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 ref: 201404127, A Medical Practice in the Lothian NHS Board area
Sector: Health
Subject: GP & GP Practices; clinical treatment; diagnosis

Summary
After suffering a stroke earlier in the year, Mr A was discharged from a hospital to a Step Down Unit in May 2014. This is a unit in a nursing home for elderly patients who are fit for discharge from hospital but need further rehabilitation before they can return home. Following a fall at the unit in early July 2014, Mr A's condition deteriorated. Over a number of weeks, he developed reduced mobility, reduced food intake and increasing pain. Mr A's daughter (Miss C) complained that, from the time of his fall until his readmission to hospital in early August, the care and treatment he received from GPs at his medical practice was unreasonable. She considered that Mr A should have been admitted to hospital earlier, and that it was unreasonable for a GP to suggest that one of the options was not to intervene, but to keep Mr A comfortable in the unit.

I took independent advice from one of my medical advisers who is a GP. The adviser had a number of concerns about the practice's failure to properly assess Mr A's condition. She said that the clinical records were sparse and lacked evidence of examination, of thorough clinical assessment, and of thorough assessment of Mr A's pain.

With regard to Mr A's food and fluid intake, she said that records showed that he lost 8.7 kilograms over a two-month period, or 16.5 percent of his body weight. This was a significant amount and she would have expected a GP to physically examine their patient to rule out any underlying cause for weight loss. She would also have expected a GP to have either made urgent arrangements for a dietician to assess the patient or to have provided simple food supplements until the dietician could attend. She noted that, under the Lothian Joint Formulary Guidelines, Mr A should have been given a MUST score ('Malnutrition Universal Screening Tool', British Association for Parenteral and Enteral Nutrition). As he had lost so much weight, he would have received the maximum MUST score, identifying the necessity of food supplements and regular monitoring.

It was thought that Mr A may have been suffering from dehydration and also possibly have a urine infection. The adviser considered that the care and treatment for these issues were not reasonable, as there was a delay in prescribing an antibiotic to treat the suspected urinary tract infection and the management plan to deal with the dehydration was not changed despite there being no improvement for weeks.

With regard to the GP's suggestion of not intervening but keeping Mr A comfortable in the unit, the adviser commented that the diagnosis of dehydration and a possible urinary tract infection were both easily treatable. She added that Mr A was malnourished and losing weight, yet there was no evidence of investigation or examination. The adviser said that the suggestion of not actively investigating or treating these potentially reversible conditions, in a patient in a unit that aims to rehabilitate patients for home, was not a reasonable standard of care.

My investigation found that the overall care provided to Mr A during the period following his fall until his readmission to hospital was not of a reasonable standard and so I upheld Miss C's complaint and made several recommendations.

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) carry out a further significant event analysis in partnership with their local clinical director. This should include consideration of: how they ensure continuity of care for their patients and regular review of those most vulnerable; GP1's suggestion of keeping Mr A comfortable in the Unit, rather than addressing his potentially reversible conditions; the need for good record-keeping and ensuring thorough recording of clinical information in a patient's medical record, so as to assist in continuity of care; and consideration of the Lothian prescribing guidelines for urinary tract infections. They should also consider referring this significant event analysis to NHS Education for Scotland for review;	31 December 2015

(ii)	familiarise themselves with the MUST scoring and Lothian guidelines for prescribing oral nutritional supplements;	30 October 2015
(iii)	take steps to ensure that other patients they care for in the Unit are receiving adequate treatment for malnutrition in line with the Lothian guidelines, where appropriate; and	27 November 2015
(iv)	issue a written apology to Miss C for the failings identified in this report.	30 October 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act states that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Miss C. Her father is referred to as Mr A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Miss C complained to the Ombudsman about the care and treatment her father (Mr A) received from GPs at his medical practice (the Practice) after he was discharged from hospital to a Step Down service (a service provided in a nursing home to people who no longer require medical intervention in a hospital setting and cannot go directly home from hospital with support). Miss C complained that GPs did not visit Mr A often enough and that their action in relation to food and fluid intake was unreasonable. She considered that Mr A should have been admitted to hospital earlier and that it was unreasonable for the GPs to discuss that one of the options was not to intervene, but to keep him comfortable and nurse him in the nursing home. The complaint from Miss C I have investigated is that the Practice's care and treatment of Mr A between his discharge from hospital on 7 July 2014 and his readmission to hospital on 5 August 2014 were unreasonable *(upheld)*.

Investigation

2. In order to investigate Miss C's complaint, my complaints reviewer has reviewed the information received from Miss C and the Practice. He has also obtained detailed advice from one of my medical advisers (the Adviser), who is an experienced GP. In this case, we have decided to issue a public report on Miss C's complaint in view of the advice we received from the Adviser.

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

Complaint: The Practice's care and treatment of Mr A between his discharge from hospital on 7 July 2014 and his readmission to hospital on 5 August 2014 were unreasonable

Background

4. On 29 May 2014, Mr A was admitted to a Step Down Unit (the Unit). This is a rehabilitation unit in a nursing home for elderly patients who have had an admission to hospital and who are felt to be medically stable and fit for discharge, but may benefit from further rehabilitation or need further assessment to decide on their final discharge destination. It is a relatively new service and is a collaboration between primary and secondary care. Mr A went to hospital with a suspected fracture following a fall on 7 July 2014, but no fracture was seen and he returned to the nursing home. He was eventually readmitted to hospital on 5 August 2014.

5. The complaint is about the care/treatment Mr A received from GPs in the Unit during the period 7 July 2014 to 5 August 2014. Miss C has complained that:

- the GPs did not visit Mr A often enough;
- the GPs' action in relation to food and fluid intake was unreasonable;
- Mr A should have been admitted to hospital earlier; and
- it was unreasonable for the GPs to discuss that one of the options was not to intervene, but to keep him comfortable and nurse him in the nursing home.

The Practice's response

6. In August 2014, Miss C wrote to the Practice to complain about the treatment Mr A had received in the Unit. She said that he had been preparing to come home with a package of care in place, but had had a fall and had been taken to hospital. He then returned to the Unit and Miss C said that she was told that they would check him on a more regular basis.

7. Miss C said that she was told that a dietician had been asked to see Mr A because he was not eating. She stated that she was then told that they were awaiting supplement drinks for Mr A, but these did not materialise and she had to buy them herself. Miss C then said that Mr A had refused fluids on 1 August 2014 and she told staff that she would like him to be assessed by a GP. She said that a GP (GP1) then telephoned her a few days later and said that there were two options: they could either make Mr A comfortable or admit him to hospital. She said that she was stunned by this and was under the impression that the GP was willing to let Mr A just slip away. She said that her father would not have become so weak if he had been admitted to hospital earlier. She stated that Mr A was admitted to hospital on 5 August 2014 and was put on a drip. She said that her complaint was about the lack of care from the GPs from the Practice.

8. The Practice Manager wrote to Miss C to acknowledge receipt of her complaint on 27 August 2014. She said that the Practice aimed to respond to written complaints within ten working days. However, she stated that as she needed to discuss Miss C's letter with GP1, who was currently on annual leave, it might take a little longer to investigate her concerns properly.

9. Miss C wrote to the Practice Manager on 30 August 2014. She asked that the Practice respond within the timescale of ten working days.

10. On 3 September 2014, another GP from the Practice (GP2) wrote to Miss C in response to her letter dated 3 September 2014. He said that GP1 had seen Mr A on 8 July 2014 and on 9 July 2014 and that his needs had been discussed at multi-disciplinary team meetings on 14 July 2014, 21 July 2014, 28 July 2014 and 4 August 2014. GP2 also said that he had been asked to see Mr A about his gradual deterioration on 1 August 2014. He said that he did not have the benefit of having met Mr A before, but nurses informed him that Mr A's speech and mobility were usual for him. He said that he noted that Mr A appeared a little dehydrated and he was suspicious of a urinary tract infection given his deterioration. GP2 said that his advice was to try to encourage more fluids and that he asked nursing staff to obtain a urine sample for analysis.

11. GP2 said that GP1 then saw Mr A on 4 August 2014 and noted that he appeared to be dehydrated. He said that she spoke to Miss C and admission to hospital was then arranged for Mr A. He also said that he would make sure that GP1 saw Miss C's letter when she returned from leave.

12. On 12 September 2014, GP1 also wrote to Miss C in response to her letter. She said that management of patients in a Step Down Unit is very much a team effort and that communication is enhanced by having a weekly multi-disciplinary team meeting with representatives of all disciplines present, plus additional support from GPs, a Medicine of the Elderly Consultant and pharmacists. She also said that she and GP2 normally shared the care for patients in the Unit and that they attended on a weekly basis, although other colleagues may attend in their absence.

13. GP1 said that Mr A had been admitted to the Unit on 29 May 2014 after suffering a stroke in January 2014. She said that a discussion had taken place with Miss C, who felt that admission for potentially reversible problems would be indicated. However, if Mr A were to suffer for instance another major stroke, she would prefer him to be kept comfortable where he was, as she felt that the quality of life was very important. GP1 then said that Mr A then had a significant fall on 7 July 2014 and nursing staff arranged for him to be assessed at an Accident and Emergency department. However, no fractures were found and Mr A was transferred back to the Unit on the same night. She stated that she attended the Unit to see Mr A on the following day. She said that she

discussed readmitting Mr A to hospital with Miss C, but this was not felt to be necessary. She also stated that she added codeine to his analgesia. She said that she went to see him again on the following day. It was reported that he had slept through the night and that he did not need any extra analgesia.

14. In her letter, GP1 said that Mr A had been discussed at multi-disciplinary team meetings on 14 July 2014, 21 July 2014 and 28 July 2014. In relation to the meeting on 21 July 2014, she said that she requested an update on his weight in order that he could be referred to the dietician, as they are restricted in prescribing nutritional supplements and need instructions/advice from dieticians on this. GP1 said that GP2 had been asked to see Mr A on 1 August 2014 whilst he was on the ward. His impression was that Mr A could be suffering from dehydration and staff were advised to encourage fluids and to take a urine sample for testing. Mr A was then seen by an out-of-hours doctor over that weekend, who treated him with antibiotics for a potential urine infection.

15. GP1 said that Mr A was discussed again at the multi-disciplinary team meeting on 4 August 2014. Nursing staff said that his oral intake had been very poor. GP1 went to see him after the meeting and found him to be very dehydrated and poorly. She said that she telephoned Miss C to discuss his gradual deterioration and options for management, including hospital admission and non-intervention. She commented that discussing non-intervention was very upsetting for Miss C and that she felt strongly that she did not want this. GP1 said that she arranged for Mr A to be admitted to hospital on the following day.

16. In her response to Miss C, GP1 said that Mr A's care had been very much a team effort and that he received daily input from various members of the health care team. She stated that looking back on the records, perhaps a learning point for the future could be that they could refer to the dietician immediately after the problem is brought to their attention. The up to date weight would then be added later.

17. On 17 September 2014, Miss C wrote to GP2. She disputed some of the comments in his letter and said that if she had followed GP1's advice, Mr A would not be alive. She also stated that Mr A had now regained weight and was thriving in his eating.

Significant Event Analysis

18. The Practice have sent us a significant event analysis that was completed by them in relation to Mr A's care. This stated that the Practice needed to ensure that it was clearly communicated to patients and relatives before admission to a Step Down Unit that the service is led by a team of physiotherapists / occupational therapists / nurses / social workers and that the extent of the GP service is the same as in the community setting. It stated that it is a multi-disciplinary team approach and that the GP will only step in if the team feels this is appropriate.

19. The significant event analysis also said that there seemed to have been communication difficulties, as Miss C had indicated that she had expressed daily concerns and they had not been made aware of this. It said that one of the GPs had presented a session about medical input at a workshop regarding the Step Down service. It also said that the Board were looking at improving services and input from dieticians to the Step Down service and that they were also looking at the guidance that nutritional supplements could only be prescribed by GPs on the advice of dieticians. It also said that development of good communication with patients and relatives remained an ongoing process.

Medical advice

20. I asked the Adviser if she considered that the overall medical care and treatment provided to Mr A by the Practice had been reasonable and appropriate. In her response to me, the Adviser said that the Step Down service has input from GPs that is the same as would be expected in a community setting. She said that GP1 had confirmed this in the significant event analysis. She had then gone on to say that the GP will only step in if the team feels this is appropriate. The Adviser said that, as with all frail and elderly patients, she would expect the GP to deliver the same standard of care as they would to all their patients in the community. She stated that this would include appropriately 'responding to' and 'treating' clinical symptoms raised by the nursing home and the family

21. The Adviser said that the additional services in the nursing home, including physiotherapy and nursing care, are there to further support the patient in terms of rehabilitative care. She said that although GP1 was correct to say that multi-disciplinary team meeting are used to decide who would be best to deal with a particular problem, this does not take away the role of a GP in terms of their expected assessment and response to clinical symptoms and

signs. She stated that the multi-disciplinary team is not a replacement for the GP regularly assessing their own patient or responding to their needs.

22. The Adviser stated that the General Medical Council (GMC) guidance on this is clear:

> 'Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains.'
>
> '15. You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:
> a. adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient
> b. promptly provide or arrange suitable advice, investigations or treatment where necessary
> c. refer a patient to another practitioner when this serves the patient's needs.
>
> 16. In providing clinical care you must:
> a. prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs
> b. provide effective treatments based on the best available evidence
> c. take all possible steps to alleviate pain and distress whether or not a cure may be possible.'

23. The Adviser said that she had a number of concerns about the Practice's failure to adequately assess Mr A's condition. In relation to record-keeping and examination, she said that on reviewing the clinical GP consultation records, she had noted that in the four-week period referred to, GP1 saw Mr A on two occasions, 8 July 2014 and 9 July 2014, before she assessed him on 4 August 2014 for admission to hospital. The Adviser said that the clinical records completed on 8 July 2014 and on 9 July 2014 were sparse and lacked evidence of examination and thorough clinical assessment. She also said that they lacked evidence that Mr A had a thorough assessment of his pain.

24. I also asked the Adviser if the actions of GPs in relation to food and fluid intake had been reasonable. In her response to me, the Adviser said that the entries in Mr A's medical records on 21 July 2014, 22 July 2014 and 28 July 2014 suggested poor intake. The Adviser said that the records also described a significant weight loss of 8.7 kilograms over a two-month period. The Adviser commented that although a routine referral was sent off to a dietician after information was passed to a different GP (GP3) on 25 July 2014, she would have expected a GP to physically examine their patient to rule out any other underlying cause for weight loss and to assess their clinical presentation. She also said that she would have expected a GP to have either arranged an urgent dietary assessment or to have started simple food supplements until such time as a dietician could attend.

25. The Adviser said that the Practice's records showed Mr A's weight to be 44.1 kilograms on 23 July 2014, which gave him a Body Mass Index (BMI) of 14.2, but his weight was not reassessed until his admission to hospital. A BMI is a measurement of healthy weight range and is based on a measurement of the patient's weight and height. Normal BMI is 18.5 to 25. Mr A's BMI had been calculated as 17 on 29 May 2014. This is also underweight and the Adviser considered that Mr A should have been referred to a dietician at that time, however, a referral was not made. When Mr A's BMI further dropped to 14.2 on 23 July 2014, which is severely underweight, his need for treatment became even more urgent. In their response to the draft copy of this report that was sent to Miss C and the Practice for comment, the Practice said that there had been no recommendation on further dietician review in the discharge letter when Mr A had been discharged from hospital on 29 May 2014. The discharge letter said that he was on a soft diet and normal fluids. The Practice also said that his weight on 8 June 2014 was 52.3 kilograms and that he was not weighed again until GP1 requested this on 21 July 2014, when the multi-disciplinary team was informed that his oral intake was poor. The Practice stated that the Unit is an interface between primary and secondary care and that every multi-disciplinary team meeting was attended by a Consultant for Medicine of the Elderly, who was the clinical lead. They stated that no other suggestions regarding the treatment/management of Mr A were offered by the Consultant.

26. The Adviser also commented that under the Lothian Joint Formulary Guidelines, patients should have had a MUST score ('Malnutrition Universal Screening Tool', British Association for Parenteral and Enteral Nutrition) when dietary advice has failed to result in weight gain. She said that if the patient is

high risk, then they should be treated and monitored monthly. If the MUST score is greater than two, then the patient should be actively treated with food supplements prescribed by the GP whilst waiting to be seen by a dietician.

27. The Adviser commented that on 22 July 2014, Mr A would have received a MUST score of 6, which is the maximum score and that, in particular, the highest risk section of step 2 in the MUST score refers to a patient losing greater than 10 percent of their body weight in the previous three to six months. Mr A was recorded as losing 16.5 percent of their body weight in less than a two-month period. The Adviser said that as such, if the GP could not ensure urgent assessment by the dietician, then under the Lothian Joint Formulary Guidelines, Mr A should have been given an initial supply of appropriate oral nutritional support.

28. The Adviser referred to comments from GP1 in her correspondence with my office. In this, she stated that, 'but as GPs we refer to a community service, hence it would not have been possible for nutritional supplements to materialise before the patient's re-admission on 5 August.' She stated that GP1 seemed to be suggesting that a patient with malnutrition cannot be treated with supplementation unless seen by a community dietician. The Adviser said that she considered that this was inaccurate.

29. The Adviser stated that in her view, it was unacceptable for a patient residing in a nursing home providing clinical care to develop malnutrition without any early active attempt to investigate, supplement their diet or arrange urgent specialist assessment. She commented that Miss C had stated that she bought supplement drinks, as the prescription for supplement drinks 'did not materialise'. The Adviser stated that it was unacceptable for Miss C to have to buy food supplementation due to lack of appropriate action by the team caring for Mr A.

30. The Adviser then commented on the Practice's management of Mr A's pain. She said that although she had noted that GP1 had issued codeine on 8 July 2014, she could not see any evidence in the clinical record that a review of Mr A's pain management had been carried out. She stated that although patients may be unable to take medication orally, there are always alternative options for administering pain medication. She also commented that a clinical entry on 29 May 2014 confirmed that in the past, Mr A had taken morphine for his pain. The Adviser stated that it was her view that a reasonable GP would

have been more thorough in their assessment and management of Mr A's pain and would have considered an alternative, such as a painkiller in the form of a patch, a sublingual preparation, or an oral liquid preparation.

31. In their response to the draft copy of this report, the Practice said that there was only one mention of pain in the nursing notes and one mention of pain in the physiotherapy notes. They stated that it was unclear if Mr A was in pain, but that analgesia was mentioned at the multi-disciplinary team meeting on 21 July 2014 and staff were advised to give this half an hour before mobilising Mr A, as he did not seem to be in pain in between mobilising. They said that it was discussed again at the multi-disciplinary team meeting on 28 July 2014 and staff were advised to give codeine regularly, as it was still not clear whether Mr A was in pain when trying to mobilise.

32. In relation to the active management and investigations carried out by the Practice, the Adviser commented that the clinical records showed that on 29 May 2014, Miss C had agreed that Mr A should be admitted to hospital for potential reversible conditions, but that she would prefer for him to be kept comfortable where he was if he suffered another stroke. On 1 August 2014, GP2 saw Mr A and noted that he was dehydrated. GP2 also recorded that he suspected a urine infection. The Adviser recorded that it would have been reasonable to treat the suspected urinary tract infection with an antibiotic at that time and to also address the dehydration. She stated that an antibiotic was not given to Mr A until he was seen by an emergency out-of-hours doctor on the following day.

33. The Adviser also commented that encouraging fluids and using a strict fluid balance chart is a recognised treatment for dehydration. However, she said that it was not reasonable to assume that encouraging fluids would be productive, when Mr A had made no improvement in that regard over a period of weeks. She said that this was not a reasonable management plan. She also stated that as Mr A had multiple medical problems, she would have also expected his blood and kidney function to have been assessed to ensure there was no evidence of poor kidney function. In addition, the Adviser commented that there was no evidence in the Practice's records that the basic measurements, such as Mr A's blood pressure and temperature, had been taken on 1 August 2014.

34. The Adviser then considered the care and treatment Mr A had received from the Practice in relation to his suspected urinary tract infection, which had been noted at the consultation on 1 August 2014. The Adviser stated that it is necessary to try to establish the cause of male urine infections. She said that a urine sample should always be obtained prior to treatment, but that treatment need not be deferred pending the result. In Mr A's case, staff were unable to get a urine sample and the Adviser said that a reasonable GP would have prescribed antibiotics at that time in line with the guidelines. Antibiotics were then prescribed to Mr A on the following day by the out-of-hours doctor in line with the Lothian prescribing guidelines.

35. The Adviser said that it was unclear if GP2 had told staff in the Unit that he would prescribe treatment if a urine sample could not be obtained. She commented that in view of Mr A's incontinence and the recognised difficulty in getting samples from patients who use pads because of incontinence, it would have been common practice for a GP to prescribe or at least leave a delayed script so as to avoid any delay or emergency call to the out-of-hours service. In her response to me, the Adviser said that she could see no reason why GP2 did not prescribe antibiotics on 1 August 2014 if he suspected and recorded a possible urine Infection.

36. I also asked the Adviser if the GPs from the Practice had seen Mr A regularly enough when he was in the Unit. In her response to me, the Adviser said that the frequency of clinical assessments by GPs is dependent on clinical need. As previously stated, she said that she did not consider that Mr A was thoroughly assessed or reviewed when symptoms of weight loss and pain were described. She also commented that the clinical records lacked sufficient detail on occasions, which suggested that a thorough clinical assessment had not taken place.

37. I then asked the Adviser if she considered that Mr A should have been admitted to hospital earlier. In her response to me, the Adviser said that the Unit had the facilities and capability of providing their patients with investigations and treatment. She stated that she was not of the view that Mr A needed to be admitted to hospital sooner. However, she stated that she considered that if Mr A's symptoms and signs of malnutrition, possible urine infection, chronic pain and malaise had been actively treated by the GPs in a timely manner and in line with prescribing guidelines, then admission may have been avoided.

38. Finally, I asked the Adviser if it had been reasonable to discuss with Miss C that one of the options was not to intervene, but to keep Mr A comfortable and nurse him in the Unit. In her response to me, the Adviser said that Miss C had clearly stated on 29 May 2014 that she wanted any reversible conditions to be treated. She commented that GP1 had made a diagnosis of dehydration and a possible urinary tract infection, both of which are easily treatable with fluids and antibiotics respectively. She said that, in addition, Mr A was malnourished without any appropriate dietary supplementation and his weight continued to fall, with no investigation or examination. The Adviser stated that the suggestion of not actively investigating or treating these potentially reversible conditions, in a patient in a unit that aims to rehabilitate patients for home, was in his view not a reasonable standard of care. She said that GP1 had effectively suggested that the patient was treated palliatively, when a palliative status or condition had never been diagnosed or discussed with the family. She stated that without further investigation and treatment, a palliative diagnosis had been premature.

39. In their response to a draft copy of this report, the Practice said that the GP notes made it clear that it was not thought at the time to be as straightforward as stated above. They said that there had been mention of 'funny turns', whereby Mr A was drooping to one side and rolling his eyes, although this had resolved by the time he was seen by a doctor. They told us that it was unclear what the cause of this was and it was thought possible to be further transient ischaemic attacks or possibly seizure activity as a result of his previous stroke. They said that it was not suggested that he was not treated, although this had been discussed as an option. The commented that there is a significant difference between discussing options and advising to choose one of the options discussed and that GP1 had not advised that one of the options should be chosen over the other. They told us that this had been discussed at the multi-disciplinary team meeting, because it had been communicated that Miss C was worried that Mr A had given up, although she denied having said this in the discussion that followed.

Decision

40. Following a fall on 8 July 2014, Mr A's condition deteriorated and, over a number of weeks, he developed reduced mobility, reduced food intake and increasing pain. During that time, Miss C voiced her concerns to staff in the nursing home. The advice I have received is that the overall care provided to

Mr A by the Practice during that period was not of a reasonable standard and that the case notes do not support a picture of proactive care by the GPs involved. Mr A was not thoroughly assessed or reviewed when symptoms of weight loss and pain were described. There was also a failure to supplement his diet or arrange urgent specialist assessment. In addition, the Practice failed to take reasonable action when diagnoses of dehydration and possible urinary tract infection were made. I have, therefore, upheld Miss C's complaint.

Recommendations

41. I recommend that the Practice	*Completion date*
(i) carry out a further significant event analysis in partnership with their local clinical director. This should include consideration of: how they ensure continuity of care for their patients and regular review of those most vulnerable; GP1's suggested option of keeping Mr A comfortable in the Unit, rather than addressing his potentially reversible conditions; the need for good record-keeping and ensuring thorough recording of clinical information in a patient's medical record, so as to assist in continuity of care; and consideration of the Lothian prescribing guidelines for urinary tract infections. They should also consider referring this significant event analysis to NHS Education for Scotland for review;	31 December 2015
(ii) familiarise themselves with the MUST scoring and Lothian guidelines for prescribing oral nutritional supplements;	30 October 2015
(iii) issue a written apology to Miss C for the failings identified in this report.	30 October 2015

42. The Practice have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Practice are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Miss C	the complainant
Mr A	the aggrieved
the Practice	the medical practice
the Adviser	the Ombudsman's medical adviser
the Unit	the Step Down unit – a rehabilitation unit in a nursing home for elderly patients who no longer require medical intervention in a hospital setting and cannot go directly home from hospital with support
GP1	the GP who initially examined Mr A
GP2	the GP who examined Mr A on 1 August 2014
GP3	the GP who referred Mr A to a dietician on 25 July 2014
BMI	Body Mass Index
MUST	Malnutrition Universal Screening Tool

Annex 2

Glossary of terms

Step Down service	a rehabilitation unit in a nursing home for elderly patients who no longer require medical intervention in a hospital setting and cannot go directly home from hospital with support
sublingual	under the tongue
transient ischaemic attacks	mini strokes

Annex 3

List of legislation and policies considered

GMC: Good Medical Practice (2013)

NHS Lothian: Lothian Joint Formularies