SPSO decision report

Case: **202305621, A Medical Practice in the Greater Glasgow & Clyde NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the treatment that their sibling (A) received from the practice. In responding to C, the practice accepted that a diagnosis had been missed. The practice also conducted a Significant Event Analysis (SEA) which resulted in learning around consideration of A's symptoms and consideration of blood testing.

C was dissatisfied and raised their complaints with SPSO. We found that while there were aspects of the treatment provided to A that were appropriate, a number of aspects were not, including taking a blood sample before all concerns had been explored, poor recording of symptoms and examination findings, and the undertaking of a telephone consultation. Additionally we found that the refusal to undertake further blood tests in the circumstances, lack of recording of reasons for, or makers of, decisions and the failure of the SEA to explore significant decisions were also aspects of treatment that were not appropriate. Therefore, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and their family for the failings identified. 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:

- Any Significant Event Analysis undertaken by the practice fully explores all relevant decisions.
- Doctors should undertake reasonable consultations with patients and fully consider what the appropriate blood tests would be for patients.
- The standard of record keeping at the practice meets General Medical Council "Good Medical Practice" standards.

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.