SPSO decision report

Case: **202104273, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) by the practice. Over a period of several months, A and/or family members had multiple contacts with the practice. A started to physically decline more rapidly and was experiencing severe pain which was presumed to be from a prolapse (a displacement of a part or organ of the body from its normal position).

Shortly afterwards, there was a more acute clinical deterioration and an Out-of-Hours medical assessment concluded that A was terminally ill and in need of end-of-life care. There were subsequent assessments by the practice and discussion on best management. A's care was continued at home with general practitioner (GP) and district nurse involvement until A's death.

We took independent advice from a GP adviser. We found that there were occasions where a face-to-face review or examination of A would have been appropriate, or where a more comprehensive assessment of the history and more detailed management discussion would have been reasonable.

Whilst a number of the reviews and adjustments of medication made by the practice were reasonable, we found that there was a lack of medication review on two occasions.

We found that the documentation of the consultations was often lacking in detail and that there was little history or clinical findings to support clinical decisions taken. On some occasions, consultations were not documented at all. Overall, we upheld the complaint that the practice failed to provide reasonable care and treatment to A.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified in respect of the complaint. 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:

- Consideration should be given to assessing elderly patients with confusion face to face following communications about a deterioration in their condition and any decisions should be recorded. If a decision is taken not to assess a patient in this way, the reasons for this should be recorded.
- Consideration should be given to examining patients following communications about a deterioration in their condition and any decisions should be recorded. If a decision is taken not to assess a patient in this way the reasons for this should be recorded.
- Pain medication should be appropriately reviewed to see if it is adequately working.
- Patients should be given timely, clear and accurate information about the management options for their condition.

- The position in relation to referrals to other specialist services should have been discussed in a timely way without delay.
- The practice should ensure the standard of record keeping meets General Medical Council Good Medical Practice standards.

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.