Scottish Parliament Region: Glasgow

Case 201204479: A Medical Practice in the Greater Glasgow and Clyde NHS Board area

Summary of Investigation

Category
Health: FHS; GP & GP Practice; complaints handling

Overview
The complainant (Ms C) who was an Advocate acting on behalf of Mrs A, raised a number of concerns that the care and treatment provided by his General Practitioner (GP) to Mrs A's husband (Mr A) were inappropriate. Ms C also complained that Mr A’s medical practice (the Practice) failed to provide an adequate response to the complaint about Mr A's treatment.

Specific complaints and conclusions
The complaints which have been investigated are that:

(a) the Practice failed to provide appropriate care and treatment for Mr A's reported symptoms of headaches; dizziness; and disorientation; in April and May of 2012 *(upheld)*; and

(b) the Practice failed to provide an adequate response to the complaint about Mr A's treatment *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Practice:	*Completion date*
(i) conducts a Significant Event Analysis of these events and that any learning outcomes are discussed at the GP's annual appraisal;	29 April 2014
(ii) conducts a review of a sample of clinical records to assess whether they meet the standards recommended by the GMC. Any learning outcomes to be addressed at the GP's annual appraisal and/or with appropriate training;	29 April 2014
(iii) conducts a review of the Practice's monitoring protocol for patients taking warfarin to ensure that it is fit for purpose;	29 April 2014

(iv)	conducts a review and revision of its complaints procedure to ensure it complies with current NHS complaints handling guidance;	1 March 2014
(v)	ensures that all staff have received appropriate training on handling complaints; and	29 April 2014
(vi)	issues a written apology to Mrs A for all the failings identified in this report.	1 March 2014

Main Investigation Report

Introduction

1. Mr A was a 63-year-old man with no significant previous medical history other than being monitored for an irregular heartbeat since 2009. He had also suffered a 'mini stroke' in 2011 and he was taking warfarin (a blood thinning medication).

2. Ms C, an Advocate acting on behalf of Mrs A stated that Mrs A said that from 3 April 2012 her husband, Mr A, complained of feeling very unwell with excruciating headache; dizziness; and disorientation. He attended his GP Practice (the Practice) on 4 April 2012 and was told he had a build-up of ear wax. He was prescribed a wax softener and also scheduled to have his ears syringed (a method of clearing excess wax from the ears) in two weeks' time.

3. Ms C said that Mr A's symptoms worsened to include vomiting and he was unable to work or leave home due to the dizziness. Ms C stated that the GP was reluctant to attend Mr A at home and he, therefore, had to call NHS 24 (a national advice helpline) several times over the next few weeks. He also attended the Accident and Emergency (A&E) department of his local hospital on three occasions.

4. Very late on 8 May 2012 Mr A attended A&E for the third time and was diagnosed as having a large bleed on the brain. He was admitted to hospital on 9 May 2012 and was declared brain dead the following day.

5. Ms C complained to the Practice on Mrs A's behalf on 9 August 2012 and the Practice responded on 20 November 2012. Mrs A was not satisfied with the response and asked Ms C to ask the Scottish Public Services Ombudsman (SPSO) to review the complaint. Ms C wrote to me on Mrs A's behalf on 24 January 2013.

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

(a) the Practice failed to provide appropriate care and treatment for Mr A's reported symptoms of headaches; dizziness; and disorientation; in April and May of 2012; and

(b) the Practice failed to provide an adequate response to the complaint about Mr A's treatment.

Investigation

7. My complaints reviewer examined all the documentation provided by the complainant and the Practice, including copies of Mr A's clinical records. My complaints reviewer also identified relevant legislation, reviewed policies and procedures and took independent advice from one of my GP advisers (the Adviser).

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

(a) The Practice failed to provide appropriate care and treatment for Mr A's reported symptoms of headaches; dizziness; and disorientation; in April and May of 2012

9. Ms C stated that Mr A had been experiencing his symptoms for a period of some six weeks before his death and despite numerous visits to his GP; A&E and calls to NHS 24 his symptoms were not investigated in a timely or appropriate manner. The actions of the A&E department and NHS 24 are not the subject of this investigation.

10. Ms C said that the GP attributed Mr A's symptoms to a build-up of ear wax and that even when his symptoms intensified such that he became housebound, the Practice told Mrs A that they were reluctant to attend patients outside the Practice and she was advised to call NHS 24. Ms C stated that this led Mrs A to believe that her husband had been 'abandoned' by the Practice. Ms C continued that no investigations, referrals or alternative treatments were suggested by the Practice.

11. The Practice response to the complaint dated 20 November 2012 stated that having reviewed Mr A's clinical records the Practice were satisfied that Mr A had received high quality care throughout his time with the Practice and that they could not have prevented his death.

12. The letter also stated that they were '… a small family practice and regularly triage patients successfully, priding [themselves] in high quality care.'. The letter continued that none of their patients were '… left at risk.'. The response stated that Mr A had used NHS 24 as a health care provider in the out-of-hours (OOH) period when the Practice was closed and stated that this

was a '… legitimate care pathway as directed by the government within Scotland.'.

13. In a further response from the Practice to SPSO dated 28 November 2013 the Practice stated that Mr A had been sent several invitations for health screening between March 2011 and May 2012 but he did not attend. The letter also stated that Mr A did not report the symptoms of headache, nausea and disorientation to the GP – only dizziness.

14. The Scottish Intercollegiate Guidelines Network (SIGN) produce advice and guidance on the investigation, diagnosis and treatment of many medical conditions for practitioners within the NHS. These are the standards that NHS staff in Scotland are expected to adhere to. SIGN 107 Diagnosis and Management of headache in adults was published in 2008 and provides guidance on the investigation of how to deal with patients presenting with headaches that are not resolving.

15. SIGN 107 includes advice to:

> 'Consider the diagnosis of secondary headache in patients presenting with new onset headache or headache that differs from their usual headache. Red flag features which should prompt referral for further investigation: New onset or change in headache in patients who are aged over 50; … non-focal neurological symptoms (e.g. cognitive disturbance [disorientation]); … patients with risk factors for cerebral venous sinus thrombosis [blood clots on the brain]; …'

16. The General Medical Council (GMC) is the regulatory body for doctors working within the NHS in the UK. The GMC also publishes guidance on good medical practice and the standards and ethics expected of doctors. The publication Good Medical Practice: Providing good clinical care includes:

> '…
>
> 2. Good clinical care must include:
>
> (a) adequately assessing the patient's conditions, taking account of the history … the patient's views, and where necessary examining the patient …
>
> 3. In providing care you must: …
>
> (f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment.

(g) make records at the same time as the events you are recording or as soon as possible afterwards …'

17. Mr A first called the Practice on 3 April 2012 and the notes state he had had a 'dizzy turn'. He was seen by the GP the following day and a build-up of ear wax was diagnosed. The record states:

'Wax in ear (Right) Smoker right ear wax-cerumol and t/r card, Cerumol Ear drops 11 ML PUT FIVE DROPS INTO THE AFFECTED EARS(S) TWICE A DAY FOR THREE DAYS'

Thereafter the chronology was:

07/04/2012	Mr A self-referred to the OOH service; he was also seen at the Victoria Infirmary that day. Mr A is recorded as reporting 'headache' 'dizziness' and 'nausea' for the previous six days
09/04/2012	Mr A self-referred to the OOH service – he is recorded as reporting 'persistent throbbing headache for 6/7 days' 'dizziness' and 'balance impaired'; Mr A was prescribed antibiotics
11/04/2012	Mr A called the Practice requesting a home visit. There is a note saying 'calling back' but it is not clear whether Mr A was calling the Practice back or the GP was to call Mr A. No details of the symptoms or problem were recorded; nor were there any details of any second call either to or from Mr A
11/04/2012	Mr A self-referred to the OOH service – reported as being 'dizzy and confused' and complaining of 'headache'. The notes also state 'saw GP on Monday [09/04/2012] at his surgery and stated on antibiotics'
12/04/2012	Mr A self-referred to the OOH service – the notes state that he was reporting 'headache worsening' since starting the antibiotics and 'worsening headache 9 days' 'states pain in head 9 – 10 on pain scale [out of 10] 'more dizzy' and 'ongoing severe frontal headache'. Mr A was admitted to Glasgow Royal Infirmary (GRI) in the early hours of 13/04/2012 and discharged later that day
19/04/2012	Mr A was seen by the GP – the notes record that he was 'feeling better' but made no reference to how his symptoms had improved

03/05/2012	Mr A called the Practice for a home visit due to 'low back pain'. The GP spoke to him by telephone and prescribed pain killers and muscle relaxants. Mr A collected the prescription later that day
08/05/2012	Mr A presented to the A&E department at GRI at 23:04 and was admitted. He died in hospital on 10 May 2012

18. My complaints reviewer established that the normal practice is for a report to be sent to a patient's GP after they had been seen by the OOH Service. This would be done ether electronically or by fax on the same day or the day following the patient being seen. There was evidence within the copy clinical records that this happened in Mr A's case.

19. The Adviser reviewed all the relevant documents and was of the view that it was not possible to tell if the decision to offer Mr A an appointment the day after he first reported his symptoms to the GP was reasonable or not. The Adviser stated that it is accepted practice within the NHS to triage (assess the urgency) requests for GP appointments and/or home visits. However, such decisions should be documented and this did not happen in this case. The Adviser was of the view that this was unsatisfactory.

20. Similarly, the Adviser was critical that when the appointment did take place on 4 April 2012, there are no notes of Mr A's symptoms – merely a diagnosis of wax in the right ear and the recording of a prescription for cerumol (a preparation to aid the removal of ear wax). The Adviser stated that there was no record of a proper medical history being taken or of relevant and appropriate examination.

21. The Adviser stated that it is not possible to tell from the GP's notes what symptoms Mr A was reporting at the appointment on 4 April 2012 but that three days later a record from the OOH service records symptoms of headache, nausea and dizziness for a period of six days.

22. The Adviser stated that if Mr A had reported his symptoms to the GP the guidance of SIGN 107 was clearly not followed as Mr A was within the age group; reporting symptoms, and in a risk group that should have prompted further investigation. The Adviser was of the view that an opportunity to intervene was missed at this first GP appointment on 4 April 2012.

23. The Adviser noted that at the next GP appointment on 19 April 2012 it is recorded that Mr A was 'feeling better' but that due to the lack of recording of symptoms at both appointments it is not clear how or why Mr A was 'feeling better'. The record of this appointment also states 'cont warf and asp' (an instruction to continue taking warfarin (a blood thinning drug) and aspirin (an anti-platelet medication that would make bleeding more prolonged)).

24. The Adviser stated that both drugs are used to treat atrial fibrillation (irregular heartbeat) and transient ischaemic attacks (TIA) which are temporary neurological events with features like a stroke but which reverse within 24 hours. However, the Adviser stated that it is unusual for both drugs to be used together and the combination exposes the patient to an increased risk of severe bleeding. Such a combination would only be used in rare cases where the benefits were thought to outweigh the increased risk. The Adviser stated that there was no evidence that this applied to Mr A's condition.

25. The Adviser did find evidence in the clinical notes that in 2009 the specialists that Mr A was seeing in the Outpatient Clinic at GRI had written to the Practice to say that Mr A should stop taking aspirin as soon as the warfarin had reached its therapeutic (effective) range. This did not happen.

26. The Adviser stated that a letter from the anticoagulation clinic in December 2011 (who were monitoring the effectiveness of the warfarin ie how 'thin' Mr A's blood was) showed that the warfarin was within the therapeutic range. The Adviser suggested that this may have led the GP to discount a TIA as the cause of Mr A's symptoms but that it was not possible to tell this due to the lack of detail in the clinical notes.

27. The Adviser stated that while there is a shared responsibility between a patient, a GP and an out-patient clinic when a patient is on long-term medication, the ultimate responsibility lies with the prescriber. In this case the GP was the prescriber and the Adviser was of the view that the GP should have been more proactive in monitoring Mr A's warfarin if, as they say, they were aware that he was not attending for health screening. If necessary the GP could have declined to prescribe further medication until Mr A attended for screening.

28. The Adviser stated that the continuation of the aspirin would have made any bleeding on the brain suffered by Mr A worse and while it was not possible

now to say whether this would have made any difference to the eventual outcome, the Adviser was of the view that it would have made Mr A's death more likely.

29. On the matter of home visits, the Adviser stated that it is accepted practice within the NHS to triage such requests. However, the clinical records do not contain sufficient information to demonstrate whether appropriate triage took place.

30. Visit requests were recorded on 3 and 19 April 2012 and there is also a note on 11 April 2012 stating 'calling back' but it is not clear whether Mr A was to call the Practice back or the GP was to call Mr A back. A further visit request was made on 3 May 2012 but again there is insufficient detail in the clinical notes to know whether this request was appropriately triaged.

31. The Adviser stated that the record of the telephone conversation between the GP and Mr A on 3 May 2012 was the most comprehensive of all the records. However, this conversation focused on the back pain that Mr A was reporting and it is not clear from the notes if Mr A's previous and on-going symptoms of headaches etc were discussed and/or taken into account in the GP's triage and subsequent prescribing for Mr A.

32. The Adviser stated that if, as Ms C has stated, the Practice declined, or even implied that they were reluctant, to visit a patient at home, this would be a breach of the GP contract and would be a serious concern.

(a) Conclusion

33. I am concerned that the standard of care and treatment provided to Mr A by the Practice fell below that expected within the NHS. The Adviser found evidence that medication that can have serious consequences in long-term use was not being sufficiently monitored. The anticoagulation clinic informed the GP in 2009 that once the warfarin reached the therapeutic range the additional aspirin should be stopped. The Adviser stated that the results sent to the GP in December 2011 by the anticoagulation clinic showed that the warfarin was within the therapeutic range at that time. However, the GP continued to prescribe aspirin and as can be seen from the record referred to in paragraph 23 advised Mr A to continue with this drug regime a few days before his death.

34. It is clear from the OOH records that Mr A was suffering from clear 'red flag' symptoms and was in two of the risk groups that should have prompted further investigations – he reported to the OOH service new onset headaches and was over 50 years old; and he was taking anticoagulation medication to prevent blood clots on the brain.

35. The GP records do not state that Mr A actually reported these symptoms to the GP. However, given there is evidence that he was reporting symptoms of persistent headaches and nausea to other clinicians he was seeing at the time, I consider it implausible that he was not suffering from these symptoms when he saw his GP. Given this, the GP either failed to record these symptoms or failed to take a full clinical history. In addition, the OOH service was reporting their encounters with Mr A to the GP as per the normal practice so the GP should have been aware of these symptoms. I am, therefore, critical of their actions in this regard. The advice I have received was that if Mr A was reporting his symptoms and this was not acted upon, there was a failure to follow the guidance of SIGN 107.

36. It is also of concern to me that the standard of the clinical records are such that it is not clear what history was taken; whether requests for home visits were adequately and appropriately triaged; what examinations or investigations were carried out; nor indeed if the GP had come to any specific diagnosis other than a build-up of ear wax. This is contrary to the guidance issued by the GMC and as referred to above.

37. I am very concerned at the failings identified above and the extremely serious impact these events had on Mr and Mrs A. Therefore, based on all the evidence and advice available to me I uphold this complaint.

(a) Recommendations

38.	I recommend that the Practice:	*Completion date*
(i)	conducts a Significant Event Analysis of these events and that any learning outcomes are discussed at the GP's annual appraisal;	29 April 2014
(ii)	conducts a review of a sample of clinical records to assess whether they meet the standards recommended by the GMC. Any learning outcomes to be addressed at the GP's annual	29 April 2014

	appraisal and/or with appropriate training; and	
(iii)	conducts a review of the Practice's monitoring protocol for patients taking warfarin to ensure that it is fit for purpose.	29 April 2014

(b) The Practice failed to provide an adequate response to the complaint about Mr A's treatment

39. Ms C complained to the Practice on behalf of Mrs A on 9 August 2012. No response was received and on 1 October 2012 Ms C chased this up with the Practice by way of a second letter. An acknowledgement letter was sent from the Practice dated 19 October 2012. A final response from the Practice, dated 20 November 2012 was then sent to Ms C. Mrs A was dissatisfied with the response and asked Ms C to ask the SPSO to review her complaints.

40. As part of the documentation provided during my investigation, the Practice provided a copy their Patient Information Leaflet setting out the Practice Complaints Procedure (the Procedure). The Procedure included:

> 'What shall we do: We shall acknowledge your complaint within 2 working days and aim to have looked into your complaint within 10 working days of the date when you raised it with us. …'

41. The Procedure also provided information as to what a complainant could do if they were not satisfied with the way their complaint had been handled. The Procedure referred to making a complaint to the Primary Care Trust and/or the Local Health Council. No mention was made of the option to bring a complaint to the SPSO.

42. The current NHS guidance on handling complaints is: Can I help you? Guidance for handling and learning from feedback, comments, concerns or complaints about NHS health care services (the Guidance). The Guidance was published in 2005 and revised and updated in April 2012.

43. The Guidance states that a complaint should be acknowledged within three working days and, where possible, responded to fully within 20 working days. Where it is not possible to meet the 20-day timescale, the Guidance states that complainants should be informed of the reason for the delay and given an indication of when the response can be expected.

44. It should also be noted that Primary Care Trusts and Local Health Councils no longer exist in Scotland. The Guidance states that the next stage in the NHS Complaints Process, if the complainant remains dissatisfied, is to ask the SPSO to review the complaint.

45. In the letter of response dated 20 November 2012, the Practice stated that they had reviewed Mr A's 'patient journey over the past decade' and felt that they had provided 'high quality care' which was evidenced through their 'accurate record keeping'. The letter did not address any of the specific issues raised by the complaint other than Mrs A's contention that the Practice were 'unwilling to attend [Mr A] outside of the practice'.

46. The letter stated that they were a small family practice and regularly triaged patients successfully and that none of their patients had to 'plead' for a home visit. The letter did conclude, contrary to the Procedure, with information about making a complaint to the SPSO.

47. My complaints reviewer asked the Adviser if the Practice's contention that they had provided Mr A with 'high quality care' evidenced by 'accurate record-keeping' was borne out by the clinical records. The Adviser stated that it was not. In paragraphs 18 to 31 I have set out some of the concerns the Adviser had, including with the standard of record-keeping.

48. In a further response to SPSO dated 28 November 2013, the Practice indicated that they did not receive Ms C's first letter of complaint and that they did not receive the second letter until 18 October 2012. The Practice stated that, therefore, in their view both the acknowledgement and response to the complaint were sent within the NHS timescales.

(b) Conclusion

49. It is clear that the Procedure was out of date at the time of the complaint as evidenced by the copy provided to my office during the investigation. I note, however, that the response letter to Ms C did contain information about my office.

50. My main concern is that even with the benefit of hindsight, in the knowledge of the outcome of Mr A's illness, the Practice do not appear to have gained any insight into the failings in their care and treatment of Mr A. In this respect the response to Ms C's complaint is wholly inadequate, including the

inappropriate reference to patients not having to 'plead' for home visits in the response letter to the complaint referred to in paragraph 45.

51. On the matter of timescales, there was a period of 49 working days before Ms C's complaint was acknowledged – and that only after Ms C had chased it up after some 34 working days. However, the Practice have indicated that they did not receive the original letter. Furthermore, they say that the follow-up letter was apparently not received until 18 October 2012

52. The Practice made no reference to this in their response to Ms C nor in the original response sent to SPSO and I would have expected them to do so. In addition, the original letter was correctly addressed and given that the follow-up letter was received, I can find no reasonable explanation as to why the letter of 9 August 2012 was not received by the Practice. I am, however, satisfied that Ms C's letter dated 1 October 2012 was acknowledged within one day of its apparent receipt. This meets the timescale set by the NHS guidance referred to above.

53. The final response was not sent until after a further 26 working days, which is outside the NHS timescales. No acknowledgement or explanation of, or apology for, this delay was provided in the response sent to Ms C on 20 November 2012. This is clearly inappropriate.

54. Based on all the evidence and advice available to me, I uphold this complaint.

(b) Recommendations

55.	I recommend that the Practice:	*Completion date*
(i)	conducts a review and revision of its complaints procedure to ensure it complies with current NHS complaints handling guidance; and	1 March 2014
(ii)	ensures that all staff have received appropriate training on handling complaints.	29 April 2014

56. Overall, I am very concerned about the failings I have identified during my investigation on both the clinical aspects of the complaint and the complaints handling process. I, therefore, make a general recommendation.

General Recommendation

57.	I recommend that the Practice:	*Completion date*
(i)	issues a written apology to Mrs A for all the failings identified in this report.	1 March 2014

58. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr A	the aggrieved's late husband
Ms C	the complainant
Mrs A	the aggrieved
the Practice	Mr A's GP Practice
the GP	the General Practitioner
NHS	National Health Service
A&E	Accident & Emergency department
SPSO	Scottish Public Services Ombudsman
the Adviser	the Ombudsman's GP adviser
OOH	Out-of-hours GP service
SIGN	Scottish Intercollegiate Guidance Network
GMC	General Medical Council
GRI	Glasgow Royal Infirmary
the Guidance	the NHS guidance on complaints handling
the Procedure	the Practice's Complaints Handling Procedure

Annex 2

Glossary of terms

anticoagulation	thinning of the blood
aspirin	an anti-platelet medication used to treat irregular heartbeat. It would also prolong bleeding
atrial fibrillation	irregular heartbeat
cerumol	a preparation to aid the removal of excess ear wax
ear syringing	a method of clearing excess ear wax
NHS 24	a national helpline providing medical advice
therapeutic	where a treatment has achieved the desired effect
Transient Ischaemic Attacks (TIA)	temporary neurological (affecting the brain) events with features like a stroke but which reverse within 24 hours
triage	to assess the urgency of a patient's condition
warfarin	blood thinning medication