SPSO decision report

Case: **201103642, A Medical Practice in the Lanarkshire NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained that her late husband Mr A (who had terminal cancer), had suffered during his illness up to his death. Mrs C stated that in her view, she could not believe so many things had gone wrong with the care and treatment Mr A had received from the practice over 17 months. These issues were a failure to follow up Mr A's admission to a hospital in the board's area after the hospital had discharged him; that a practice GP had provided incorrect information about Mr A during a home visit and that the practice failed to follow the appropriate processes and procedures when completing the Do Not Resuscitate Form (the DNR).

Our adviser considered all aspects of Mrs C's complaint and said that Mr A had lung cancer and that it was the responsibility of the hospital clinician that arranged Mr A's investigation to follow up and act on the results, not the practice.

Our adviser stated that a practice doctor had provided incorrect information during a home visit; however, the practice doctor had speedily corrected this and apologised.

The adviser stated that the DNR Form (as part of end-of-life care), assists with the management of terminally ill people and compliments the expertise of those using it. We took account of the adviser's advice and considered that the practice had followed the correct DNR procedures. Mrs C's complaint was partially upheld.

Recommendations

We recommended that the practice:

- re-examine along with the District Nursing Team as a whole, their role in this case within the Liverpool Care Pathway continuous Quality Improvement Programme (to include the completion of the DNR form), to see (and reinforce) if there are lessons to be learned and how they can be applied to prevent such a scenario arising in the future (reference to both complaints 3 and 4).