SPSO decision report

Case: **202310446, A Medical Practice in the Greater Glasgow and Clyde NHS Board area**
Sector: Health
Subject: Communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their adult child (A) received from the practice following their discharge from hospital.

C complained that A had struggled to get an appointment with a GP and that the practice failed to provide a reasonable standard of care in relation to pain management, A's mental health needs, and follow-up with the health board.

The practice said that they were short-staffed and had been working on an emergency-only basis at the time of the complaint. When A had enquired about seeing a GP, there had been no indication that an emergency appointment was required. A was advised to phone again the next day or to attend A&E.

In respectof A's pain, the practice said that the discharge medication had been managed in accordance with their policy and in recognition of the nation-wide shortage of the drugs prescribed. A was given an appointment to discuss pain when they reported that the medication was not working and a prescription for nerve pain was given.

In reference to A's mental health, the practice said that this was discussed during a phone appointment. However, A had breached the practice's zero tolerance policy during the conversation. A was issued with a warning letter after the incident but was not removed from the practice (as would be policy) in recognition of the mental health difficulties that they were experiencing.

This incident was reviewed as a part of a Significant Event Analysis Review (SEAR) and the practice identified learning to manage this type of occurrence in the future.

In respect of A's follow-up with the health board, the practice confirmed no post-discharge requests had been made and that it was the responsibility of the hospital to issue clinic appointments.

We took independent advice from a GP. We found that the practice had reasonably managed the discharge prescription for pain medication. While A had been appropriately directed to other services when no appointments were available, we found that the messaging could have been clearer and that reception staff had unreasonably provided advice about pain medication.

We considered A's appointment with the GP to discuss pain was unreasonable as there was a failure to document any assessment or information to support the nerve pain conclusion reached.

In terms of A's mental health, we considered that the phone consultation had been reasonably managed, as was the decision to issue a zero tolerance warning letter. The conclusions reached by the SEAR on this matter were also reasonable. We found that the practice's actions in relation to A's follow-up with the hospital was reasonable.

On balance, we considered that the care and treatment provided fell below a reasonable standard and we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this report. The apology should meet the standards set out inthe SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Advice relating to medical matters should be given by GPs or appropriately qualified members of staff.
- The practice should keep reasonable records of consultations undertaken with patients that clearly record any assessment undertaken and the basis for the diagnosis.

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.