SPSO decision report

Case: **201100418, Orkney NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the treatment she received from a GP employed by the board. She visited the medical practice complaining of neck pain, muscle weakness and fatigue. Blood tests were taken and Ms C was told that she was fine. However, she was found to have low levels of vitamin D and was prescribed a calcium supplement. Ms C subsequently developed indigestion, heart palpitations, eyesight deterioration and shortness of temper. She complained to us that the GP was dismissive of her symptoms.

About six weeks after the first consultation, Ms C's condition deteriorated to the extent that she found it difficult to walk. She began taking medication that she sourced on the internet and adjusted her diet. This resulted in some improvement to her energy levels, but she deteriorated again. She went back to the GP, and it was discovered that her original blood tests had shown a vitamin B12 deficiency. Specialist investigations confirmed that this was the cause of her symptoms.

After taking advice from one of our medical advisers, we upheld most of Ms C's complaints. We found that the board had used a number of locum (temporary) doctors throughout the period in question, which had led to a lack of continuity of care. We found that the medical practice's clinical records were unsystematic and lacked any clear management plan for Ms C. As such, an important diagnosis was missed by incoming staff. Although Ms C's B12 deficiency was overlooked we were, however, satisfied with the efforts that the GP then made to minimise the potential impact of this oversight and we did not make any recommendations about this.

Ms C had also complained about the system the medical practice had in place for requesting, tracking and reporting blood tests. While we concluded that the system in place at the time was not fit for purpose, we found that they have since introduced a procedure which is in line with good working practice. On

her complaint about the board's complaints handling, we found that many of the points Ms C raised went unanswered and we made recommendations to address this.

Recommendations

We recommended that the board:

- remind complaint handling staff of the importance of answering all points raised by the complainant; and
- take steps to ensure their complaint handling staff work in accordance with the NHS Scotland complaints procedure.