SPSO decision report

Case: **201201811, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mrs A, who lived in a care home, became ill in the early hours of the morning. The care home contacted the out-of-hours service, and one of their doctors came and examined Mrs A. He recorded that there were signs on her teeth that she had vomited blood and that her abdomen was soft and non-tender. He diagnosed gastritis (inflammation of the stomach lining) and said that the care home should observe Mrs A, and if she vomited blood again or complained of pain in her abdomen, they should call 999. He also said she should see a GP from her own practice. One of the practice doctors visited later that day, and considered that she had an upper gastrointestinal tract bleed. She was then examined by the practice on a number of occasions and was eventually admitted to hospital three weeks after the out-of-hours doctor first examined her. Mrs A died in hospital of a small bowel obstruction nine days later.

Mrs A's son (Mr C) complained about the care and treatment provided by the out-of-hours doctor. He was of the view that the doctor had failed to diagnose that Mrs A had a small bowel obstruction and felt that he should have referred her to hospital. After taking independent advice from one of our medical advisers, however, we did not uphold his complaints. We found that the doctor's investigation, diagnosis, care and treatment of Mrs A were of a reasonable standard. Her presentation was not consistent with the symptoms or signs of bowel obstruction and we did not consider that the doctor failed to identify this. The only option the out-of-hours doctor had for referring Mrs A to hospital was as an emergency admission, and it would have been for her own GP to refer her for an out-patient assessment. We found that the medical records showed that Mrs A did not warrant emergency admission and so the doctor had arranged for her GP to see her. We also found that the doctor's clinical records were adequate and that his instructions to the care home staff were comprehensive.

Mr C was welfare power of attorney for his mother (ie he was able to take decisions about her care and welfare), and he also complained that the out-of-hours doctor failed to consult him about the treatment provided to Mrs A and about her future care plans. We found, however, that there would have been no reason for that doctor to contact Mr C in the early hours of the morning, as he made no treatment decisions when he visited Mrs A. He simply verified that she did not need to be admitted as an emergency, and referred her to her own GP the same day. There was also no requirement for him to tell Mr C that he had visited Mrs A, which we considered was the responsibility of care home staff, during normal working hours.