Scottish Parliament Region: Central Scotland

Case 200500798: A Medical Practice, Lanarkshire NHS Board

Summary of Investigation

Category

Health / FHS: GP & GP Practice; Clinical treatment/diagnosis

Overview

The complaint concerned the actions of a GP at a home visit. The complaint was that the GP failed to carry out an adequate examination of the patient or arrange for her to be admitted to hospital.

Specific complaint and conclusion

The complaint which has been investigated is about the failure of GP 1 to carry out an appropriate examination or admit Mrs C to hospital (*no finding*).

Redress and recommendation

The Ombudsman has no recommendation to make.

Main Investigation Report

Introduction

1. On 20 June 2005 the Ombudsman received a complaint from a woman (referred to in this report as Miss C) about the treatment which her late mother (Mrs C) received from her local medical practice (the Practice) in February 2005. In particular, Miss C complained that a GP (GP 1) who made a home visit failed to carry out an appropriate examination or admit Mrs C to hospital. Mrs C died a few days after GP 1's home visit.

2. The complaint from Miss C which I have investigated is about the failure of GP 1 to carry out an appropriate examination or admit Mrs C to hospital.

Investigation

3. The investigation of this complaint has involved reading all the documentation supplied by Miss C, Mrs C's medical records and the complaint file (Miss C also complained about the treatment provided by the district nurses at the Practice. The district nurses are employed by Lanarkshire NHS Board - Primary Care Operating Division and were the subject of a separate investigation). Clinical advice has been obtained from one of the medical advisers to the Ombudsman (The Adviser). A written enquiry was made of the Practice and they have provided me with additional information. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found at Annex 1 and a glossary of medical terms used is at Annex 2. Miss C and the Practice have been given an opportunity to comment on the draft of the report.

4. Mrs C, who was 73 years of age and had a history of heart disease and chronic obstructive pulmonary disease (COPD), lived at home with support from her family and occasional visits from the District Nursing Service. Mrs C became unwell and GP 1 made a home visit on 9 February 2005. The district nurses made a home visit on 11 February 2005 to fit a catheter. The family called for an ambulance on 12 February 2005 as they were concerned about Mrs C's health and she was admitted to hospital that day. Mrs C's condition continued to deteriorate and she died in the early hours of 13 February 2005. The cause of death was

stated to be pneumonia with chronic obstructive airways disease (COAD) and congestive cardiac failure.

Complaint: The failure of GP 1 to carry out an appropriate examination or admit Mrs C to hospital

5. Miss C complained in a letter to the Practice that a request had been made for a home visit on 10 February 2005 (Note: Miss C maintained that the visit took place on 10 February 2005, however, the clinical records indicate the home visit was carried out on 9 February 2005 and I am minded to accept that date as correct). Miss C described her mother's symptoms at this time as being distressed, pale colour with a blue face, immobile, slurred speech, breathing difficulties, swollen ankles, feet and legs, and with blisters all over her lower legs. When GP 1 visited, Miss C said he only felt her mother's lower legs and feet and said he would make a referral to a circulation clinic because Mrs C could lose her lower legs. He also mentioned that the blisters on her legs were some sort of infection. Miss C wanted to know why her mother died two days after the GP's visit and why doctors at the Practice had not carried out regular drug reviews on her mother.

6. During local consideration of the complaint, GP 1 responded to Miss C in a letter dated 15 March 2005. He explained that the reason for the visit on 9 February 2005 had been logged on the Practice computer as a concern about the coldness of Mrs C's legs. At the visit, GP 1 found no evidence of, and was not notified of any concerns, about breathing difficulties or slurred speech. The purpose of the visit was to assess the circulation in Mrs C's legs. GP 1 had asked Mrs C if she still smoked and whether she was suffering from pain affecting her arthritic knees. Mrs C told GP 1 that she was not having pain at rest in her lower legs or feet. GP 1 assessed Mrs C's cardio-vascular system to check her heart rate and rhythm. He also checked her lower legs for colour, warmth, the presence of pulses and for signs of gangrene or blackening of her toes, which would indicate that an urgent hospital admission was required. He found there was a significant reduction in the temperature affecting the lower half of Mrs C's calves and feet but there was no evidence of blueness or cyanosis of her feet or blackening or gangrene. He could not find evidence of pulses in Mrs C's lower legs, which was consistent with a diagnosis of peripheral vascular disease. GP 1 did not feel there was a need for an immediate hospital admission in view of the symptoms which had been presented. On return to the surgery, GP 1 dictated a letter to the

vascular surgical clinic at the hospital for a specialist assessment of Mrs C's vascular disease.

7. Miss C did not accept the response from GP 1 and wrote to the Senior Partner (GP 2) at the Practice on 18 April 2005 with her concerns. In addition to the issues previously raised, she asked why her mother had been prescribed temazepam for approximately seven years, which would not be appropriate for a patient with heart failure. GP 2 responded to Miss C in a letter dated 28 April 2005. He explained that he felt GP 1 had made an appropriate and competent assessment of the situation presented at the home visit on 9 February 2005. He said that on 11 February 2005 a request had been made for two doctors to attend Mrs C because she had fallen out of bed and needed help back to bed. Advice was given to contact the police or an ambulance for assistance.

8. GP 2 explained the ambulance records indicated that, originally, the call was for emergency assistance but was downgraded to non-emergency and the crew returned Mrs C to bed. The crew who attended to Mrs C did not find her to be injured and they had no concerns about her condition or they would have conveyed her to hospital. On 12 February 2005, Miss C called an ambulance again and this time the attending crew found Mrs C to be in a life-threatening condition and she was transported to hospital. On arrival at the hospital, dyspnoea was noted. Mrs C was admitted under the care of a consultant physician and, despite supportive therapy, her condition deteriorated and she died the following day. GP 2 also explained that Mrs C's drugs were reviewed on 1 November 2004, 7 April 2004 and 5 February 2004. He agreed that temazepam is ill-advised in patients with COPD and there is a Practice policy of advising patients against the long-term use of temazepam.

9. The Adviser commented that the dispute centred on the interpretation of Mrs C's condition at the visit on 9 February 2005. The records reflect that GP 1 assessed the peripheral circulation in Mrs C's legs and noted she was in atrial fibrillation as before. This could have been assessed by feeling the pulse at the wrist or better by listening to the heart with a stethoscope. Miss C said that GP 1 only examined Mrs C's legs and GP 1's response letter is a little vague on this point. The Adviser said that if the symptoms were as described by Miss C then further history, examination and diagnostic formulation would have been called for.

If the symptoms were as recorded by GP 1 then the thinking and actions outlined in the response letter represented a reasonable standard for the initial contact. He also said that it could not be established whether Mrs C had pneumonia on 9 February 2005 but, as pneumonia in an elderly patient very often causes rapid deterioration, it is quite possible that it was not present when GP 1 saw her.

10. The Adviser commented that, although the records indicated medication reviews took place, there was no detail of what was asked or considered. He also explained that temazepam is a sleeping tablet and is a useful aid in the short term. Good practice advises against long-term prescribing. However, most GPs would have a number of patients on long-term sleeping tablets. These patients are habituated to their medication and it can be difficult to change. In such a situation, the GP would explain the risks and dangers of long-term prescribing and attempt to enlist the patient's help to change the medication. He added that temazepam was not specifically unsuitable in patients who suffered from heart disease.

11. The Adviser had some concerns about the brevity of the clinical records and mentioned a couple of issues where, in one, a visit had been made but no details were entered and another where a blood test had been taken but no details as to who had requested that and their reasons for doing so. It was decided to seek further information from the Practice in relation to the reasons for requesting and the documenting of medication reviews; and comments on record keeping and requesting blood tests.

12. In response to my enquiry, the Practice provided their protocol for drug reviews; information on what was reviewed at specific drug reviews, and information relating to entries in the clinical records. In particular, it was noted that a visit had been recorded in error on 17 February 2004 and that they were unable to establish who had ordered the blood test, although the results were found to be normal and no action was required.

13. The Adviser thought the drug review protocol was adequate and the explanations provided about how it is now integrated with chronic disease management were reassuring. Overall, the Adviser was of the opinion that the Practice were performing to a reasonable standard although medication reviews were not fully reflected in their record keeping. He has suggested that the Practice

be invited to reflect on how we have been impressed by the quality of reasoning over medication reviews and give consideration to how they could practically reflect some of that information in their medical records.

Conclusion

14. Miss C maintained that GP 1's examination of Mrs C on 9 February 2005 was inadequate and that, given her condition, she should have been admitted to hospital for further treatment. GP 1 has said that the reason for the visit was a concern about the coldness of Mrs C's legs and that he did not notice or was made aware of any concerns about breathing difficulties or slurred speech. He had asked relevant questions about the circulation in Mrs C's legs. He could not find evidence of pulses in Mrs C's lower legs, which was consistent with a diagnosis of peripheral vascular disease. He did not feel there was a need for an immediate hospital admission and made a referral to the vascular surgical clinic at the hospital for a specialist assessment of Mrs C's vascular disease.

15. Clearly there is a difference of opinion between Miss C and GP 1 regarding Mrs C's condition on 9 February 2005. The Adviser commented that if the events were as described by Miss C then further examination and history taking would have been appropriate. However, if the events were as entered in the clinical records and described by GP 1 then his actions too would have been appropriate. I have also taken into account that Mrs C was seen by an ambulance crew and district nurses on 11 February 2005 and was not admitted to hospital, but I am conscious that Mrs C was admitted to hospital on 12 February 2005. I note the Adviser's comment that it would not be possible to establish if Mrs C had pneumonia when GP 1 made the visit.

16. In view of the difference of opinion over Mrs C's condition on 9 February 2005 and the lack of other available evidence, I am unable to reach a firm conclusion. Accordingly I make no finding on this complaint. However, the Ombudsman has invited the Practice to note the Adviser's comments regarding completion of the clinical records (see paragraph 13).

28 November 2006

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs C	Miss C's mother
The Practice	The medical practice where Mrs C was a registered patient
GP 1	The GP who made the home visit on 9 February 2005
GP 2	The senior partner in the Practice
The Manager	The practice manager
The Adviser	The medical adviser to the Ombudsman

Annex 2

Glossary of terms

Term	Definition
Atrial fibrillation	An irregular heartbeat
Catheter	A hollow flexible tube inserted into the bladder to drain urine
Chronic Obstructive Airways Disease (COAD), also known as Chronic Obstructive Pulmonary Disease (COPD)	Chronic slowly progressive disease which obstructs the airways usually related to smoking
Congestive cardiac failure	Inability of the heart to maintain adequate blood circulation causing shortness of breath
Cyanosis	A bluish discolouration of the skin caused by a lack of oxygen in the blood
Dyspnoea	Shortness of breath
Peripheral Vascular Disease	Impaired peripheral circulation usually seen in the lower legs
Pneumonia	Inflammation of the lung caused by infection
Temazepam	Sleeping tablet – form of sedation