Scottish Parliament Region: Central Scotland

Case 201300108: A Medical Practice in the Lanarkshire NHS Board area

Summary of Investigation

Category

Health: Family Health Service; General Practice; clinical treatment; diagnosis

Overview

The complainant (Mr C) raised a number of concerns that his mother (Mrs A) had received inadequate care and treatment in October 2011 resulting in a failure to diagnosis kidney failure or admit Mrs A to hospital. Mrs A subsequently died on 2 November 2011.

Specific complaint and conclusion

The complaint which has been investigated is that between September 2011 and October 2011, doctors at Mrs A's medical practice (the Practice) failed to take into account Mrs A's symptoms, previous medical history and family concerns and that they did not arrange an emergency hospital admission (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) review the GMC Guidance on record-keeping and evaluate a sample of their case notes to see if they are fulfilling the required standards;	23 April 2014
(ii) review with the doctors involved in Mrs A's care the SIGN guidance on chronic kidney disease and its management and identify this as a learning need within their appraisals;	26 March 2014
(iii) discuss this complaint and its evaluation with the doctors involved in Mrs A's care in their yearly appraisal;	26 August 2014
(iv) carry out a significant event analysis of this incident and discuss the results within the practice team; and	23 April 2014
(v) apologise sincerely to Mr C and his family for the	12 March 2014

failures in the care and treatment provided to Mrs A.

The Practice have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mr C is the son of Mrs A, who died on 2 November 2011 as a consequence of kidney failure. Mrs A was a woman with multiple medical problems who had frequent consultations with her medical practice (the Practice). Over a period of 19 days, starting on 7 October 2011 Mrs A had contact with doctors from the Practice six times. Mrs A had a history of kidney problems and was vomiting and refusing food throughout this period. Mr C believes that Mrs A should have been admitted to hospital on 24 October 2011. On 26 October 2011 Mr C was very concerned about Mrs A's condition and requested that a doctor from the Practice visit her. Following this visit Mr C was told by the doctor that unless there was concern about the results of Mrs A's blood test results, she would not be admitted to hospital. On 27 October 2011 Mr C found Mrs A wandering inside her property in a confused state and took her directly to Hairmyres Hospital in his car. Upon admission Mrs A was found to be suffering from kidney failure. Although Mrs A was transferred as an emergency to Monklands Hospital and dialysis was started, Mrs A died at 05:55 on 2 November 2011.

2. The complaint from Mr C which I have investigated is that between September 2011 and October 2011, the doctors at the Practice failed to take into account Mrs A's symptoms, previous medical history and family concerns and that they did not arrange an emergency hospital admission.

Investigation

3. As part of the investigation all the information provided by Mr C and by the Practice has been given careful consideration. This included all the complaints correspondence and Mrs A's relevant medical records. An independent clinical opinion was obtained from a General Practice specialist adviser (the Adviser) and this too has been taken into account.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Between September 2011 and October 2011, doctors at the Practice failed to take into account Mrs A's symptoms, previous medical history and family concerns and that they did not arrange an emergency hospital admission

5. Mr C said that Mrs A was taken to the Practice on 30 September 2011 for a consultation and was prescribed antibiotics for a chest infection and co-codamol for lower back pain. The records provided by the Practice show that Mrs A was seen on 7 October 2011 by a GP (Doctor 1), when these items were prescribed. On 11 October 2011 Mrs A began to vomit after eating. On 16 October 2011 Mrs A was visited by an out-of-hours (OOH) GP (Doctor 2), who gave her an anti-sickness injection and more antibiotics. On 22 October 2011, an OOH GP (Doctor 3) was again called out to Mrs A and he suggested that the cause of the nausea might be the antibiotics she was taking. Doctor 3 then gave Mrs A another injection to control her nausea.

6. Mrs A was visited by a GP from the Practice (Doctor 4) on 24 October 2011. Doctor 4 was unable to gain access as the door was locked. Doctor 4 called again later that day and saw Mrs A, but told Mr C that he was not too concerned about her and would return the following day with a nurse.

7. Mr C and other family members visited Mrs A on the evening of 24 October 2011. They were very concerned by her condition and believed she should have been admitted to hospital. On 25 October 2011, Mr C visited his mother in the morning and ensured she had taken her medication. By 12:30 Mr C became concerned that no doctor had visited and telephoned the Practice. He was informed that no visit was scheduled for either a doctor or a nurse, but a visit was due on 28 October 2011. An offer was made to contact the district nurse, and a visit was arranged for 26 October 2011.

8. On the morning of 26 October 2011, Mr C was again concerned about Mrs A's condition and another GP from the Practice (Doctor 5) visited. Doctor 5 said that Mrs A would not be admitted to hospital unless there was concern following the results of the blood tests being taken by the district nurse. Doctor 5 then prescribed anti-sickness tablets and arranged a visit for 28 October 2011.

9. On 27 October 2011 Mr C visited Mrs A, but she did not answer the door. Looking through the windows of the property, Mr C could see that she was wandering from room to room, using the walls of the property to support herself.

Mr C gained access to the property, and found Mrs A sitting on a couch in a confused state. He immediately took Mrs A to hospital by car, where she was found to be suffering from kidney failure. Mr C said that at the hospital staff expressed surprise that Mrs A had not been referred to them sooner. Mr C subsequently learned that the Practice had been attempting to visit Mrs A at home that morning, as her blood tests had indicated to them she was suffering from kidney failure.

The Practice's Comments

10. The Practice responded to the complaint by letter on 13 December 2011. The Practice set out Mrs A's symptoms on 30 September 2011 and on 16 October 2011. The reply said that following the visit by Doctor 2 from the OOH service, no home visit from the Practice had been required.

11. The Practice said that the family had again contacted the OOH service on 22 October 2011 and that as antibiotics had been suggested as a cause for the nausea Mrs A was suffering, these had been stopped and an injection given to control the vomiting. No follow up visit from the Practice had been requested.

12. Doctor 4 from the Practice had visited Mrs A on 24 October 2011 and it was reported to him that Mrs A had been generally unwell and that her oral intake had been poor. Doctor 4 had noted Mrs A felt a little better and had requested that blood samples be taken by the district nurse. On 26 October 2011, the Practice said that Doctor 5 was already on house visits, when the receptionists at the Practice passed on a request for a visit to Mrs A. Doctor 5 had noted that upon arrival Mrs A was sitting fully dressed in a chair. She had greeted the doctor by name and had seemed alert and responsive. During the examination Mrs A had complained of nausea, but no abdominal pain. Mrs A had not been sick that morning, although she had very little appetite.

13. Doctor 5 noted Mrs A had complained of back pain. The Practice noted Mr C's belief that this should have indicated renal failure, however, they also observed that Mrs A suffered from arthritis, which was suspected as the cause of this symptom. The Practice said that Doctor 5 recalled that Mrs A showed no signs of confusion, although a family member present expressed concern over intermittent confusion over the previous few days. The Practice said that examination of Mrs A's cardiac and respiratory systems showed no

abnormalities. During the visit, the district nurse arrived to take the bloods requested by Doctor 4 on 24 October 2011.

14. The Practice said that Doctor 5 had made a clinical decision to wait for the result of the blood tests taken on 26 October 2011, as there was no indication a hospital admission was required at that time. The Practice said that under normal circumstances, if the blood test results indicated urgent attention, the lab would contact either the Practice or NHS 24 by telephone as soon as the results were available. The Practice said on this occasion, unfortunately the blood samples had taken an unusually long time to arrive at the lab and that the Practice had not been supplied with results that evening as they would normally have been. As soon as the results were received on 27 October 2011, Doctor 5 had made an immediate visit to Mrs A's house. By then, however, she had already been taken to hospital.

15. The Practice said that as a result of Mrs A's case, renal failure would always now be considered when attending an elderly or vulnerable patient. In addition, the Practice accepted that they had not been aware of the protocol for bagging urgent blood samples separately and sending advance notice to the laboratory carrying out the blood tests. This information had been shared with all doctors working at the Practice.

Advice Received

16. My complaints reviewer obtained independent clinical advice about the complaint. The Adviser noted that Mrs A was a woman with a number of medical problems who had frequent consultations with the Practice. The Adviser said that having reviewed the clinical records there were a number of issues which concerned her.

17. The Adviser said that the first issue was the prescription of antibiotics by the Practice on 7 October 2011 and 13 October 2011. The first record of a consultation she had identified during this period was by Doctor 1 on 7 October 2011. At this visit, the Practice prescribed amoxicillin (a common antibiotic used to treat respiratory infections). The Adviser noted that the clinical record showed Mrs A was prescribed amoxicillin on 7 October 2011 and again on 13 October 2011. There was no record of who took the decision to repeat the prescription on 13 October 2011. In addition the records contained no assessment of Mrs A, nor any note of the reasoning behind the decision to prescribe the same antibiotic again. The Adviser noted that the Practice's

records stated ‘16 October 2011 - Mrs A was seen by NHS 24 and was prescribed antibiotics for a chest infection’. The Adviser said that from the clinical records, this appeared to be incorrect, as the prescription was issued by the Practice on 13 October 2011 some three days earlier. The Adviser said she had confirmed this through a review of the OOH assessment for the visit on 16 October 2011. This showed Doctor 2 had prescribed an anti-sickness injection and stronger pain killers, but no antibiotics.

18. The Adviser said she questioned the appropriateness of repeating a course of antibiotics, when the patient did not appear to have improved. She felt it would have been more appropriate to reassess the patient to see if a different antibiotic would be more effective. Additionally, the repeat prescription had been issued without a documented clinical assessment and the Practice had responded inaccurately to the family's complaint, by stating the OOH service had prescribed the antibiotics, despite this being contradicted by the clinical record.

19. Secondly the Adviser said that the home visit on 24 October 2011 also highlighted failings on the part of the Practice. The clinical record notes Mrs A as ‘Generally unwell – anorexia, pallor, was nauseated but better – for basic bloods’. The Adviser said there were no recorded observations of blood pressure, temperature, pulse or urinalysis and there was no documented clinical examination of the patient. She said it would have been reasonable to expect an examination to have been carried out and these observations to have been recorded, as the previous recorded blood pressure reading was taken on 12 September 2011.

20. The Adviser also noted the OOH record for the visit on 22 October 2011 noted that Mrs A was producing brown vomit after medication and food. There was no reference to this in the clinical record of the visit on 24 October 2011 nor was there any assessment of the brown vomit. The Adviser said this was concerning, as brown vomit could be a sign of hematemesis (vomiting blood). The Adviser said that the clinical assessment, examination and record-keeping for the visit on 24 October 2011 were not of a reasonable standard. In addition, in her view the description in the record was of a patient who was generally unwell and the Adviser said her view was that blood tests should have been carried out urgently that day.

21. The Adviser had further concerns based on the record of the home visit on 26 October 2011. This was the sixth contact with the GP at the request of Mrs A's family within 19 days, with Mrs A suffering from on-going vomiting and being described as unwell. The clinical record for the visit on 26 October 2011 states 'Still generally unwell, not eating, poor oral intake. Family feel should be in hospital but nil specific, nausea only – half eaten toast and tea on plate … Await results. Try maxolon. Review 2 days. Additional info added - O/E Pale, chest clear and conversing easily'. The Adviser said that again the standard of clinical assessment, record-keeping and examination fell below a reasonable standard. She said the examination on 26 October 2011 was insufficiently thorough, given the length of time Mrs A had been unwell and given the number of contacts she had had with doctors over the preceding 19 days. There was no record of blood pressure, pulse, temperature, urinalysis or abdominal examination. The Adviser said that the recent chronology of Mrs A's ill health had not been taken into account and the doctor had relied solely on Mrs A's presentation at that visit, as the blood samples had not been taken for testing.

22. The Adviser said that in her view Mrs A's condition was not improving and it would have been appropriate by 26 October 2011 to admit her to hospital for further investigation. This would have allowed her condition to be stabilised and closer monitoring of her condition to be conducted. The Practice had not taken the concerns expressed by Mrs A's family into account, despite the fact that the family had initiated all the previous requests for assessment and in the Adviser's view were best placed to gauge Mrs A's deterioration over a short period of time.

23. The Adviser also noted 19 days had elapsed before Mrs A underwent blood tests. She said that in a patient with existing renal impairment and on-going vomiting as well as other recognised medical problems, this represented an unreasonable delay.

24. The Adviser said that the Practice's response to Mr C's complaint stated that neither Doctor 2 nor Doctor 3 requested a return visit from the Practice for Mrs A. She said the OOH service had provided a thorough report to the Practice of the clinical care they had provided. The Practice were provided with these OOH consultation documents and the Adviser said that it was not, therefore, relevant whether the OOH requested a follow up visit from the Practice. The Practice had a responsibility to read the consultation documents provided by the OOH service, they should have used this, in conjunction with

their knowledge of Mrs A to decide whether she should have been reassessed, rather than waiting for a request from either the OOH service or Mrs A's family.

25. The Adviser went on to describe the care Mrs A received as fragmented, noting that Mrs A had six contacts in 19 days from five or six different doctors. She noted that it was impossible to be certain of the exact number, since the record did not identify the surgery GP who repeated the amoxicillin prescription on 13 October 2011. The Adviser said that although both OOH GPs attending Mrs A referred to her medical history, neither of the Practice GPs recorded a clinical account of their overall view of Mrs A's presentation for this period. The Adviser said she felt they had not taken the chronology or the whole clinical picture into account when visiting Mrs A. As a result, she felt the treatment Mrs A had received had been unacceptably reactive, rather than taking a proactive approach to her management.

Conclusion

26. Mr C has clearly expressed the view that Mrs A was not properly assessed by the Practice and that they failed to take into account her medical history and the concerns expressed by family members. This led to a failure to admit Mrs A to hospital when this would have been the most appropriate action.

27. Although the Practice have accepted they did not consider renal failure when assessing Mrs A and that they have learnt lessons from the failure to mark her blood samples as urgent, the advice given to my complaints reviewer was that there were still serious, unaddressed failings on the part of the Practice. The record-keeping by the Practice was of an unacceptable standard and the clinical examination and assessment of Mrs A by doctors from the Practice on two separate occasions was also of an unacceptable standard.

28. It was the Adviser's opinion that overall Mrs A's care had lacked focus. The Practice had not taken a proactive approach to the situation, nor had they managed Mrs A's care and treatment reasonably over the 19 day period. Mrs A's family had to repeatedly request assessments for Mrs A, but their concerns and opinion of her condition had not been given adequate consideration by the Practice. The Practice had not taken account of the multiple medical conditions that Mrs A suffered from and had failed to request blood tests timeously.

29. In addition inaccuracies have been identified in the Practice's response to Mr C's complaint. The Practice incorrectly stated that the second course of antibiotics were prescribed by the OOH service rather than the Practice. This error is concerning as the clinical record supplied by the Practice is clear on the dates the prescriptions were issued. It is important that responses to complaints are chronologically accurate and clearly identify all the individuals making decisions on a patient's care, as errors of this nature undermine their credibility.

30. Careful consideration has been given to all the evidence available and whilst I note the actions the Practice has already taken, the advice received by my complaints reviewer has identified a number of other failings which remain unaddressed. In the Adviser's view this meant that the care provided to Mrs A fell below a reasonable level. In view of this advice I uphold this complaint.

31. The Practice should now apologise sincerely to Mrs A's family for the failures identified in her care and treatment. Additionally I recommend that the Practice should review the General Medical Council (GMC) guidance on record-keeping and should then evaluate a sample of their case notes to ensure that they are meeting the required standards. The doctors responsible for Mrs A's care should review the Scottish Intercollegiate Guidance Note (SIGN) guidance on chronic kidney disease and its management and this should be identified as a learning need in their appraisals. The doctors should also discuss this complaint and its evaluation their yearly appraisal. The Practice should also conduct a significant event analysis of this incident and discuss the findings within the practice team.

Recommendations

32. I recommend that the Practice:	*Completion date*
(i) review the GMC Guidance on record-keeping and evaluate a sample of their case notes to see if they are fulfilling the required standards;	23 April 2014
(ii) review with the doctors involved in Mrs A's care the SIGN guidance on chronic kidney disease and its management and identify this as a learning need within their appraisals;	26 March 2014
(iii) discuss this complaint and its evaluation with the doctors involved in Mrs A's care in their yearly	26 August 2014

appraisal;

(iv) carry out a significant event analysis of this incident and discuss the results within the practice team; and — 23 April 2014

(v) apologise sincerely to Mr C and his family for the failures in the care and treatment provided to Mrs A. — 12 March 2014

33. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	the complainant
Mrs A	the complainant's late mother
the Practice	Mrs A's Medical Practice
the Adviser	the independent adviser on general practice medicine
GP	General Practitioner
Doctor 1	a GP at the Surgery, who saw Mrs A on 7 October 2011
OOH	out-of-hours service, which provides access to GP's outside of normal working hours or in emergencies
Doctor 2	OOH GP who saw Mrs A on 16 October 2011
Doctor 3	OOH GP who saw Mrs A on 22 October 2011
Doctor 4	GP from the Practice who saw Mrs A on 24 October 2011.
Doctor 5	GP from the Practice who saw Mrs A on 26 October 2011
GMC	General Medical Council
SIGN	Scottish Intercollegiate Guidelines Network

Annex 2

Glossary of terms

Amoxicillin	antibiotic used to treat bacterial infections
Cardiac System	the system by which the heart pumps blood round the human body
Hematemesis	vomiting blood
Maxolon	a drug prescribed to prevent vomiting
Nausea	an urge to vomit
Renal Failure	failure by the kidneys to perform their normal function of filtering blood
Urinalysis	a range of tests performed on a patient's urine to assist with diagnosis

Annex 3

List of legislation and policies considered

SIGN 103 – Diagnosis and management of chronic kidney disease

General Medical Council – Good Medical Practice