SPSO decision report

Case: **201406580, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mr C, who is an advocate, complained on behalf of his client (Mrs A) about the care and treatment provided to Mrs A's late husband (Mr A) by his medical practice. Mr A had a history of chronic obstructive pulmonary disease (COPD, a disease of the lungs in which the airways become narrowed). Mr A called the practice and during the phone consultation reported having strained a muscle. The practice advised Mr A to take painkillers and prescribed him co-codamol (a painkiller formed of a mixture of paracetamol and codeine). They told him to contact them again if the condition got worse. Three days later Mr A attended the practice. The GP examined him and considered the possibility of a lung infection, however, decided it was more likely to be muscle strain and prescribed a stronger pain killer. Later that day Mr A was taken into hospital and died three days later from pneumonia (a serious lung infection).

Mr C complained that Mr A's condition was not assessed properly by the GP. Mrs A also raised specific concerns that at Mr A's COPD review the practice did not have a pulse oximeter (an instrument used to measure oxygen levels in the blood). Mrs A also raised concerns that Mr A was prescribed co-codamol and that this medication is not recommended for patients with COPD. When Mr C complained to the practice the GP who had examined Mr A responded to the complaint and Mrs A and Mr C said this was not impartial.

During our investigation we sought independent advice from one of our GP advisers. The adviser was satisfied that when Mr A attended the practice his symptoms were indicative of muscle strain and that the GP's actions were reasonable. The adviser was also satisfied that co-codamol is an appropriate painkiller to prescribe to patients with COPD as long as the prescriber is aware of the patient's COPD condition, as they were in this case.

The practice told us that they are a small practice of only one GP. As the complaint related to clinical matters, the complaint needed to be responded to by a doctor. We found this to be a reasonable position and for the reasons above did not uphold the complaints.

However, our adviser did say the practice should have had access to a pulse oximeter. The practice told us that they had already purchased one and we recommended that they ensure it is used appropriately.

Recommendations

We recommended that the practice:

- provide us with evidence of the steps taken to ensure the pulse oximeter is utilised as required.