SPSO decision report

Case: **202005296, Lothian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that there had been an unreasonable delay in their late parent (A) receiving a prescription of antibiotics following a consultation with an out-of-hours GP from the unscheduled care service, operated by the board. During the consultation, the GP considered that A had developed a lower respiratory tract infection (an infection of the lungs), which should be treated with Co-amoxiclav (a type of antibiotic). However, the GP had attended the consultation without a prescription pad and did not carry the medication in their vehicle. The GP subsequently arranged for A's prescription to be faxed to a pharmacy on their return to base to be provided to A the next day. However, the pharmacy to which the prescription had been faxed was closed the following day due to a public holiday, which resulted in a delay of 48 hours before the prescription could be provided to A.

In response, the board apologised that the GP had attended the consultation without a prescription pad and for the distress that this had caused A and their family. The board stated that it could not explain why the GP had attended without a prescription pad but had reminded staff in a monthly update to ensure that prescription pads were checked prior to carrying out home visits and that prescriptions were only faxed to pharmacies that could provide medication in a timely manner. The board also confirmed that it was in the process of developing a checklist system and a written policy and protocol specifying the checks that staff were required to complete at the start of each shift prior to commencing home visits.

We took independent advice from a GP. We found that it had been unreasonable for the GP to attend the consultation without a prescription pad and to fail to ensure that the antibiotics A required were available to them sooner based on A's presentation at consultation. We also considered that the reminder provided by the board to staff was insufficient to ensure that a similar occurrence did not happen again. However the checklist system and written policy and protocol the board had indicated it was developing was likely to be appropriate to address the issues arising in this case.

For these reasons, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with reasonable care and treatment. 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:

- Out-of-hours GPs should be in possession of all required equipment prior to the commencement of each shift. In addition, where a patient's clinical presentation requires medication to be prescribed, out-of-hours GPs should take all reasonable steps to ensure that there is likely to be no undue delay in the prescription becoming available to the patient.

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.