SPSO decision report

Case: **201204838, A Medical Practice in the Lanarkshire NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his late mother (Mrs A) by her medical practice. He also complained that they failed to refer her to hospital for definitive diagnosis. Mrs A had been living in a care home. She was examined by a doctor from the out-of-hours service in the early hours of the morning. He recorded that there were signs that she had vomited blood and that her abdomen was soft and 'non-tender'. He recorded that his diagnosis was gastritis and that the care home should observe Mrs A. Mrs A was seen by a GP from the practice later that day. The GP considered that she had melaena (passing blood in the stool), haematemesis (vomiting blood) and an upper digestive tract bleed. He did blood tests and stopped some of her medication. He also prescribed omeprazole (medication used to reduce the amount of acid produced in the stomach). Mrs A was examined by the practice on a number of occasions over the next few weeks and was admitted to hospital three weeks after the first GP had examined her. Mrs A died of a small bowel obstruction in the hospital nine days later.

The practice GP who examined Mrs A decided to keep her at the care home and carry out non-invasive investigations, and to adapt her medication. After taking independent advice from one of our medical advisers, we considered that this was reasonable. Mrs A was bleeding from the digestive tract, and there was no evidence to suggest that she had a small bowel obstruction at that time. Our adviser said that even if she had been admitted to hospital earlier, the decision not to carry out invasive procedures would still likely have been made, given her overall frailty and general poor health. There would also have been no benefit in admitting Mrs A to hospital as an emergency, when there were nursing staff in the care home who could monitor her condition. We found that the practice's management of Mrs A's care and treatment was reasonable and there were no failings in the clinical treatment provided.

That said, Mr C was welfare power of attorney for his mother, and so her care should have been discussed with him. There was no evidence that the practice consulted him about the treatment provided to Mrs A and about her future care plans. We found that the practice had incorrectly assumed that the care home staff would have told Mr C about this. However, there was no evidence that the practice checked that this had happened or that they spoke directly to Mr C to discuss his mother's condition. In their response to Mr C's complaint, they had apologised and said that they would review their communication processes to improve on this.

Recommendations

We recommended that the practice:

- provide evidence that they have taken action to review their processes for communicating with relatives in light of Mr C's complaint.