Scottish Parliament Region: Lothian

Case 200501189: Lothian NHS Board

Summary of Investigation

Category

Health: FHS Clinical treatment

Overview

The complainant (Mrs C) complained to the Ombudsman about the care and treatment received by her husband (Mr C) from Lothian NHS Board (the Board)'s Unscheduled Care Service.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) a GP (GP 2) should have arranged Mr C's admission to hospital (*upheld*);

(b) a GP (GP 3) was unhelpful and provided Mrs C with inadequate information (*upheld*); and

(c) there was undue delay by the Board in dealing with Mrs C's complaint (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) enables GP 2 to reflect on the importance of assessing hydration status in future case management;

(ii) ensures that GP 3 gives full details of any arrangements he has made or intends to make, on behalf of a patient, to the patient or the person acting for the patient;

(iii) consider whether there would be benefit in reminding all GPs working for the Unscheduled Care Service that clear comprehensive communication with callers is essential; and

(iv) ensures that complainants are kept up-to-date with progress and expected timescales in accordance with the NHS complaints procedure.

Main Investigation Report

Introduction

1. On 3 August 2005, a woman, referred to in this report as Mrs C, complained to the Ombudsman about the care and treatment received by her husband, Mr C, from the Unscheduled Care Service of Lothian NHS Board (the Board).

2. Mr C's GP (GP 1) visited him at home on the morning of 7 February 2005 because he had been ill through the night with sickness. In the evening of the same day Mr C was still unwell and Mrs C called NHS 24. A GP from the Board's Unscheduled Care Service (GP 2) attended and gave Mr C drugs to stop him vomiting and to relieve pain. He told her to telephone again if Mr C's condition deteriorated. About two hours later Mrs C called NHS 24 again. Another GP from the Board's Unscheduled Care Service (GP 3) attended. GP 3 arranged for Mr C to be admitted to hospital. When in hospital Mr C was found to be dehydrated and to have acute renal failure.

3. The complaints from Mrs C which I have investigated are that:

(a) GP 2 should have arranged Mr C's admission to hospital;

(b) GP 3 was unhelpful and provided Mrs C with inadequate information; and

(c) there was undue delay by the Board in dealing with Mrs C's complaint.

Investigation

4. The investigation of this complaint involved obtaining and reading all the relevant documentation and medical records. I obtained advice from a clinical adviser to the Ombudsman, an experienced GP (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance is overlooked. A list of abbreviations used in this report is given at Annex 1 and an explanation of the medical terms used is at Annex 2. Mrs C and the Board have been given the opportunity to comment on a draft of this report.

5. NHS 24 provides callers with access to the out-of-hours service provided by local NHS Boards, in this case the Board's Unscheduled Care Service. NHS 24 is responsible for the call handling service and advice given by their staff. Complaints about attending doctors are the responsibility of local NHS Boards.

6. On 7 February 2005 Mrs C telephoned Mr C's GP Practice for a house call because Mr C had been ill through the night with sickness. She explained that Mr C

had an ileostomy and that his outage had been excessive. He was passing and vomiting white frothy fluid. He was unable to tolerate any fluids.

7. GP 1 attended. GP 1 contacted the Western General Hospital, Edinburgh (the Hospital) where Mr C had undergone his surgery, and asked for advice regarding his treatment. She then prescribed anti-sickness pills and hydrating sachets. GP 1 advised Mrs C to contact the surgery again if Mr C did not get any better throughout the day. She said that there was a possibility that he may need to be admitted to hospital if he continued to dehydrate. Mrs C was aware that because Mr C had had his colon removed he would dehydrate quicker than was usual.

8. As the day progressed Mr C began to vomit again and he was in pain with severe cramps in his legs and feet. Mrs C has said she knew this was due to loss of body salts. He also had spasms in his hand. His ileostomy bag continued to fill up as quickly. By early evening he appeared to be severely dehydrated. Mrs C called NHS 24 and GP 2 attended at about 19:15. By that time Mr C had also developed severe stomach pain.

9. GP 2 recorded Mr C's pulse and temperature, that his tongue was moist, that his upper abdomen was tender, and that there was no detectable abnormality in the bowel sounds. He also recorded that Mrs C should call back if Mr C remained unwell, or alternately that she should telephone his own GP in the morning.

10. GP 2 gave Mr C an injection of Cyclizine to help stop the vomiting and an injection of Tramadol for the pain. Mrs C said she told GP 2 that she felt Mr C needed a drip as he was dehydrating and also that she was concerned about the leg cramps and degree of pain that he was suffering.

11. The note of the visit records advice given by GP 2 as being:
'If still unwell call back, alternate [tele]phone own GP in morning.'

12. Two hours after GP 2's visit the sickness and cramps had not stopped. The ileostomy bag was by then filling up with dark green liquid. Mrs C called NHS 24 and GP 3 attended at around 22:40.

13. GP 3 agreed to arrange a hospital admission. He called the Emergency Bed Bureau (the Bureau) to arrange this. The records from the Bureau say that GP 3 called them at 22:45. They also say that the Bureau ordered an ambulance at 22:47 to pick up Mr C from home within the next hour. He was to be taken to the Hospital's

Acute Receiving Unit (the ARU) for the attention of a waiting colorectal surgeon. The record from the Bureau also said that at 22:50 the ARU was advised of Mr C's details. The Ambulance Service Patient Report Form states that the ambulance called for Mr C at 23:47.

14. The Hospital notes record that Mr C was given Morphine and Cyclizine at 02:15 on 8 February 2005. They also record that he was started on an IV fluid regime at either 01:05 or 02:05 (the note is not clear), and this was continued until the afternoon of the next day. Another note timed at 06:00 on 8 February states that Mr C was severely dehydrated. Blood tests also indicated that he was suffering from renal failure.

15. Mr C remained in hospital until 11 February 2005, when he was discharged having made a full recovery.

(a) GP 2 should have arranged Mr C's admission to hospital

16. Mrs C told GP 2 that she felt Mr C needed a drip as he was dehydrating and also that she was concerned about the leg cramps and degree of pain that he was suffering. Mrs C feels that GP 2 did not listen to her. She said that GP 2 did not check when Mr C last passed urine, which had been 17 hours before. She also said she was afraid that sleeping would make Mr C's condition even worse because he would not be taking in any fluids but he would continue to lose fluid into his bag. Mrs C said GP 2 told her to telephone again if Mr C got any worse.

17. In his statement to the Board GP 2 further explained his reasons for not arranging a hospital admission. He said that he had felt that because most cases of this condition were self-limiting and because of the risks of cross infection, in the first instance, an attempt should be made to settle Mr C at home. He gave Mr C anti-sickness and pain relieving injections. He said that he explained to Mr and Mrs C that he hoped that this treatment would stop his vomiting and allow him to retain the oral re-hydration GP 1 had prescribed earlier and to get some rest. He had advised them to observe Mr C's condition for an hour or so and if it did not settle they should telephone NHS 24 and he would arrange a hospital admission for Mr C. GP 2 said that he realised that Mrs C was very worried about Mr C and sought to comfort her. He did not think she was being neurotic and had no intention to patronise her. He has also subsequently said to me that the system for recording visits did not allow for detailed notes of communication with patients.

18. GP 2 said that when he returned to base he wrote a hospital admission letter for Mr C and left this with the receptionist. He did this in case, while he was out attending other calls, or after he had completed his shift, Mr C's condition did not improve. Later, having returned from another home visit he was informed by the receptionist that Mr C's admission had been arranged.

19. The Adviser commented that the history taking and examination recorded in the clinical notes by GP 2 looked reasonable and that assessment of dehydration by clinical signs at the bedside without the advantage of laboratory tests is quite crude and it is not possible to always get this assessment right. However, he also noted that when Mr C was assessed in the Hospital, around six hours after he was examined by GP 2, he was found to be severely dehydrated and suffering a degree of acute renal failure. In light of this the Adviser feels that it appears likely that GP 2 underestimated the problems that Mr C was experiencing with fluid balance.

(a) Conclusion

20. From the notes I have seen and the advice I have received I am satisfied that GP 2 took an appropriate history from Mr C and conducted an adequate examination of him.

21. In her complaint to the Ombudsman Mrs C said that it was inappropriate for GP 2 to have given the drugs to Mr C and should instead have arranged his admission to hospital. However, I do not accept that these are alternatives. GP 2 could have given the drug treatment and arranged admission to hospital, or arranged an admission without giving drugs. The drug treatment was essentially the same as that given in the Hospital. I can see no reason to believe that it was inappropriate.

22. The more serious question is whether GP 2 should have arranged a hospital admission at the time of his house call. In reaching a decision on this complaint I have to reach a conclusion as to whether GP 2's decision not to arrange an admission to hospital fell within the bounds of acceptable normal practice.

23. There are issues around GP 2's visit to Mr C that cause me concern. Several hours before GP 2 attended, GP 1 was sufficiently concerned by Mr C's condition to seek advice from the Hospital. During the hours before GP 2 attended Mr C's condition deteriorated. GP 2 has subsequently stated that he did give more detailed advice which there was insufficient space to record at the time, but the record appears to suggest if Mr C did get worse waiting till the morning to contact GP1 could be an alternative to contacting NHS 24 again. I have received clinical advice that it

appears likely that GP 2 did underestimate the problems Mr C was having with fluid balance. Six hours after GP 2 assessed him, Mr C was severely dehydrated and had acute renal failure. My conclusion is that GP 2 did underestimate the problems Mr C was having with dehydration and that, in all the circumstances, GP 2 should have arranged an admission at the time of his visit to Mr C. In all the circumstances I uphold the complaint.

(*a) Recommendation*

24. The Ombudsman recommends that the Board enables GP 2 to reflect on the importance of assessing hydration status in future case management.

(b) GP 3 was unhelpful and provided Mrs C with inadequate information

25. Mrs C said that she explained the situation to GP 3 and he said 'So you want him into hospital' emphasising the 'you'. Mrs C replied that she did and, without further discussion he agreed to arrange a hospital admission. Mrs C was angry at GP 3's tone and she was left confused and worried. She did not know whether an ambulance would come or whether a doctor would call back.

26. After what seemed to her a long time Mrs C telephoned NHS 24 again and asked what was happening. She was informed that a bed had been organised for Mr C at the Hospital but that no transport had been organised. She was told someone would call her back shortly. Someone did call back and apologised and said that an ambulance was on the way.

27. In a statement made during the Board's investigation of the complaint, GP 3 said that he had not seen GP 2's notes and had not heard of the case before. GP 3 wrote that he said to Mrs C 'You want your husband into hospital and I will arrange for his admission straight away'. He did not emphasise the 'you'. GP 3 said that he thought Mrs C would understand that his statement 'I will arrange for his admission straight away' meant exactly that and that was exactly what he did. He said 'I do realise that [Mrs C] was distressed…'. He felt that she mistook efficiency 'for arrogance, rudeness, condescension and abruptness'.

(b) Conclusion

28. It is evident from the records that GP 3 made appropriate arrangements, through the Bureau, for an ambulance to be called and for Mr C to be admitted to the Hospital. It is also clear that these arrangements worked. I cannot find fault with GP 3 about this. There appears to have been some confusion within NHS 24 when Mrs C called them for the third time. This was soon cleared up but, understandably, has contributed to undermining Mrs C's confidence in the service provided by GP 3.

29. Mrs C said that she was angry at GP 3's manner and that when he left she was confused and worried. It is clear to me that, both Mrs C and GP 3 have strong feelings about this. However, in the absence of independent witnesses I cannot reach any conclusions as to the tone of voice used by GP 3 or his general manner. It is agreed that GP 3 told Mrs C that he would 'arrange for his admission straight away'.

30. It is important in distressing and difficult circumstances that GPs give clear information to carers. GP 3 believes that in telling Mrs C he was arranging an immediate hospital admission he explained the arrangements clearly to Mrs C. I disagree. He did not give Mrs C any indication of how the admission was being arranged. I agree with GP 3 that there was a need for efficiency in an urgent situation, but it would not have taken any significant time for him to make clear to her that an ambulance was being arranged to call at the house within one hour. I can understand how this lack of clear information could lead to confusion and worry for Mrs C.

31. In his statement to the Board GP 3 said that he recognised that Mrs C was distressed. I am concerned, given this recognition, that even after receiving this complaint, GP 3 does not accept that his communication with Mrs C might have been inadequate.

32. In all the circumstances I uphold the complaint.

(b) Recommendations

33. The Ombudsman recommends that in future the Board ensures that GP 3 gives full details of arrangements he has made or intends to make for patients to the patient or the person acting for the patient. She also recommends that the Board consider whether there would be benefit in reminding all GPs working for the Unscheduled Care Service that clear comprehensive communication with callers is essential.

(c) There was undue delay by the Board in dealing with Mrs C's complaint

34. Mrs C complained that the Board did not deal with the complaint according to their own guidelines in that they did not comply with their time limits.

35. The Scottish Executive[1] guidance on the NHS complaints procedure, which came into force on 1 April 2005, includes:

> 'It is important that a timely and effective response is provided in order to resolve a complaint, and to avoid escalation. An investigation of a complaint should, therefore, be completed, wherever possible, within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the person making the complaint, and anyone named in the complaint, must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not normally be extended by more than a further 20 working days.
>
> While it may be necessary to ask the person making the complaint to agree to the investigation being extended beyond 40 working days … they should be given a full explanation in writing of the progress of the investigation, the reason for the requested further extension, and an indication of when a final response can be expected.'

36. Mrs C's letter of complaint was received by the Board on 28 February 2005. On 1 March 2005, the Clinical Director of the Unscheduled Care Service acknowledged receipt of Mrs C's complaint and explained that as she was shortly due to go on annual leave she would not be able to reply to the complaint until after her return on 21 March 2005. It is evident from the Board's complaint file that before she went on annual leave the Clinical Director arranged for the GPs involved to provide comments on the complaint. However, the Board did not write again to Mrs C until 10 May 2005 when a complaints officer apologised for the delay and said that they do try to respond within 20 working days or at least explain if there is going to be a delay. No explanation was offered for why there had been no contact with Mrs C between the Clinical Director's return to work on 21 March 2005 and 10 May 2005. The Complaints Officer said that Mrs C would receive a full reply to her complaint very shortly.

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[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive. The latter term is used in this report as it applied at the time of the events to which the report relates.

37. On 18 May 2005 Mrs C chased a reply to her complaint by email. The complaints officer apologised for the delay and explained that there had been a number of difficulties with various people being on leave which prevented a quick reply. He agreed that Mrs C had had to wait an unreasonable time for a reply to her complaint. A substantive reply was sent to Mrs C on 19 May 2005 by the Chief Executive of the Board. He also apologised for the delay in replying to Mrs C's complaint and said that the recent changes to the provision of Unscheduled Care Services had resulted in problems that they had been trying to address.

(c) Conclusion

38. The Board received Mrs C's complaint on about 1 March 2005 which means that the target dates of 20 and 40 working days were on about 29 March and 26 April 2005 respectively. It is evident that the Board exceeded these targets. The procedure allows for investigations to be extended beyond 40 days but only if the complainant is kept up-to-date with progress.

39. I accept that there may have been valid reasons why the Board's response to Mrs C was delayed and I am pleased to note that the Board apologised for these delays. However, Mrs C was not fully informed of the reasons for the delays or given a proper indication of when she could expect a formal response. In all the circumstances I uphold this complaint.

(c) Recommendation

40. The Ombudsman recommends that the Board ensures that complainants are kept up-to-date with progress and expected timescales in accordance with the NHS complaints procedure.

41. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

19 December 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Mrs C's late husband
The Board	Lothian NHS Board
GP 1	General Practitioner from Mr C's GP Practice
GP 2	General Practitioner from the Board's Unscheduled Care Service
GP 3	General Practitioner from the Board's Unscheduled Care Service
The Adviser	Clinical adviser to the Ombudsman
The Hospital	Western General Hospital, Edinburgh
The Bureau	The Emergency Bed Bureau
ARU	Acute Receiving Unit

Annex 2

Glossary of terms

Ileostomy	Surgical formation of an artificial anus by connecting the ileum to an opening in the abdominal wall