SPSO decision report

Case: **201702536, A Medical Practice in the Lanarkshire NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her late sister (Miss A). Miss A had attended a routine appointment with a practice nurse for her asthma, and had reported symptoms of a urinary tract infection. The nurse had taken a urine sample and had the on-call GP prescribe antibiotics. Several days later Miss A's condition deteriorated and she was admitted to hospital with sepsis (a blood infection), where she then died. Ms C complained that the practice nurse should have realised how unwell Miss A was and carried out further checks such as heart rate, temperature and blood pressure. Ms C felt that if these had been carried out Miss A would have had appropriate treatment sooner.

We took independent advice from a practice nurse and a GP. We found that there was nothing in the medical record to note what symptoms Miss A presented with or any assessment undertaken, and we considered this to be unreasonable. We found that based on the symptoms described by the practice nurse in her complaint investigation statements, the practice nurse should have undertaken a thorough history of Miss A's symptoms, checked her temperature, pulse and blood pressure, and checked for signs of pain. We upheld this aspect of Ms C's complaint.

Ms C also raised concerns that Miss A's blood test results were not acted upon in the weeks leading up to her death. We found that the blood tests that were being monitored were part of the practice's routine screening for chronic disease, and that any abnormal results were followed up appropriately and were not related to Miss A's later diagnosis of sepsis. We did not uphold this aspect of Ms C's complaint.

Finally, Ms C complained about the practice's handling of her complaint. We found that the practice failed to handle Ms C's complaint reasonably and that it did not meet the complaints handling guidance in place at the time. We upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to appropriately assess Miss A and for failing to handle her complaint reasonably. The apology should meet the standard set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Patients should receive full and appropriate assessments, from the appropriate person, based on their reported symptoms. These should be documented in accordance with recognised standards such as the NMC Code of Conduct.

We have asked the organisation to provide us with evidence that they have implemented the recommendations

we have made on this case by the deadline we set.