

SPSO decision report

Case: 202311004, A Medical Practice in the Highland Board area
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment given to their late spouse (A) by the practice before A died from metastatic renal cancer. C raised concerns that A was misdiagnosed by the practice and that they did not make appropriate referral for further investigation when they should have done.

In response, the medical practice provided a detailed timeline of appointments, symptoms, treatments, and actions taken. They concluded that A had a complicated medical history and that the fact that A found it difficult to attend face-to-face appointments, made it difficult for doctors to gauge how much pain they were in. The medical practice acknowledged that there was some miscommunication between the practice and secondary care colleagues in physiotherapy.

We took independent clinical advice from a GP adviser. We found that much of the care and treatment provided to A had been reasonable. However, we also found that some consultations were unreasonable, and that red-flags were not always appropriately identified and/or recorded and were not followed up. We also found that the SAER was not completed in line with the guidelines. As such, we upheld both complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failures identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/meaningful-apologies.

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

- Instigated a monthly meeting with professionals to discuss patients with complex medical presentations. Hold gold standard meetings monthly including the clinical team, district nurses, and MacMillan nurses. Identified a number of learning points from the SAER that was carried out.
- Documentation of consultations, examinations carried out, and the points raised and discussed should be accurate and complete. Treatment should be in line with the relevant NICE guidelines specifically in reference to red-flag symptoms and signs. Clinicians should take action to identify if any red-flag symptoms are present and take appropriate action when they are.
- Patients should be escalated/ referred to hospital pathways when their presentation indicates it is appropriate. Communication and interactions with other health care teams should be carried out reasonably and effectively.

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.