Scottish Parliament Region: Mid Scotland and Fife

Cases 200802262 & 200900284: A Medical Practice, Fife NHS Board and Fife NHS Board

Summary of Investigation

Category

Health: Community Psychiatry and GP; prescription of anti-depressants and duty to refer concerns about the actions of another health professional

Overview

The complainant (Ms C) raised a number of concerns that a GP from her mother (Mrs A)'s GP Practice (the Practice) and a consultant psychiatrist working for Fife NHS Board (the Board) prescribed anti-depressants and anti-psychotics to her mother without adequate assessment and had failed to report concerns about potential unprofessional conduct of a nurse to the appropriate organisation.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Practice unreasonably prescribed anti-depressants to Mrs A based on information from a third party (*not upheld*);

(b) the Practice unreasonably changed a routine psychiatric referral to an urgent referral based on information from a third party (*not upheld*);

(c) the Practice failed to refer the actions of another health professional, which they knew had given rise to professional concern, to the appropriate authority (*upheld*);

(d) the Board unreasonably prescribed medication to Mrs A based on information from a third party (*not upheld*); and

(e) the Board failed to refer the actions of a health professional, which had given rise to professional concern, to the appropriate authority (*upheld*).

Redress and recommendations

There are no recommendations in respect of the Practice.

The Ombudsman recommends that the Board take steps to remind all clinical staff, including Primary Care staff and Family Health Service providers in the

Board area, of their professional duty to act when they have a concern about the fitness to practise of a health professional.

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

Main Investigation Report

Introduction

1. On 5 December 2008 the Ombudsman received a complaint from the complainant (Ms C) concerning the care and treatment of her late mother (Mrs A) by her GP (Doctor 1), a doctor in the local practice (the Practice). In particular Ms C complained that Doctor 1 had failed to report the actions of a nurse (Nurse 1) to her employer although he had reason to suspect she had lied about Mrs A's condition to ensure Doctor 1 prescribed anti-depressant medication and obtained an urgent psychiatric referral for Mrs A. Ms C later added further complaints about the actions of the consultant psychiatrist (Doctor 2) in similarly failing to refer Nurse 1 to her employer and in prescribing anti-depressant medication to Mrs A on the evidence of Nurse 1 without undertaking his own medical review of Mrs A.

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

(a) the Practice unreasonably prescribed anti-depressants to Mrs A based on information from a third party;

(b) the Practice unreasonably changed a routine psychiatric referral to an urgent referral based on information from a third party;

(c) the Practice failed to refer the actions of another health professional, which they knew had given rise to professional concern, to the appropriate authority;

(d) Fife NHS Board (the Board) unreasonably prescribed medication to Mrs A based on information from a third party; and

(e) the Board failed to refer the actions of a health professional, which had given rise to professional concern, to the appropriate authority.

Investigation

3. Investigation of these complaints involved reviewing Mrs A's medical records and correspondence between Ms C and the Board and Doctor 1. I have also met with Ms C and sought the advice of a GP adviser (Adviser 1) and medical adviser (Adviser 2) to the Ombudsman. I have also reviewed the Scottish Commission for the Regulation of Care (the Care Commission) report into a complaint submitted to them about some of these matters.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C, the Practice and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mrs A had a diagnosis of Alzheimer's Disease and had been transferred from hospital to a privately run care home (Care Home 1) in early August 2004. Ms C told me that Nurse 1, who was employed by a private company as the manager of Care Home 1, expressed the view that Care Home 1 could not cope with Mrs A because of her aggressive behaviour, although Ms C did not agree with this and felt that Nurse 1 was motivated to have her mother moved because she was wholly funded by social services who paid a lower fee to the care home than they might otherwise be paid by a self-funding resident. Thereafter Ms C told me that Nurse 1 gave false impressions of her mother's behaviour to Social Services, Doctor 1 and Doctor 2 to secure anti-depressant medication for Mrs A in September 2004 and make Mrs A appear to be in need of care in a specialist dementia home and ultimately secure a transfer away for Mrs A. Ms C told me that Mrs A's condition deteriorated markedly once she was put on anti-depressant and anti-psychotic medications. She became very lethargic and would not eat or drink. At Ms C's request Mrs A was transferred to a new (non-specialist) care home (Care Home 2) in November 2004, most of the medications she was on at transfer were stopped immediately and her condition improved as she gained weight. Mrs A died several months later in 2005 while still a resident of Care Home 2.

6. Ms C raised concerns about the actions of Nurse 1 while her mother was still resident in Care Home 1. Social Services supported Ms C's concerns about the actions of Nurse 1 and challenged Nurse 1's view of Mrs A at meetings with Care Home 1 management and Doctor 2. Ms C referred her concerns to the Care Commission who have regulatory responsibility for Care Home 1, who duly investigated and reported in February 2005, upholding Ms C's complaint. In particular the report noted that the documentation provided to Doctor 2 by Nurse 1 misled Doctor 2 and caused him to prescribe medication that he may not have otherwise done. Ms C later referred her concerns about the behaviour of Nurse 1 to the Nursing and Midwifery Council (NMC) and the Procurator Fiscal who considered the matter but declined to investigate further. Ms C told me that it was her understanding that this was at least in part due to the lack of clarity in the statements these organisations obtained from Doctor 1 and Doctor 2

(a) The Practice unreasonably prescribed anti-depressants to Mrs A based on information from a third party

7. Ms C wrote to Doctor 1 on a number of occasions seeking further information about the drugs he had prescribed for her mother and his review of the prescriptions. On 13 November 2008 Ms C wrote to Doctor 1 making a complaint that Doctor 1 had prescribed mirtazapine (an anti-depressant medication) to Mrs A on 30 September 2004 while she was resident in Care Home 1 when Mrs A was recorded as denying having any problems.

8. Doctor 1 expressed the view that he had prescribed and later increased Mrs A's medication in response to her reportedly (by Nurse 1) being anxious intermittently, verbally abusive and swearing at staff. He felt Mrs A might have been depressed and commenced treatment on 28 September 2004, increasing it on 14 October 2004 as he felt she was not improving. Following a call from Mrs A's named nurse (Nurse 2) at Care Home 1 advising that Mrs A appeared overly sedated, he reduced the prescription again on 27 October 2004 - the medication sheets from Care Home 1 indicate that in fact the prescription was not reduced until Mrs A moved to Care Home 2 in November 2004.

9. Adviser 1 told me that it is important that any GP considering prescribing anti-depressants speaks to relatives and carers and obtains a coherent history to go along with his own examination of the patient. The decisions taken may rely on the information obtained from others as behaviour in Alzheimer's patients can be very changeable and their mood on examination may not reflect their mood and behaviour at other times. Adviser 1 considered that on the basis of the information available to Doctor 1 his decision to prescribe anti-depressant medication was a reasonable one.

(a) Conclusion

10. Adviser 1 has told me that the decision to prescribe was in his view a reasonable one as it reflects the usual practice for a GP to gather information from those who regularly interact with the patient. I accept that in this case it was reasonable for Doctor 1 to assume that the information he was provided with was correct. Mrs A's illness could present with very variable moods and behaviours. I, therefore, do not uphold this aspect of the complaint.

(b) The Practice unreasonably changed a routine psychiatric referral to an urgent referral based on information from a third party

11. On 13 November 2008 Ms C wrote to Doctor 1 making a complaint that he had rearranged the planned community psychiatric review of Mrs A by requesting an urgent review. Ms C was concerned that this was requested purely on the basis of a call from Nurse 1 to Doctor 1 and without any personal observation of Mrs A on the part of Doctor 1. The impact of this was that Doctor 2 visited Mrs A without Ms C being present, although she had previously expressly asked that she be present, and that Doctor 2 prescribed anti-psychotic medication for Mrs A on the information provided to him by Nurse 1 who was present at the review.

12. Doctor 1 commented that he had asked Doctor 2 to assess Mrs A much quicker than planned because Nurse 1 had advised him that Care Home 1 was struggling to cope with Mrs A's behaviour.

13. Adviser 1 told me that Doctor 1 believed what he was being told by Nurse 1 and had no reason to think he was being anything other than helpful at this point and accordingly Adviser 1 considered the request for an urgent review was a reasonable one.

(b) Conclusion

14. Adviser 1 has told me that the decision to request an urgent review was in his view a reasonable one as again it reflects the usual practice for a GP. I accept that in this case it was reasonable for Doctor 1 to assume that the information he was provided with was correct. I, therefore, do not uphold this aspect of the complaint.

(c) The Practice failed to refer the actions of another health professional, which they knew had given rise to professional concern, to the appropriate authority

15. On 13 November 2008 Ms C wrote to Doctor 1 making a complaint that he had failed to report the actions of Nurse 1 to an appropriate authority once he had been advised by Doctor 2 that Nurse 1 had 'lied' about Mrs A's behaviour and that there had been inconsistencies between what Nurse 1 had told social work staff and Doctor 1 and Doctor 2. Mrs A's GP notes for 11 November 2004, written by Doctor 1, record the telephone conversation with Doctor 2 and note that Doctor 2 is 'quite upset at prescribing antipsychotic drugs on little justification (as it turns out)'.

16. Doctor 1 commented that it became apparent to him that the NMC and the police would be involved and that the investigation would take place fairly soon. He believed Doctor 2 had already made a complaint when he spoke to Ms C at a later date (this was in 2008). He felt that as the matter was already in the hands of the relevant authorities and he cooperated fully with those enquiries he would add nothing further by a complaint from him.

17. Adviser 1 commented:

> 'The provision of medical services only works when the professionals in it feel that the information passed from one to another is true. Therefore, trust is paramount even between professionals who are not known to one another. The General Medical Council (GMC) have rules regarding this [Annex 2]. [Doctor 1] has taken his professional duty seriously by cooperating fully with every investigation and this would be enough for the normal citizen. Professionals however need to be proactive in this situation and therefore it is my opinion that his action in not ensuring [Nurse 1]'s behaviour was reported to the relevant authority was unreasonable.'

Adviser 1 told me that he was conscious that Doctor 1 had found himself in a difficult situation and quite possibly a number of other Doctors would have acted as he had done but that there is a duty on all professionals to stamp out dishonesty.

(c) Conclusion

18. I acknowledge that Doctor 1 subsequently cooperated fully with all the official enquiries (as he has done with our own). In 2008 he was of the view that Doctor 2 had made a complaint (although in fact he had not) but my concern is that on 11 November 2004 Doctor 1 was advised that he had been misled and possibly lied to, by another health professional and that this had led to the prescribing of anti-depressant and anti-psychotic medication which may not have been appropriate. This must have cast doubt in Doctor 1's mind on the professional competence and fitness to practice of Nurse 1 but he took no action to raise this with the appropriate authority (her employer in the first instance) in line with the GMC guidance of the time. I conclude that Doctor 1 failed to follow the appropriate guidance and I, therefore, uphold this aspect of the complaint. In doing so I recognise that this is a difficult area of practise for all health professionals and that Doctor 1's inaction may reflect what many other

heath professionals would have done. However, vulnerable patients do not always have a relative or other person able to act on their behalf and it is vital to the public trust in health professionals that the GMC guidance is adhered to.

(c) Recommendation

19. The complaint against Nurse 1 has subsequently been considered by the NMC who took no further action. The Ombudsman, therefore, has no recommendation to make about the specific events of this complaint but see recommendation following complaint heading (e).

(d) The Board unreasonably prescribed medication to Mrs A based on information from a third party

20. Ms C wrote to the board on 28 December 2008 raising a number of concerns including concerns about the change of community psychiatric visit from a routine to an emergency one and aspects of the choice of drug prescription. Ms C received a written response on 10 February 2009 and had a meeting with Doctor 2 on 26 February 2009. Ms C told me that she found the meeting very useful and accepted a number of the responses offered by Doctor 2 who had been very honest and direct in his dealings with her. She remained concerned though that she had not been present at the emergency appointment and had not been able to make her views known when she had specifically requested that she be present, and that the prescription of anti-psychotic drugs was excessive in her mother's case as she was a 93-year-old lady in a wheelchair.

21. Adviser 2 told me that the assessment conducted by Doctor 2 at the emergency appointment was reasonable in that he reviewed a behaviour chart and spoke with Nurse 1 as well as spending 15 minutes with the patient. Adviser 2 noted that it was not clear whether or not Doctor 2 knew that Ms C had wanted to be present at the meeting. While Adviser 2 did not feel it was unreasonable for Doctor 2 to have prescribed without speaking to Ms C, he considered it would have been sensible and courteous for him to have spoken with Ms C at some point and inform her of his views about her mother's treatment, unless Mrs A had specifically asked him not to and there is no suggestion that that was the case. Adviser 2 also commented that there was no indication of whether Mrs A lacked capacity to make decisions for herself and that in the absence of such an assessment being made it would be usual for the doctor to discuss the proposed medication with the patient but that this would not usually be recorded.

(d) Conclusion

22. Adviser 2 told me that he considered that Doctor 2 had acted reasonably in prescribing the medication for Mrs A based on his own observations and the history presented to him by another health professional. Based on this advice I do not uphold this aspect of the complaint although I note that communication with Ms C by Doctor 2 at that time would have highlighted the concerns about the information provided by Nurse 1 at an earlier opportunity.

(e) The Board failed to refer the actions of a health professional, which had given rise to professional concern, to the appropriate authority

23. Ms C complained to the Board that Doctor 2 had not reported Nurse 1 to the NMC when he discovered that she had lied to him and had falsified documentation she had shown him, all with extreme consequences for Mrs A. Ms C told me that Doctor 2 had now written to the NMC regarding the conduct of Nurse 1 following their meeting on 26 February 2009 when she had made him aware of the Care Commission report's findings.

24. Adviser 2 told me that he felt that Doctor 2's clinical decisions taken during his assessment of Mrs A in Care Home 1 were reasonable in light of all the circumstances, as it is usual practice to act on the basis of own observation and reports from other health professionals. Adviser 2 noted that once Doctor 2 became aware at a later date that Nurse 1 had misled him or been dishonest in her representation of Mrs A or he formed a view that her integrity was seriously in question, he should have taken steps to report Nurse 1 to her employer as required by the GMC (see paragraph 17 above).

(e) Conclusion

25. Adviser 2 has told me that he considers Doctor 2's concerns about the actions of Nurse 1 should have prompted him to inform her employer and not doing so amounted to a failure to follow GMC guidance. Based on this I uphold this aspect of the complaint but also note the direct action subsequently taken by Doctor 2 in contacting the NMC earlier this year (2009) and in discussing events with Ms C.

(e) Recommendation

26. The Ombudsman recommends that the Board take steps to remind all clinical staff, including primary care staff and Family Health Service providers in

the Board area, of their professional duty to act when they have a concern about the fitness to practice of a health professional.

27. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the board notify him when the recommendation has been implemented.

28. There are no recommendations in respect of the Practice.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mrs A	Ms C's mother, the aggrieved
Doctor 1	Mrs A's GP in Care Home 1
The Practice	Mrs A's GP Practice
Nurse 1	The nurse manager of Care Home 1
Doctor 2	The consultant psychiatrist who reviewed Mrs A in Care Home 1
The Board	Fife NHS Board
Adviser 1	A GP adviser to the Ombudsman
Adviser 2	A medical adviser to the Ombudsman
The Care Commission	The Scottish Commission for the Regulation of Care – the regulatory body for all care homes in Scotland
Care Home 1	The care home where Mrs A was resident from August 2004 to November 2004
Care Home 2	The care home where Mrs A was resident from November 2004 until her death in 2005

NMC	Nursing and Midwifery Council – the body with statutory responsibility for the professional conduct and registration of nurses
Nurse 2	Mrs A's named nurse in Care Home 1
GMC	The General Medical Council – the body with statutory responsibility for the professional conduct and registration of doctors

Annex 2

List of legislation and policies considered

Good Medical Practice 2001

Dealing with problems in professional practice

Conduct or performance of colleagues

26. You must protect patients from risk of harm posed by another doctor's, or other health care professional's, conduct, performance or health, including problems arising from alcohol or other substance abuse. The safety of patients must come first at all times. Where there are serious concerns about a colleague's performance, health or conduct, it is essential that steps are taken without delay to investigate the concerns, to establish whether they are well-founded, and to protect patients.1

27. If you have grounds to believe that a doctor or other healthcare professional may be putting patients at risk, you must give an honest explanation of your concerns to an appropriate person from the employing authority, such as the medical director, nursing director or chief executive, or the director of public health, or an officer of your local medical committee, following any procedures set by the employer. If there are no appropriate local systems, or local systems cannot resolve the problem, and you remain concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation or the GMC for advice.

28. If you have management responsibilities you should ensure that mechanisms are in place through which colleagues can raise concerns about risks to patients. Further guidance is provided in our booklet Management in Health Care: The Role of Doctors.

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[1] Section 35 of the Medical Act 1983 (as amended) places a legal duty on doctors to supply, on request from the GMC, any document or information which appears relevant to the discharge of the GMC's professional conduct, professional performance or fitness to practice functions. In addition, where a decision has been taken to investigate a doctor's conduct, performance or health through our formal procedures, the Act requires us to obtain from that doctor the names of his or her employers or bodies for whom he or she contracts to provide services