Scottish Parliament Region: North East Scotland

Case 200501485: A GP Practice, Tayside NHS Board

Summary of Investigation

Category

Health: GP; Clinical treatment

Overview

There were concerns that the complainant's 88-year-old father was not properly monitored by his GP Practice in the months following his commencement of a diuretic medication, that this caused him to be hospitalised and that the Practice sent him to a community, instead of an acute, hospital.

Specific complaints and conclusions

The complaints which have been investigated relate to:

(a) the Practice's monitoring between August 2004 and January 2005 (*not upheld*); and

(b) the timing of the hospital referral and the choice of hospital (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. I shall refer to the complainant and her father as Ms and Mr C. Annex 1 is a reminder of this, and other, terms used. On 8 August 2005 the Ombudsman received Ms C's complaint.

2. Ms C's complaint was, in fact, about Tayside NHS Board's independent review convener (and was the subject of a separate report by this office). However, as the underlying complaint was about the Practice, I told her that I would additionally investigate the Practice's actions. I should say here that it is part of this office's functions to decide what issues to investigate. Bearing this in mind, the complaints which I have, therefore, investigated relate to:
(a) the Practice's monitoring between August 2004 and January 2005; and
(b) the timing of the hospital referral and the choice of hospital.

Investigation

3. I was assisted in the investigation by one of the Ombudsman's advisers, a GP. His role was to explain to me, and comment on, some of the clinical aspects of the complaint. We examined the papers provided by Ms C, the Practice's complaint file and Mr C's clinical records from the Practice and from the community hospital. To identify any gaps and discrepancies in the evidence, the content of some of the papers was checked against information elsewhere on file and also compared with my own and the adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. The adviser's advice was tested to check that it contained no discrepancies and that, where appropriate, it followed logically from the documentary evidence. Therefore, I am satisfied that that evidence, also, has been tested robustly and, therefore, I accept the adviser's advice. In line with the practice of this office, the standard by which the events were judged was whether they were reasonable in the circumstances. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Practice were given an opportunity to comment on a draft of this report.

(a) The Practice's monitoring between August 2004 and January 2005

(b) The timing of the hospital referral and the choice of hospital

5. I shall cover the complaints together as they are linked. The events complained of start in August 2004, when Mr C was aged 88. He had suffered long term from moderately severe swelling of the legs (which I shall refer to as oedema, a term for fluid collection in the body). For this he was being treated with a diuretic drug, furosemide. (Put simply, a diuretic reduces fluid in the body by increasing the urination.) The clinical records indicate that the Practice were monitoring him by blood tests. This was to ensure that, with the increased urinary loss, there was no loss of essential chemicals in the body (especially sodium and potassium) because a decrease in these (especially potassium) can occur with diuretic treatment and can cause an imbalance of these chemicals and can lead to heart problems. The last such test before the time in question is shown in the records as having been done in May 2004, with a normal result.

6. Mr C was seen by one of the Practice GPs (the GP) in August 2004 because of the concerns of his chiropodist about his swollen feet. The GP prescribed metolazone, another diuretic, in addition to the furosemide. The British National Formulary (BNF) is an authoritative medical publication, containing information about medicines and their use, to help doctors in their prescribing decisions. It says that metolazone is particularly effective when combined with a diuretic such as furosemide but that a strong diuretic action may occur and that the patient should, therefore, be monitored carefully. Ms C felt that from that time her father became increasingly tired, weak and confused, although she explained that she did not link this at the time to the metolazone. At a consultation in October 2004 the GP noted that Mr C had not yet taken any of the metolazone, and later records explain that he did start taking it soon afterwards. I record here that Ms C disputes this, explaining that this delay did not occur. Mr C's continuing poor health prompted several further consultations with the Practice over the following months.

7. In the GP's response to Ms C's complaint to him, he acknowledged that Mr C's blood should have been tested in November or December 2004 because of the metolazone which had been prescribed in August 2004.

8. On 10 January 2005 the GP made a home visit and immediately admitted Mr C to the local community hospital, where he was seen to be dehydrated (over-dry), with a significant water, sodium and potassium imbalance. Prompted by her concern that a community hospital could not adequately deal with her father's condition, Ms C asked the Practice to arrange his transfer to an acute hospital, which was done on 12 January and where rehydration and rebalancing were successfully done. She considered that an acute hospital (that is, with more equipment and other facilities) should have been chosen in the first place. The GP's response to Ms C's complaint to him explained why he had chosen a community hospital. I need not repeat the detail here, except to say that he said he had considered that Mr C's condition would be manageable at the community hospital and that the Practice, as a matter of routine, review such situations to take account of new information, including blood test results. In other words, a patient might be referred to the community hospital but would be transferred to another hospital if that became appropriate.

9. The Practice carried out an analysis of what happened. These are sometimes called Significant Event Analysis and usually involve a meeting between the GPs (and sometimes others) of a GP Practice to consider something that has happened and whether any improvements to care and treatment can be identified. In this case the Practice's Significant Event Analysis was attended by most of their GPs. Their internal notes of the discussion say they agreed that, in future, the Practice would be more cautious about their use of diuretics for oedema in the elderly (particularly combinations of diuretics), would restrict their use of metolazone, would do early monitoring and would request (from the appropriate body) that the warning in the BNF about careful monitoring be expressed more strongly. Ms C was concerned that the Practice's Significant Event Analysis had been prompted by her complaint and by her changing her father's GP. She felt that the events themselves should have prompted it. And she did not feel that the Practice's internal note of it showed evidence of any actual analysis. The GP said that the Significant Event Analysis had not been prompted by the complaint. He also said that, before receiving her complaint, he had written, offering Ms C a

meeting, because he had heard within the Practice that she had concerns and that that meeting took place just after the Significant Event Analysis.

10. Finally, Ms C complained about the GP's failure to return two telephone calls to her and her father on 31 December 2004. In his response to Ms C, the GP gave a full explanation.

(a) and (b) The adviser

11. Paragraphs 11 to 14 summarise comments from the adviser. Although Mr C's oedema is not uncommon in elderly people, it is not easy to treat. Diuretic monitoring should be done. An appropriate timescale could comprise monitoring approximately every six months, or earlier if there is a change in a patient's condition. But it should be stressed that there are no clinical recommendations about frequency. Mr C's last blood test had been in May 2004. Bearing in mind the starting of the metolazone and the warning in the BNF about careful monitoring, it would have been good practice to have done blood tests at the time of prescribing the metolazone (August 2004) and also (to assess Mr C's reaction) approximately two to four weeks later. A slight dryness in November 2004 and a possible transient ischaemic episode (mini-stroke) in December 2004 were changes in condition which were suitable prompts for another blood test around that time. The warning in the BNF was sufficiently clear to alert the GP to the need for careful monitoring.

12. Before the GP's visit to Mr C on 10 January 2005, there were no particular indicators for a hospital admission. (For example, he had been seen on 5 January 2005 by another GP, who is shown in the clinical records to have carried out an appropriate examination, in which he saw nothing to indicate an admission.) The timing of the admission on 10 January was, therefore, reasonable. A community hospital is appropriate for patients who need minor medical treatment but do not appear at that time to require the fuller services of a general hospital. As implied by the GP, it is usual for a GP Practice to arrange transfer from a community hospital to another hospital if, for example, blood tests show a very serious result. And rehydration would be well within the capability of a community hospital. The choice of a community hospital in the first instance was, therefore, reasonable.

13. The failure to arrange blood tests at an appropriate time and to take increased care on prescribing metolazone were indicators for a Significant Event Analysis to take place. However, different practitioners have differing views about which events are serious enough to merit such analysis. Notes taken by a Practice of such meetings are not intended as formal or public documents and cannot be assumed to be a full record of discussion.

14. The GP's explanation (see paragraph 10) for not telephoning the family on 31 December 2004 is a convincing explanation of a genuine misunderstanding by the Practice – on a day of the year which one would expect to be particularly busy. If accurate, it makes the issue a minor point. It has not been investigated because it would not be possible to establish the facts. Therefore, no comment can be made about the explanation's accuracy. However, the Practice could put in place simple measures to try to avoid a recurrence.

(a) and (b) Conclusions

15. I have already explained (see paragraph 3) that I accept the adviser's advice. I should add that it is the practice of this office not to uphold a complaint where the organisation which is the subject of the complaint has already taken action which this office considers to be satisfactory before our involvement. In this case, it is clear to the adviser and to me that the Practice had already learnt from the case. The GP had acknowledged that it would have been better to have done tests in November or December 2004 and the Practice had decided that, in future, monitoring would start at an early stage and that a cautious approach would be taken. That is welcome and satisfactory. In all the circumstances, therefore, I do not uphold complaint (a). The adviser considers the timing of the hospital referral and the choice of hospital to have been reasonable. Therefore, I do not uphold complaint (b).

16. It is not possible to know whether the GP would have arranged a Significant Event Analysis if he had not heard (see paragraph 9) of Ms C's concerns and if she had not changed Mr C's GP. However, even if he arranged it only because of those factors, the adviser considers that this does not fall outside the bounds of acceptability indicated at paragraph 3. The failure to make telephone calls on 31 December 2004 has not been investigated, and the Ombudsman makes no recommendation. However, she suggests that the Practice advise reception staff

that, ideally, the GPs should be informed of a patient's or relative's telephone call, even when there is a computer note that a GP intends to contact either of them, and that computer notes should make it clear whether the call in question is to be made to the patient or the relative. That should help to avoid a recurrence.

(a) and (b) Recommendations

17. The Ombudsman has no recommendations to make.

31 October 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr C	Ms C's father
GP/s	GP/s at Mr C's general practitioner Practice
Oedema	A condition which is characterised by an excess of watery fluid collecting in the body
The BNF	The British National Formulary, a medical publication about medicines
Significant Event Analysis	A Practice's analysis of certain events