Scottish Parliament Region: Highlands and Islands

Case 200800761: A Medical Practice, Highland NHS Board

Summary of Investigation

Category

Health: General Practitioner; treatment and referral

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment that her late father (Mr A) had received from his GP Practice (the Practice) before his death.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Practice delayed in examining Mr A after his family contacted them stating that he had chest pain on 28 June 2007 (*upheld*); and

(b) the action taken to 'flag' Mr A's notes that he had special requirements was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:

(i) apologise to Mrs C for the delays in examining Mr A on 28 June 2007;

(ii) organise a review of their triage systems and ensure that the revised procedures are communicated effectively to staff;

(iii) apologise to Mrs C for the failure to effectively flag Mr A's notes; and

(iv) consider how they can effectively flag the electronic records of a patient with significant health problems.

The Practice have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The complainant (Mrs C) made a number of complaints to the Ombudsman about the treatment that her late father (Mr A) had received from his GP Practice (the Practice) before his death on 9 January 2008. The Ombudsman's GP adviser (the Adviser) was asked for his comments on the matter. He reviewed the actions of the Practice and said that they had acted reasonably in relation to most aspects of the complaint. However, he was concerned about the Practice's delay in examining Mr A after his family contacted them stating that he had chest pain on 28 June 2007. He also said that he was concerned that the Practice had not adequately 'flagged' Mr A's notes that he had special requirements.

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

(a) the Practice delayed in examining Mr A after his family contacted them stating that he had chest pain on 28 June 2007; and

(b) the action taken to 'flag' Mr A's notes that he had special requirements was inadequate.

Investigation

3. Investigation of the complaint involved reviewing Mr A's medical records relating to the events and the Practice's complaints file. I also sought the views of the Adviser and met Mrs C and her sister to discuss their 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 Practice were given an opportunity to comment on a draft of this report.

(a) The Practice delayed in examining Mr A after his family contacted them stating that he had chest pain on 28 June 2007

5. Mr A was a 79-year-old man who had previously been diagnosed with Chronic Kidney Disease. His family telephoned the Practice and spoke to a receptionist at 13:37 on 28 June 2007. They have told me that they said that he was suffering from chest pains and tightness in his chest. They also said that they told the receptionist that he sounded as if he had fluid in his lungs. They said that Mr A had previously had a stroke and had high blood pressure. They asked that a doctor visit the house as soon as possible. The family have told

me that the receptionist said that there were no appointments to see a doctor until the middle of the following week. The family said that Mr A needed to see a doctor urgently and the receptionist agreed to ask a doctor to call them back.

6. The family have also told me that no one called back within the next 15-20 minutes and they decided to take Mr A to the Practice by car. On arrival, they explained the situation to the receptionist. They have told me that the receptionist initially said that the Practice did not take emergencies, but then said that she would ask a doctor to see Mr A. The receptionist then spoke to the doctor who was on triage duty (GP 1). He advised that another doctor (GP 2) should see Mr A, but there were four or five patients in front of him.

7. The family have told me that it was evident that Mr A was seriously ill. They said that he was pale, had tightness in his chest and was struggling for breath. They said that other patients in the waiting room indicated that they would be happy to wait until Mr A had been seen. The family have told me that they spoke to the receptionist on at least two occasions, but Mr A was left for 50 minutes before being seen. They have told me that he was not seen until 15:00, some 83 minutes after the initial call to the Practice. GP 2 examined Mr A and said that he should be taken to Raigmore Hospital (the Hospital) immediately. She recorded on the referral letter that he had a history of heart problems and had been suffering from chest pains from 06:00 that morning. The family said that Mr A left the surgery at 15:35 and was subsequently admitted to the Hospital. On the following day, the family were advised that Mr A had suffered a heart attack.

8. We asked the Practice for information about their triage procedures. In their response, they said that one doctor was on triage duty each morning and afternoon and was available to deal with telephone calls, appointment requests, urgent calls etc. They said that the doctor on triage duty deals with each request, and, if they consider that the patient needs to be examined, each doctor has two slots available during each surgery. When these slots are used, the doctor on triage duty should arrange to see the patient themselves at a suitable time.

9. We asked the Practice if they had a record of the timings of the calls on 28 June 2007. They said that the initial call was at 13:37 and that they had recorded that this had been dealt with at 14:14. In response to Mrs C's complaints to them about the matter, they had stated that it seemed unlikely

that any of the Practice's very experienced staff would respond to a request for an urgent visit for chest pains in this way. They said that the Practice staff are trained to contact the triage doctor at once and an urgent visit is normally made.

10. The Practice said that GP 1 was the triage duty doctor on 28 June 2007. The medical records show that he tried to telephone Mr A's family at 14:05, but the call was not answered. They said that GP 1 recalled leaving a message on the answer machine asking Mr A to call back. He said that a family member called back quite quickly and said that Mr A had a very tight chest and was feeling unwell. He said that the family confirmed that Mr A was fit to travel to the Practice and an appointment was made for him to see GP 2 at 14:20. GP 1 said that the family acknowledged that these arrangements were satisfactory. The family have stated that GP 1 could not have spoken to someone at their house, as they were at the Practice by 14:10. They have also said that the receptionist did not tell them that an appointment had been arranged for 14:20 when they arrived at the Practice.

11. There is no specific contemporaneous evidence in the medical records in relation to how long Mr A had to wait to be examined after he arrived at the Practice, although there is a note on the referral letter from the Practice to the Hospital that he was given a GTN spray[1] at 15:30. The Practice have stated that it was GP 1's recollection that GP 2's surgery was running particularly late and that a family member asked reception staff when Mr A would be seen. They said that staff assured the family member that GP 2 would see Mr A as soon as she was available. The Practice said that GP 1 was not aware at any stage of a clinical deterioration in Mr A's symptoms. However, the family have stated that the receptionist spoke to GP 1 about the urgency of the situation on a number of occasions.

12. I referred the matter to the Adviser and requested his comments. He raised concerns that it took the Practice 37 minutes to respond to a patient with chest pains. He said that the Practice had stated that GP 1 first tried to contact Mr A at 14:05, but this was still 28 minutes after the call was received. Although the Practice have recorded that the matter was dealt with at 14:14, there is no evidence in the contemporaneous records that a doctor spoke to the family at that time. The Adviser said that, nevertheless, it was unreasonable for the Practice not to be in contact with Mr A or his family for 37 minutes after the

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[1] Glyceryl trinitrate spray is to relieve chest pain associated with angina.

initial call. The Adviser also said that in normal circumstances, considering the seriousness of his symptoms, Mr A had to wait too long to be seen when he arrived at the surgery and he criticised the Practice for this. He also commented that the Practice's triage procedures were not clear and should be improved.

(a) Conclusion

13. I have carefully considered the evidence and the comments I have received from Mrs C, the Practice and the Adviser. Chest pain is a significant symptom and I consider that the Practice delayed in dealing with the telephone call from Mr A's family. In view of the seriousness of Mr A's symptoms, he should have been seen urgently when he attended the Practice. It is clear from the evidence that I have seen that this was not the case. I, therefore, uphold the complaint.

(a) Recommendations

14. The Ombudsman recommends that the Practice:

(i) apologise to Mrs C for the delays in examining Mr A on 28 June 2007; and

(ii) organise a review of their triage systems and ensure that the revised procedures are communicated effectively to staff.

(b) The action taken to 'flag' Mr A's notes that he had special requirements was inadequate

15. Mr A's family met the Practice on 21 September 2007 to discuss a number of concerns that they had. It was agreed at this meeting that Mr A's notes would be 'flagged', as he had significant health problems. Mrs C subsequently complained to the Practice that the family had tried to arrange an appointment on 17 October 2007 for Mr A to see a doctor (GP 3). She said that they were told that GP 3 could not see Mr A for at least two weeks, but that he could see another doctor within one or two days. GP 3 telephoned Mr A later that day and said that he could not see him before 23 October 2007 due to annual leave and other commitments. However, he arranged for Mr A to see another doctor (GP 4) on the following day. GP 4 carried out tests and Mr A was admitted to the Hospital with acute renal failure later that day.

16. Mr A's family told me that they met the Practice Manager on 19 October 2007. They said that the Practice Manager assured them that the notes had been flagged. They asked why Mr A had not been seen urgently when they telephoned on 17 October 2007. The Practice Manager said that he

would investigate this. The family asked to see Mr A's computer record to confirm that it had been flagged, but were advised that the computer system was down.

17. The family wrote to Highland NHS Board (the Board) to complain about the Practice on 3 December 2007. In their letter, they said that patients' electronic records should have a flag/marker to indicate that they were seriously ill. They said that this would alert reception staff to escalate calls to the triage doctor rather than treating them as non-urgent calls, as they did with Mr A on several occasions. The complaint was referred to the Practice and they were asked to provide a response to the Board. In their response, they said that Mr A was flagged within the Practice as a patient with significant health issues.

18. Mr A's family have stated that they telephoned a receptionist at the Practice on 10 January 2008. They said that they asked her about a flag on Mr A's records, but the receptionist was not aware of any flag. We asked the Practice if they had flagged Mr A's notes and, if so, how this was done. In their response, they said that after the meeting on 21 September 2007, as agreed, all staff and doctors were informed by email that Mr A was a patient with significant health problems.

19. The Adviser considered this aspect of Mrs C's complaint and said that he was concerned about the so called flagging of the notes. He commented that the Practice said that they had done this by sending an email to all staff, but nothing was added to the patient's notes to alert either doctors or receptionists that this was a 'special' patient. He said that this did not seem to be an effective way of warning staff of patients with special needs.

(b) Conclusion

20. The Practice have told me that they flagged Mr A's notes by informing all staff and doctors that he had significant health problems in an email. I do not consider that this was an effective way of drawing his specific needs to the attention of all staff who may have been contacted by Mr A or his family some time after the email was received. In view of this, I uphold the complaint.

(b) Recommendations

21. The Ombudsman recommends that the Practice:

(i) apologise to Mrs C for the failure to effectively flag Mr A's notes; and

(ii) consider how they can effectively flag the electronic records of a patient with significant health problems.

22. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr A	The aggrieved – Mrs C's father
The Practice	Mr A's GP Practice
The Adviser	The Ombudsman's GP adviser
GP 1	A doctor at the Practice
GP 2	A doctor at the Practice
The Hospital	Raigmore Hospital
GP 3	A doctor at the Practice
GP 4	A doctor at the Practice
The Board	Highland NHS Board