried out was unreasonable. We found that the opinion that A was drug-seeking was premature as no differential diagnoses were considered or ruled out. We also noted that an adverse event review was not carried out which we considered to be unreasonable. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to carry out a reasonable and thorough examination of A when they presented at the practice for a consultation, for failing to consider/rule out differential diagnoses to explain A's symptoms and for failing to carry out an adverse event review to investigate what happened and promote learning for the staff involved. 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 should be examined thoroughly. When examination is difficult, and/or it is difficult to obtain a clear history, care should be taken not to reach conclusions prematurely without ruling out differential diagnoses as appropriate.
- When a patient dies shortly after they have been seen at the practice, an adverse event review should be carried out in line with the National Framework for Scotland to ensure that any learning (and good practice) can be identified and acted on.

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.