SPSO decision report

Case: **201810906, A Medical Practice in the Ayrshire and Arran NHS Board area**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment their late spouse (A) received from the practice. C had arranged a same-day appointment at the practice as A had been sick over the weekend. When the time approached; A was too ill to attend, therefore, C called the practice to request a house visit. A triage phone call took place that morning. A's symptoms were noted, advice provided and medication prescribed for sickness and diarrhoea. The following day, C requested a house visit as they felt that A's condition had worsened. Arrangements were made for a house visit to take place. C was concerned that A's condition was further deteriorating, so they contacted the practice to check when the doctor would arrive. The practice subsequently arranged for an emergency ambulance. A was taken to hospital but died shortly thereafter. The primary cause of death was found to be diabetic ketoacidosis (a complication of diabetes mellitus) and respiratory tract infection.

In responding to the complaint, the practice said that they could not always judge the severity of the symptoms over the phone; however, from the symptoms provided to the doctor, the appropriate action was taken in A's case. C remained dissatisfied with the care and treatment A had received and raised the matter with us. C was also unhappy that the practice's response to the complaint did not adequately cover all of their concerns.

We took independent advice from a GP. We found that, at the time of the triage phone call, there was an unreasonable failure to take an adequate history and further assess A (by way of an examination either by a house visit or hospital admission). We, therefore, upheld this aspect of the complaint. During our investigation, the practice provided us with some evidence of reflection and learning that had taken place.

In terms of C's concerns about the practice's response to their complaint, we found that they had appropriately contacted C in a timely manner in an attempt to obtain clearer information about C's specific concerns. Whilst it was not clear whether the practice attempted to get a better understanding of the complaint over the phone when C declined the offer of a meeting to discuss their complaint, we did not consider that they had failed unreasonably to respond to the complaint. We, therefore, did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable failure to gather sufficient information, including history, examination and testing, in order to make an informed diagnosis. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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.