SPSO decision report

Case: **201405203, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

When it was originally published on 16 December 2015, this case referred to a Medical Practice in the Tayside NHS Board area. This was incorrect, and should have read a Medical Practice in the Fife NHS Board area. This was due to an administrative error which we have now corrected, and we apologise for any inconvenience that this has caused.

Summary

Mr C complained about the treatment his late wife (Mrs C) received from the practice. Mrs C suffered from chronic obstructive pulmonary disease (a collection of lung diseases) and died three days after she had attended the practice. It was also the day after Mr C had phoned the practice as he had concerns that the medication which Mrs C had been given was ineffective. He said that he had wanted to speak to a GP but was offered a phone consultation which was scheduled for later in the day that his wife died.

We took independent advice from one of our GP advisers, who said that she had concerns about the consultation Mrs C had attended. Our adviser was critical that the GP who saw Mrs C did not check Mrs C's oxygen saturation levels (pulse oximetry); did not ensure that Mrs C was able to use her inhaler appropriately; and failed to prescribe steroid medication. We found that the treatment which was provided to Mrs C was not of a reasonable standard.

We also considered whether Mr C's phone call to the practice was actioned appropriately. Mr C believed that he was contacting the practice to explain that Mrs C's medication was not working and that her condition was deteriorating. The receptionist at the practice had recorded the phone call as 'medication and issues' and had not contacted a GP for advice and had made arrangements for Mr C to have a phone consultation with a GP. We found that Mr C should have been given the opportunity to speak to a GP on the day of his phone call and that had they done so then the GP would have had the opportunity to make a clinical judgement as to whether a further consultation was required. The practice have accepted that the system which was in use for phone calls required updating. The system has now been updated and our adviser believes that the service has now been improved.

Recommendations

We recommended that the practice:

- apologise to Mr C for the failings identified;
- review chronic obstructive pulmonary disease management;
- ensure the GP in question discusses the case at their yearly appraisal;
- consider a peer reviewed Significant Event Analysis (provided by NHS Education Scotland) about the way the situation was managed; and
- apologise to Mr C for the failure to offer him the opportunity to speak to a GP when he phoned the practice.