SPSO decision report

Case: **202005361, A Medical Practice in the Ayrshire and Arran NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the practice did not take reasonable action in response to their late spouse (A)'s symptoms and condition. A had a long history of degenerative disc disease affecting their spine (when normal changes that take place in the discs of your spine cause pain) and a history of stomach cancer. A visited or contacted the practice several times over three months regarding pain in the neck and shoulder, numbness in the right hand and jerking of the right leg. Tests were undertaken, medication and therapies prescribed and a referral to an orthopaedic specialist (a specialist in the treatment of diseases and injuries of the musculoskeletal system) was made. Following a fall at home, A was admitted to hospital where a spread of cancer to A's spine was diagnosed.

A died shortly after C submitted a complaint to the practice about their response to A's symptoms and condition over the previous few months. In response, the practice recounted the actions they had taken in response to A's visits and contacts in their final months, highlighted blood tests whose results did not indicate any significant abnormality or spread of cancer and explained that A's symptoms were relatable to their ongoing diagnosis of degenerative cervical disc and spinal stenosis (a condition where the space around the spinal cord narrows, compressing a section of nerve tissue). The practice advised that a significant case review had been carried out. This had highlighted that A's orthopaedic referral could have been upgraded to urgent when it was clear A's symptoms were not being controlled, but stated that it was doubtful this would have had any impact on the outcome. C was unhappy with this response and brought their complaint to this office.

We took independent advice from a GP. We found that the practice took reasonable action in response to A's symptoms and condition until a point. However, when it was clear that A's symptoms were not being controlled and began to worsen, the practice's actions were unreasonable. We found that the potential significance of test results reported to the practice and the potential link with A's symptoms were not reasonably recognised by the practice until they reviewed A's care and treatment as a result of our investigation of the case. Therefore, we upheld C's complaint. However, while we noted that earlier action by the practice may have led to an earlier admission to hospital, it was extremely unlikely to have prevented A's death.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified. The apology should make clear mention of each of the failings identified, whether that was identified by the practice or this office. 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:

- The practice should review how it deals with blood samples that are significantly outwith the normal range. This would include consideration about how they are communicated with the patient, how they are highlighted in the notes and how they are followed up.

- The practice should review their current policy on home visiting patients who are too frail or too unwell to attend the practice to ensure there is a clear criteria for accepting or refusing a home visit and that safeguards are in pace when a home visit request is turned down.

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.