SPSO decision report

Case: **202305141, A GP Practice in the Ayrshire and Arran NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their elderly parent (A). A had a known history of high blood pressure and white coat syndrome (when a patient's blood pressure rises in response to a stressful situation, such as, a doctor's appointment or visit to the hospital). A had been prescribed a combination of two diuretic medications (types of drug that cause the kidneys to make more urine) to treat this. During an appointment with a locum GP, it was noted that A's blood pressure was high so they prescribed a third diuretic medication. A became unwell and attended the practice a few days later. They were then admitted to hospital and diagnosed with hyponatraemia (a lower than normal level of sodium in the blood). C was concerned that the practice prescribed an unnecessary third diuretic that led to A's admission to hospital and that they did not perform checks on A's bloods before prescribing this medication.

The practice said that the medications were safe to be prescribed together with close blood monitoring. They explained that they have a system in place to monitor patients who are prescribed 'triple whammy' drugs (a combination of drugs of different types: non-steriodal inflammatories, diuretic, and ACE inhibitors). They also highlighted that they took bloods during the consultation before A's admission to hospital.

We took independent advice from a GP. We found that the decision to prescribe the third diuretic was unreasonable and unsafe. The consultation that took place before the admission to hospital was reasonable and bloods were gathered. However, the practice's procedure to monitor triple whammy drugs does not apply in this case as A was prescribed three diuretics and none of the other drug types. Therefore, A's case would not be picked up by this monitoring programme. We found that the practice should have carried out a Significant Adverse Event Review and did not acknowledge any failings in their complaint response. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for failing to carry out a reasonable consultation on their first visit, failing to ensure that the medication prescribed was necessary and safe, failing to acknowledge any mistakes and failing to carry out a Significant Adverse Event Review, when they should have done. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- When serious significant adverse events occur that could have caused or did result in harm, reviews should be carried out in line with the national guidance: Learning from adverse events through reporting and review – a national framework for Scotland.
- Clinicians should ensure that medication prescribed is required and is safe to be prescribed in combination with other medications before a new medication is issued. If required, blood monitoring should be carried

out before commencing a patient on new medication.
- Temporary staff such as locum GPs should be aware of relevant practice procedures and working practices so that they may act in line with them.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.