SPSO decision report

Case: **202110464, A Medical Practice in the Lanarkshire NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C presented to the medical practice with nausea and weight loss. Following blood tests, a significant drop in haemoglobin levels was noted and anaemia (deficiency of healthy red blood cells in blood) was diagnosed. C complained that they were not referred on to secondary care for admission or investigation at this point. A few days later, C collapsed and suffered internal bleeding as a result of a large gastric ulcer (a perforation or hole in the lining of the small intestine, lower oesophagus or stomach).

The practice advised that C was a new patient to the practice and had recently been in hospital with acute kidney injury. On first presentation they had a urine infection, which was treated with antibiotics. Following the blood test results, examinations were carried out to check for internal bleeding. No signs of bleeding had been found but C had a bladder full of urine and their catheter was bypassing. The doctor referred to district nursing for a catheter change and a repeat blood test. This was to check whether C was experiencing further kidney injury. There were no obvious signs of dyspepsia (a condition where digestion is impaired) as no heart burn was recorded.

We took independent medical advice from a GP adviser. We found that it would have been appropriate to make an urgent cancer referral based on the symptoms, but that it was reasonable not to have suspected a gastric ulcer. We also found that there was no record that the causes of the anaemia had been fully explored or that a treatment plan and safety netting advice had been considered or communicated.

We upheld the complaint as we considered that although many of the actions had been reasonable, it did not appear that a cancer referral, a treatment plan or safety netting had been properly considered, recorded or communicated. We did not consider that this had changed C's outcome and acknowledged that the practice had taken steps to learn from the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for not fully exploring C's symptom history and medication, for not communicating a treatment plan and for not providing worsening advice in case of deterioration. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflet.

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

- The practice should consider scheduling regular peer reviews to ensure that consultations are fully recorded including treatment plan and safety netting advice. Staff should be aware of NICE Guidelines and Scottish Referral Pathways for suspected cancer.

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.