Scottish Parliament Region: Glasgow

Case 200600644: A Medical Practice, Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: GP

Overview

The complainant (Mr C) raised a number of concerns that doctors at the GP Practice (the Practice) failed to take action when his brother (Mr A) reported headaches following his discharge from hospital in April 2005. Sadly Mr A died on 9 July 2005 after suffering an aneurysm (dilation of an artery, vein or the heart).

Specific complaint and conclusion

The complaint which has been investigated is that the treatment provided by the Practice following Mr A's discharge from hospital was inadequate *(not upheld)*.

Redress and recommendations

The Ombudsman recommends that the Practice take note of the Adviser's comments in regard to record-keeping.

The Practice have accepted the recommendation and will act on it accordingly.

[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, any recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

Main Investigation Report

Introduction

1. On 30 May 2006 the Ombudsman received a complaint from Mr C that doctors at the Practice failed to take action when his family and Mr A reported headaches following Mr A's discharge from hospital in April 2005. Sadly Mr A died on 9 July 2005 after suffering an aneurysm. Mr C had complained to the Practice but was dissatisfied with their response.

2. The complaint from Mr C which I have investigated is that the treatment provided by the Practice following Mr A's discharge from hospital was inadequate.

Investigation

3. In writing this report I have had access to Mr A's clinical records and the complaint correspondence between Mr C and the Practice. I also obtained clinical advice from one of the Ombudsman's professional medical advisers (the Adviser) who is a General Practitioner on the clinical aspects of the complaint. I also made a written enquiry of the Practice.

4. 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 is contained in Annex 1. Mr C and the Practice were given an opportunity to comment on a draft of this report.

Complaint: The treatment provided by the Practice following Mr A's discharge from hospital was inadequate

5. Mr C complained to the Practice that following Mr A's discharge from hospital in April 2005, on numerous occasions his family contacted the Practice to raise concerns that Mr A was suffering from severe headaches. Although numerous home visits from a doctor were requested only one took place the day before Mr A's death. Mr C said that the district nurses visited Mr A on a regular basis but it was felt that the Practice failed to give Mr A appropriate support. (Note: Mr C has made it clear he was not complaining about the actions of the district nurses).

6. A Senior District Nurse (the Nurse) responded to Mr C that following surgery for an abdominal aneurysm repair, district nurses attended Mr A a total of 54 times from 25 April 2005 to 24 June 2005. Their role was to change

dressings covering the wounds at the surgical incision sites. The Nurse explained that Mr A complained of a headache on 27 May 2005 and a doctor prescribed medication for a urinary tract infection (UTI). The next reported headache was on 20 June 2005 when a district nurse tested Mr A's urine and a doctor again prescribed an antibiotic. When a district nurse visited on 24 June 2005, Mr A complained of a headache. He was sitting up and did not appear distressed. He was still being treated for the urine infection and the district nurse advised him to take simple analgesia such as Paracetamol. The plan was then for Mr A to revert to his pre-surgery treatment plan which was an eight weekly district nursing visit for catheter care.

7. Another GP, (GP 1) also wrote to Mr C that a home visit was made by him to Mr A on 8 July 2005 at the request of his brother. GP 1 said Mr A was complaining of generalised headache which was felt to be due to his UTI. Mr A was alert and a discussion ensued about the long term use of antibiotics due to the recurring infections. GP 1 said Mr A told him he was due to meet his consultant the following week and would discuss matters with him. In the meantime a prescription of Ciprofloxacin (antibiotic) was left. GP 1 explained there were no other records of requests for doctors to visit Mr A at home. GP 1 said there was an occasion when Mr A's brother had mentioned Mr A might require oxygen and another GP (GP 2) had attempted to visit but Mr A refused him entry as he said he did not need to see a doctor.

8. The Adviser said that from the records he could confirm that Mr A was 57 years old and was a paraplegic with paraplegia of his lower limbs and also the need for a permanent in-dwelling catheter to the bladder. Mr A was under the regular care of the district nursing team who saw him every eight weeks to care for his bladder/catheter. Mr A saw an orthopaedic specialist and he was also seeing a consultant vascular surgeon concerning an abdominal aortic aneurysm. Mr A underwent angioplasty (surgery) to his iliac arteries (dilating a narrowed area) on 17 March 2005 at which time he was noted to suffer from diabetes. Mr A's GP was asked to follow-up this new diagnosis. The Practice did so and performed the appropriate blood tests on 24 March 2005 and 14 April 2005. Mr A was admitted to hospital for surgery on 18 April 2005 and discharged on 22 April 2005.

9. The Adviser said it was noted that the district nurses visited Mr A 54 times between 25 April 2005 and 24 June 2005 when it was determined that Mr A's surgical wounds had healed. That was an indication of good care of a post-

operative patient. In her letter to Mr C the district nurse reported that Mr A complained of a headache on 27 May 2005. It was thought this was due to a urinary infection and the GP prescribed an antibiotic. The letter stated Mr A did not report another headache until 20 June 2005 despite there being daily contact with him. On that day Mr A rang the district nurse to report the headache, she visited and tested the urine. This testing was consistent with there being another urine infection and the district nurse contacted the GP who prescribed antibiotics. Mr A complained of headaches to the district nurse again at the visit of 24 June 2005. According to the district nurse Mr A did not appear distressed and as he was undergoing treatment for the urine infection, she advised him to take Paracetamol. The Adviser did not believe this was reported to a GP. As the surgical wound had healed Mr A was discharged from the daily district nurse visit and resumed the regular eight week care regime which the Adviser felt was appropriate.

10. The Adviser felt there was a poor record of the GP visit on 8 July 2005 (see paragraph 7). There is no evidence in the record of any examination or of a proposed plan or follow-up. However, from the evidence contained in the GP's records the Adviser believed Mr A was assessed appropriately with urine testing and treated appropriately with antibiotics on 27 May 2005 and 20 June 2005. With these findings the Adviser considered the treatment by GP 1 on 8 July 2005 by prescribing further antibiotics and testing the urine was appropriate. It would seem probable that Mr A suffered a haemorrhage at some time after GP 1 visited and was admitted to hospital.

11. In response to my enquiry the Practice provided information regarding the procedures for recording requests for home visits. The Practice does not hold a house visit request book but such requests are entered on the Practice computer system and are subsequently seen by the doctor who is on duty for visits that day and s/he decides whether a visit is required or telephones the patient for more information. GP 1 also explained that his recording of the visit of 8 July 2005 was limited as there was no reason to expand on what he felt was a straightforward problem of yet another UTI in exactly the same presentation as before on a number of occasions.

12. The Adviser said he could confirm that there was no record of the family requesting a visit for Mr A. The Adviser felt Mr A did have a headache on occasion and the district nurse was told who in turn discussed it with a GP who believed the headache to be associated with the UTI. It was noted there was a

positive test result for urine infection on 20 June 2005. Mr A had had several UTI's and he reported headaches with these infections. The Adviser could understand why there was a paucity of information for the record of the visit on 8 July 2005, but considered that GP 1 should be reminded that it is his duty under national guidelines to write full records of any consultation with a patient. On balance the Adviser felt that the headaches which Mr A reported to the nurse were due to the infection as this is borne out by the timing and past history of such events. He did not believe the Practice could have prevented the final outcome which occurred after Mr A saw GP 1.

Conclusion

13. Mr C felt that the Practice failed to act on the headaches which Mr A and his family reported. I have not been able to resolve the issue about the family reporting the headaches to the Practice (see paragraph 12). The Practice have explained the procedure which is adopted when a request for a home visit is made and that the matter would be referred to the doctor on home visit duty. However, in the event, it is clearly noted that on occasions Mr A did report some headaches and the staff involved thought they were as the result of the recurrent UTI's which he suffered. The advice which I have received and accept is that, following Mr A's discharge from hospital on 22 April 2005, Mr A received appropriate treatment from staff at the Practice and that the assumption that his headaches were related to the UTI's was reasonable. Accordingly I do not uphold this complaint.

Recommendation

14. The Ombudsman recommends that the Practice take note of the Adviser's comments in regard to record-keeping.

15. The Practice have accepted the recommendation and will act on it accordingly.

20 June 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	The complainant's brother
The Practice	The medical practice where Mr A was registered patient
The Adviser	The Ombudsman's medical adviser
The Nurse	The senior district nurse who responded to the complaint
UTI	Urinary Track Infection
GP 1	The GP who saw Mr A on 8 July 2005