SPSO decision report

Case: **202000192, A Medical Practice in the Tayside NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the practice's care and treatment of their parent (A) who died as a result of sepsis several days after being admitted to hospital. According to the death certificate, one of the underlying causes of A's death from sepsis was an infected grade four sacral ulcer (an injury that breaks down the skin and underlying tissue, grade 4 is the most severe type) that had been there for several months.

C complained that in the period preceding admission to hospital, GPs from the practice never assessed A's sacral ulcer, despite C's requests for them to do so. C complained about a house visit consultation carried out by a GP (GP1) when the family suspected A may have sepsis. They complained about GP1's decision to prescribe oral antibiotics even though A was known to have swallowing problems. C also complained about the GP's refusal to assess the ulcer visually and their decision not to arrange admission to hospital. C also complained about a telephone consultation a few days later, in which a GP (GP 2) declined to carry out a house visit and arranged admission to hospital on a non-urgent basis.

We took independent advice from a GP. We accepted GP1's clinical assessment that oral antibiotics were appropriate. However, we were critical of GP1's failure to record observations during the house visit, noting that in the absence of these records it was not possible to establish the basis on which GP1 concluded A did not have sepsis. We found it unreasonable that GP2 declined to carry out a house visit or arrange urgent admission to hospital, even though this may not have changed the ultimate outcome for A. We found there were omissions in the records in relation to anticipatory care/palliative care planning. There was also a lack of recorded discussions with A's family. Taking all of this into account we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family in writing for each of the failings identified in our investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- GPs should take and record observations where appropriate. GPs should review a grade 4 ulcer if requested to do so, with District Nursing support as required. GPs should carefully consider house visit requests where concerns about sepsis are raised. GPs should ensure record-keeping meets a reasonable standard. Where appropriate, anticipatory care plans/palliative care plans should be in place, documented and discussed with relevant parties. GPs should ensure patient records contain summaries of discussions with key family members and other health care staff.

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.