Scottish Parliament Region: Lothian

Case 200601874: Lothian NHS Board

Summary of Investigation

Category

Health: Primary Care

Overview

The complainant (Mrs C) raised a concern about the treatment which her son (Mr A) received from a GP (the GP) from NHS Lothian Unscheduled Care Service (LUCS) on 25 April 2006. Mrs C said the GP failed to diagnose that Mr A was suffering from pneumonia which resulted in an emergency hospital admission on 26 April 2006.

Specific complaint and conclusion

The complaint which has been investigated is that the GP provided Mr A with inadequate treatment and failed to diagnose that he was suffering from pneumonia (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board share this report with the GP to reflect on the lessons learned in relation to the importance of chest examination in diagnosing chest disease and the difficulties of assessment of patients with communication difficulties and share the case with his appraiser at annual appraisal if he has not already done so.

The Board have accepted the recommendation and will act on it accordingly

Main Investigation Report

Introduction

1. On 20 September 2006 the Ombudsman received a complaint from Mrs C about the treatment which her son (Mr A) received from the GP on 25 April 2006. Mrs C said the GP failed to diagnose that Mr A was suffering from pneumonia which resulted in an emergency hospital admission on 26 April 2006. Mrs C complained that Mr A was showing the clinical signs of pneumonia yet the GP did not diagnose the condition. Mrs C complained to Lothian NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Mrs C which I have investigated is that the GP provided Mr A with inadequate treatment and failed to diagnose that he was suffering from pneumonia.

Investigation

3. In writing this report I have had access to Mr A's NHS Lothian Unsheduled Care Service (LUCS) clinical records and the complaints correspondence. I also obtained details of Mr A's hospital records for the emergency admission. In addition I listened to a recording of the telephone call from Mr A's carer to LUCS. I obtained advice from one of the Ombudsman's professional advisers (the Adviser), who is a GP, regarding the clinical aspects of the complaint.

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. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical History

5. Mr A is 36 years old and lives in supported accommodation. He has Down's Syndrome and suffers from epilepsy which is controlled by medication. He has communication difficulties and has difficulty describing his symptoms. Between 4 March 2006 and 20 April 2006 Mr A had eight contacts with his GP Practice. (Note: Mrs C has complained about the actions of [deleted at this stage for confidentiality reasons] and that is subject to a separate Ombudsman's investigation report – See 200602086). On 25 April 2006 contact was made with LUCS and the GP visited Mr A and advised him that he should take paracetamol. On 26 April 2006, Mr A's sister was concerned about

his condition and took him to the Accident and Emergency Department at St John's Hospital where a diagnosis of pneumonia was made.

Complaint: The GP provided Mr A with inadequate treatment and failed to diagnose that he was suffering from pneumonia

6. Mrs C complained that Mr A almost died due to the untreated pneumonia and had to have a major chest operation in order to deal with the condition. Mrs C felt that Mr A's condition must have taken some time to develop and had the GP examined Mr A properly then he would have been admitted to hospital earlier. Mrs C said that Mr A would normally describe all his ailments as a 'sore tummy'. Mrs C felt that with patients with learning difficulties who are unable to fully describe their symptoms, then doctors should rely more heavily on clinical tests and refer the patient to hospital if there was uncertainty about the cause of the condition.

7. The Board's Chief Operating Officer (the Chief Officer) responded to Mrs C. He explained that Mr A's carer (the Carer) had telephoned NHS 24 (National Emergency NHS Contact Centre) at 20:26 on 25 April 2006 to report Mr A had had laboured breathing and stomach pains for a few hours. There was also a complaint of back pain and nausea. The NHS 24 nurse adviser was also told Mr A had abdominal pain and retching that night. Mr A did not have diarrhoea or vomiting but was breathless at times and was becoming distressed. The NHS 24 nurse adviser asked a LUCS GP to telephone the Carer back within one hour which did occur and it was decided that a home visit was appropriate so that Mr A could be assessed. The GP visited Mr A at home and was fully aware of the previous discussion between the Carer and LUCS. The GP took a full history from the Carer who confirmed abdominal pain and back pain as the major symptoms. The Carer mentioned Mr A's previous liver problems and that he was on antibiotics for a chest infection. The GP was aware of the limited history provided by the Carer and Mr A. The GP noted Mr A's abdominal problem and alteration to his breathing pattern. There was no indication of a cough; shortness of breath; change in colour to suggest low oxygen levels in his blood; or coughing up sputum. It was also noted that Mr A's symptoms had decreased in severity from the telephone call twenty minutes previously.

8. The Chief Officer continued that the GP felt that Mr A was not dehydrated; had no tenderness in his abdomen and appeared to be comfortable. Mr A's bowel sounds were normal and the GP remembered listening to Mr A's chest

where no respiratory or cardiac abnormality was noted. The GP had commented that the Carer was not present during the entire examination which lasted approximately 15 minutes. The GP took care to involve Mr A in history taking and to uncover physical findings. The GP was told by the Carer that Mr A had improved in the past when prescribed paracetamol. The GP recommended that Mr A take a dose of paracetamol and should the symptoms not settle then further contact could be made with LUCS for a further assessment.

9. Mrs C wrote back to the Chief Officer after reviewing Mr A's clinical records and explained that she disputed that Mr A had no breathing difficulties when the GP called as this was the reason given for the call out. She also noted that the records did not contain information that the GP conducted a chest examination. Even if the GP had listened to Mr A's chest she felt he would not have felt any air movement on the right side due to a large quantity of fluid which had occluded his right lungs. The following day, prior to the hospital admission, Mr A was bent double; had great difficulty breathing; and was cyanosed (skin appears blue in colour due to lack of oxygen in the blood). Mrs C said she was told by medical staff that the symptoms would have been evident the previous day.

10. The Adviser said that Mr A's laboured breathing was part of the initial complaint to LUCS. There is comment that Mr A had improved by the time the GP arrived but the Adviser felt that there would still have been some sort of respiratory difficulty and this should have prompted a chest investigation. The Adviser noted that the GP was aware that antibiotics had been prescribed to Mr A two weeks earlier for a chest infection. The Adviser noted also that the Board's investigation mentioned that 'the GP had made a quick general listening of Mr A's chest as he usually does with patients with Down's Syndrome'. The Adviser told me that patients with Down's Syndrome have an increased risk of cardiac abnormalities that may cause heart murmurs etc. The Adviser was not convinced that the GP's investigations would have identified the problem as it may have involved listening over the heart for murmurs and possibly to have listened to both bases at the back to exclude heart failure. It did not appear to the Adviser that the GP's check was a careful systematic examination of the chest which is required to identify a chest infection. The Adviser explained that the science of chest examination is quite complex and could involve general abnormalities such as temperature, pulse, colour and respiratory rate. There may also be specific abnormalities when the chest is examined in relation to

shift of the trachea (windpipe); differences in percussion when tapping the chest; differences in the nature of breath sounds heard with a stethoscope; and the possibility of additional sounds being present.

11. The Adviser reviewed Mr A's hospital records and said that it appeared Mr A had some form of pneumonia which was complicated by a pleural effusion (fluid between the chest wall and the lungs). The Adviser noted that when Mr A was admitted to hospital on 26 April 2006 he had marked chest signs. He felt these abnormalities would have been present on 25 April 2006 and would have been identified if a careful chest examination had been carried out by the GP. The Adviser continued that even if a pleural effusion had been suspected it might not have led to an admission that night unless it was causing significant respiratory distress.

Conclusion

12. Mrs C had concerns that the GP failed to diagnose that Mr A was suffering from pneumonia and that a hospital admission was required. The Adviser has said that Mr A had marked chest signs on 26 April 2006. These would have been present on 25 April 2006 and had a careful chest examination taken place then those would have been identified. However, even had there been a suspicion of pleural effusion at that time, an emergency hospital admission would only have been appropriate if Mr A was showing significant signs of distress. There is evidence that Mr A's symptoms had improved pending the arrival of the GP.

13. Mr A had communication difficulties and this obviously had an impact on his ability to accurately describe his symptoms. However, the Carer has provided a reasonable history and coupled with the GP's examination this should have resulted in the GP reaching a reasonable diagnosis. Taking the available evidence into account I have decided that the GP's examination of Mr A's chest was inadequate and that it should have been conducted more thoroughly. Accordingly I have decided to uphold the complaint. I note, however, that had such an examination taken place, a hospital admission would only have been considered if clinically appropriate and was influenced by signs that Mr A was significantly distressed.

Recommendation

14. The Ombudsman recommends that the Board share this report with the GP to reflect on the lessons learned in relation to the importance of chest examination in diagnosing chest disease and the difficulties of assessment of patients with communication difficulties and share the case with his appraiser at annual appraisal if he has not already done so.

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

18 July 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	Mrs C's son
The GP	The LUCS GP who visited Mr A on 25 April 2006
The Board	Lothian NHS Board
LUCS	Lothian Unscheduled Care Service – Emergency Lothian NHS Service outwith normal hours
The Adviser	The Ombudsman's professional medical adviser
Chief Officer	A Board Chief Operating Officer
The Carer	One of Mr A's carers
NHS 24	National NHS Emergency Contact Centre