SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case 201402431: A Medical Practice in the Lothian NHS Board area

Summary of Investigation

Category

Health: FHS – GP clinical diagnosis; treatment

Overview

The complainant (Mrs C) raised a number of concerns that her late brother (Mr A) had been inappropriately assessed when he attended his GP Surgery (the Practice) on 29 July 2013. She complained that Mr A should have been referred to hospital for further tests rather than being prescribed medication for an inflamed stomach. Mr A died suddenly of a heart attack on 31 July 2013.

Specific complaints and conclusions

The complaint which has been investigated is that on 29 July 2013 the Practice failed to provide Mr A with appropriate medical care (*upheld*).

Redress and recommendations

I recommend that the Practice:		*Completion date*
(i)	issue an apology to Mrs C for the failings identified;	21 February 2015
(ii)	review the level of education and training required to carry out the NP role, particularly in relation to clinical assessment and diagnosis;	21 April 2015
(iii)	review the assessment/supervision and on-going monitoring and appraisal requirements in place for the nurse practitioner; and	21 April 2015
(iv)	submit a Significant Event Analysis (SEA) which is in the standard format used nationally.	21 April 2015

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

Main Investigation Report

Introduction

1. Mr A was a 51-year-old man who smoked cigarettes, had a family history of cardiovascular disease (narrowing of blood vessels leading to the heart) and high cholesterol (fat found in the body and bloodstream). He was not a frequent attender at his medical practice (the Practice) but on 29 July 2013 he attended an appointment due to epigastric pain (area of the abdomen just below the breastbone).

2. When Mr A attended the Practice he was assessed by a nurse practitioner (the NP), who recorded that Mr A's pain was not radiating and that he had taken some omeprazole tablets (medication to reduce stomach acid) which had helped. There were no symptoms of shortage of breath or cardiac symptoms (relating to the heart). On examination, Mr A's abdomen was soft, only tender epigastrically, and he was questioned about his alcohol intake recently. His blood pressure was recorded as 134/70 and lansoprazole medication (medication to reduce stomach acid) was prescribed, with advice on its usage.

3. Mr A died suddenly on 31 July 2013, with the cause of death recorded as haemopericardium (collection of blood between the lining of the outer wall of the heart and the outer heart muscle) secondary to ruptured myocardial infarct (heart attack). Mr A's sister (Mrs C) complained to the Practice about the standard of medical treatment provided to her brother.

4. The complaint from Mrs C which I have investigated is that on 29 July 2013 the Practice failed to provide Mr A with appropriate medical care.

Investigation

5. My complaints reviewer reviewed relevant national guidance, policies and procedures. He also made enquiries of the Practice; reviewed the documentation provided by Mrs C and the Practice; and took advice from a medical adviser (Adviser 1) and a nursing adviser (Adviser 2).

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

Complaint: On 29 July 2013 the Practice failed to provide Mr A with appropriate medical care

Mrs C's complaint

7. Mrs C stated that she had obtained a copy of Mr A's medical records and the Practice had failed to explain why he was sent away from the Practice on 29 July 2013 with antacid tablets (medication to combat acid in the stomach) when he had had pain in his left arm and chest pains for three days previously. The family needed to understand what happened and why Mr A was not given an ECG (electrocardiograph – a test which records the electrical activity of the heart) or sent to hospital. It was clear that Mr A was not a frequent attender at the Practice and that his records showed that there was a family history of cardiac problems. In addition, there was no evidence that the Practice had taken action to check Mr A's cholesterol or blood pressure on a regular basis.

The Practice's response

8. The Practice responded to Mrs C's complaint and stated that Mr A had been registered with the Practice for four years and was seen on an infrequent basis with only minor issues. He was not on regular medication and had never reported any cardiac symptoms. While there was mention in the new patient questionnaire that there was a history of high cholesterol and blood pressure from 2007, it was also recorded that there was no personal or family history of heart disease. It was also recorded that cardiac investigations in 2007 proved negative. On 29 July 2013, Mr A was given an appointment with the NP as the request was to be seen that day. The receptionist who made the booking did not record any notes about the mention of chest symptoms or she would have informed the duty doctor, in line with the Practice protocol. On assessment by the NP, there was no mention of any history of chest pain or tingling in the left arm. Mr A's blood pressure and pulse were checked, with no evidence of cardiovascular abnormality evident. Had the NP felt there were signs which pointed to a cardiac cause for the pain, she would have alerted the duty doctor.

9. The Practice continued that they were all saddened to hear of Mr A's sudden death two days later and, in line with their policy on unexpected deaths, they undertook a Significant Event Analysis (SEA). They provided a copy of the SEA report which concluded that, on the basis of the information available to the NP and the history provided by Mr A, she had acted appropriately and that any action by the GPs at the Practice would not have been different. They had revisited the scope of the nurse practitioner role and although there was no change they had introduced fortnightly case based discussions with the GPs, so

there is a greater awareness of the type of patients being seen and treated by the nurse practitioners.

Relevant evidence

10. The Scottish Intercollegiate Guidance Network (SIGN) issues guidance to healthcare staff working in the NHS in Scotland on the investigation, diagnosis and management of a range of medical conditions.

11. SIGN 97 deals with the 'Risk estimation and the prevention of cardiovascular disease'. Five factors which should be taken into account are: the nature of the symptoms; history of ischaemic heart disease; sex; increasing age; and the number of traditional cardiovascular risk factors present.

12. SIGN 93 deals with 'Acute coronary syndromes'. This mentions that patients with suspected acute coronary syndrome should be assessed immediately by an appropriate healthcare professional and a 12 lead electrocardiogram (ECG) should be performed. Repeat 12 lead electrocardiograms should be performed if there is diagnostic uncertainty or a change. For patients who appear stable but who have possible symptoms of angina, they should be referred for an exercise ECG to secondary care.

Advice received

13. Adviser 1 and Adviser 2 were both asked by my complaints reviewer to consider whether there were any concerns about the assessment carried out by the NP; whether there was a need to refer Mr A for an ECG or a hospital admission on 29 July 2013; and whether they had any comments about the SEA which was carried out.

14. Adviser 1 said that, with regard to SIGN 97, Mr A was describing epigastric pain which is a common cardiac symptom although the NP recorded 'no cardiac symptoms'. Epigastric pain could be due to heart problems if the pain is triggered by physical activity and relieved by rest; the pain feels heavy, pressing or tight; the patient has other symptoms, such as breathlessness, nausea, sweating or pain that spreads to the arm; and that there is a risk factor for coronary heart disease, such as being a smoker, high blood pressure, diabetes (chronic disease where there is a raised level of sugar (glucose) in the blood), high cholesterol, family history or obesity. Adviser 1 mentioned that the NP did not record if the symptoms were on exertion or provide a description of the type of pain. Although the NP did record that Mr A was not short of breath and had

no radiation of pain, Adviser 1 was not reassured that the NP asked all the appropriate questions necessary which would have been expected from a senior autonomous practitioner.

15. Adviser 1 continued that the NP had not recorded if there was a family history of cardiovascular disease or if Mr A had had any previous investigations. Mr A was aged 51 and his gender put him at higher risk of cardiovascular disease. He smoked and there was no assessment for diabetes or recording of his current diet. In regard to high cholesterol Adviser 1 noted that, although there was mention of high cholesterol and blood pressure from 2007, this was not summarised in the GP records provided. However, Adviser 1 felt that the NP should have asked about past medical history regarding cholesterol. Mr A also had a Body Mass Index (a measure for estimating body fat) reading of 24.6, which is at the higher range of normal.

16. Adviser 1 then commented that the records do not note the length of the pain and suggested that it only happened on the day of the assessment. The NP did not examine Mr A's chest to assess for pulmonary oedema. There is no cardiac examination described. A cardiac examination involving listening to the patient's heart and lungs with a stethoscope would be expected. There was no record of pulse or auscultation (listening through a stethoscope) of the heart and, therefore, nothing to clarify if Mr A had an irregular heart rate.

17. Adviser 1 felt that the NP should have taken action in accordance with SIGN 93 and arranged for Mr A to undergo a 12 lead electrocardiogram.

18. Adviser 1 felt that Mr A showed evidence of sufficient risk factors to suggest that a cardiac cause for his epigastric pain should be considered and excluded. She did not believe the NP had provided a reasonable standard of care or that she had carried out a reasonable assessment and, as such, did not have sufficient information to make an informed diagnosis and management plan.

19. With regard to the SEA, Adviser 1 said that the analysis itself was not completed to a reasonable standard, with no reflection by the Practice as to any failures in their practice systems. She felt the 'outcomes and recommendations' section contained no outcomes or recommendations and included quite a defensive description of events. It also stated that 'the NP took a full and thorough history and examination and she made comprehensive notes'.

Adviser 1 has already explained why she felt this did not happen. Adviser 1 explained that all GPs have to carry out significant events each year as part of their yearly appraisal process – and generally will use the appraisal documentation from SOAR (Scottish Online Appraisal Review) – and the form used in this case does not resemble the generally agreed national significant event template.

20. Adviser 2 noted the job description for nurse practitioners. This stated that a nurse practitioner will 'use advanced nursing skills to take a comprehensive health history, examine/diagnose and manage patients' and 'manage acute illnesses/injuries and refer to other health professionals as appropriate'. Adviser 2 saw that the record of the consultation excluded cardiac symptoms but took into account increased alcohol intake. No referral to a GP was made and no further investigations were carried out. Adviser 2 explained that, in terms of being seen by a nurse practitioner, the key issue is that a nurse practitioner is acting in a wider role than that of a registered nurse and, as such, her competence at undertaking the role normally carried out by a GP should be the same. A nurse practitioner should be aware of the wider possible diagnosis and if in any doubt should have referred to a GP.

21. Adviser 2 explained that nurse practitioners are autonomous practitioners and, therefore, accountable for their own practice, ie, a GP delegating a skill to a nurse practitioner does so with the knowledge that the nurse becomes accountable for the care given according to the Nursing and Midwifery Council Code including:

> 'as a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions; you must have the knowledge and skills for safe and effective practice when working without direct supervision; you must recognise and work within the limits of your own competence; and you must make a referral to another practitioner when it is in the best interests of someone in your care.'

22. Adviser 2 was critical of the actions taken by the NP, which indicated she was unaware of the significance of the symptoms presented by Mr A as she did not adhere to the SIGN guidelines, as previously highlighted.

23. Adviser 2 agreed that Mr A had demonstrated a number of signs and symptoms which should have alerted the NP to further examination and referral.

As a result, Mr A did not receive further investigation or treatment, which may have resulted in a different outcome for him. If the NP was acting in a role normally carried out by a GP, the same level of assessment and care is expected. If the NP had any doubts about the diagnosis, she should have referred Mr A to a GP.

24. With regard to the SEA, Adviser 2 said that she would have expected to see statements from the GPs and the NP as part of the SEA or, at the least, a note of the meetings. While the Practice have described the notes as being informal and said that they were not retained, this was not acceptable and an indication of poor practice. Adviser 2 was also critical that the SEA did not identify any failings. This suggested that the learning from a SEA should be improved.

Conclusion

25. The matter which I have considered is whether the Practice provided Mr A with appropriate treatment when he attended on 29 July 2013. I am aware that there is a discrepancy between the family view that Mr A was experiencing chest pains for some days and the Practice view that Mr A did not report such symptoms. As a result of there being no independent witnesses or recorded evidence to the event, I am unable to consider that issue further. However, I am able to consider whether Mr A received appropriate treatment when he attended the consultation with the NP. The advice which I have received, and accept, is that Mr A was exhibiting symptoms which warranted further assessment or investigations. I am satisfied that the level of service which was provided by the NP was not reasonable and that she should have referred Mr A to a GP or other health professional for further assessment or investigations such as an ECG. The failure to do so may have had an impact on the eventual outcome. I am also critical about the way the SEA was managed by the Practice, as it was not performed in accordance with the national guidelines. I uphold the complaint.

26. I hope that my report will go some way to reassure Mrs C and Mr A's family that I fully understand the effect which the failings which have been identified have had on them. I trust that they gain some comfort from the knowledge that their concerns have been taken seriously and that the recommendations which have been made will help prevent a similar situation occurring in future.

Recommendations

27. I recommend that the Practice	*Completion date*
(i) issue an apology to Mrs C for the failings identified;	21 February 2015
(ii) review the level of education and training required to carry out the NP role, particularly in relation to clinical assessment and diagnosis;	21 April 2015
(iii) review the assessment/supervision and on-going monitoring and appraisal requirements in place for the NP; and	21 April 2015
(iv) submit a Significant Event Analysis (SEA) which is in the standard format used nationally.	21 April 2015

28. 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 A	Mrs C's brother
the Practice	Mr A's GP Practice
the NP	a nurse practitioner who saw Mr A on 29 July 2013
Mrs C	the complainant
Adviser 1	the Ombudsman's medical adviser
Adviser 2	the Ombudsman's nursing adviser
ECG	Electrocardiograph
SEA	Significant Event Analysis (analysis of adverse clinical events)
GPs	General Practitioners
SIGN	Scottish Intercollegiate Guidance Network

Annex 2

Glossary of terms

angina	lack of oxygen to the heart muscle, which manifests itself as chest pain
antacid	medication to combat acid in the stomach
auscultation	listening through a stethoscope
Body Mass Index	a measure for estimating body fat
cardiovascular	narrowing of blood vessels leading to the heart
cholesterol	fats found in the body and bloodstream
diabetes	chronic disease where there is a raised level of sugar (glucose) in the blood
electrocardiograph (ECG)	a test which records the electrical activity of the heart
epigrastrically	pertaining to epigastrium, which is an area of the abdomen just below the breast bone
haemopericardium	a collection of blood between the lining of the outer wall of the heart and the outer heart muscle
ischaemic heart disease	narrowing of the blood vessels which supply blood to the heart
lansoprazole	medication to reduce stomach acid
myocardial infarct	a heart attack
nurse practitioner	a specially qualified senior nurse

omeprazole	medication to reduce stomach acid
pulmonary oedema	fluids gathered in the lungs, which causes breathlessness