Scottish Parliament Region: Lothian

Case 200502445: A General Practitioner, Lothian NHS Board

Summary of Investigation

Category

Health: General Practice; Clinical Treatment & Complaint Handling

Overview

The complainant (Miss C) raised concerns that her mother had received inadequate care and treatment at her GP practice (the Practice) between 20 January 2000 and 26 September 2000. Miss C was also concerned about the length of time taken by the Practice to respond to her complaint.

Subjects and Conclusions

The complaints which have been investigated are that:

(a) the care and treatment provided by the Practice was inadequate *(not upheld*); and

(b) the Practice failed to properly handle the complaint and did not properly follow the NHS complaints procedure *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Practice apologise in writing to Miss C for the lengthy delays in responding to her complaint.

The Practice have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 2 December 2005 the Ombudsman received a complaint from Miss C regarding the care and treatment of her late mother (Mrs A) by her local GP practice (the Practice) in the Lothian area and their subsequent handling of her complaint. The underlying events occurred between 20 January 2000 and 26 September 2000. Miss C raised a complaint on behalf of her mother with the Practice on 19 June 2001. The Practice provided a written response on 15 February 2002. Miss C was not happy with this response and following further correspondence she requested an Independent Review of her complaint on 18 March 2002. This request was refused by the Convener on 28 March 2002 and the complaint was referred back for further local resolution. Further correspondence resulted in a meeting being held between Miss C and a GP from the Practice (GP 2) on 27 September 2004. This meeting was not successful in resolving Miss C's concerns. Independent Review was removed from the NHS Complaint Process in April 2005, so Miss C then approached this office. Sadly Mrs A died in November 2005 shortly before Miss C approached this office.

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

(a) the care and treatment provided by the Practice was inadequate*;* and

(b) the Practice failed to properly handle the complaint and did not properly follow the NHS Complaints Procedure*.*

Investigation

3. Investigation of this complaint involved reviewing Mrs A's relevant hospital and GP records, obtaining the opinion of a medical adviser (referred to in this report as the adviser) and reading the documentation provided by Miss C. Miss C and the Practice have both had an opportunity to comment on the draft report. A summary of terms used is contained in Annex 1. A glossary of medical terms is contained in Annex 2. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Medical Background

4. Mrs A underwent heart valve surgery in England on 16 June 1998 and required warfarin treatment thereafter. In November 1998, Mrs A was admitted to

hospital in England with a low INR level. The discharge letter for this admission indicated that Mrs A should be admitted to hospital for intra venous anticoagulation therapy with heparin if her INR fell below 2.0.

5. Mrs A moved to Scotland in January 2000 and registered with the Practice. Her INR levels were checked at the Practice on a number of occasions. On 14 August 2000 the INR level was noted to be 1.5. Mrs A suffered a CVA on 26 September 2000.

(a) The care and treatment provided by the Practice was inadequate

6. Miss C complained that the Practice failed to properly note Mrs A's need for hospital admission if her INR level fell below 2 and failed to admit her as necessary when her INR level dropped to 1.5. Miss C further complained that the Practice had not adequately monitored Mrs A's INR levels.

7. A considerable amount of the discussion and correspondence in this complaint has involved differing views of the INR results and dates of results. These differences occur between the documentation provided by Miss C (being Mrs A's record) and the records in the Practice. All INR tests for the relevant time period were processed by the Haematology Department at the Royal Infirmary of Edinburgh (RIE). I have obtained a copy of all Mrs A's results for this time directly from the Haematology Department and it is these figures I have used in my investigation. I have also obtained copies of the Accident and Emergency Admission sheets from RIE for Mrs A during the relevant time period. I am grateful to staff at the RIE who have assisted me in obtaining these records. I note in my report where a difference in data has caused a difference in view.

8. The INR record card for Mrs A held by the Practice notes the target range to be between 3.0 and 4.5. It states the reason for the prescription of warfarin to be 'a mechanical prosthetic valve'. The discharge letter dated 16 November 1998 from the Cardiac Unit which performed the mitral valve replacement surgery stated that:

> 'She [Mrs A] needs to be on anticoagulation with warfarin for life. Her INR needs to be maintained at a therapeutic ratio of 3.0 – 3.5…If her INR ever drops below 2.0 she needs admitting for intravenous anticoagulation with heparin.'

9. The INR result for 20 January 2000 (the first test run by the Practice) was 2.4. The dosage of warfarin was altered and subsequent INR test results varied from levels of 5.6 on 3 March 2000 to 1.5 on 14 August 2000. At this point Miss C considered her mother should have been admitted to hospital in line with the guidance in the discharge letter.

10. During local resolution of this complaint the Practice stated that Mrs A advised them on 14 August 2000 that she was taking 7 mg of warfarin daily but had later called to alter this to 5 mg or 6 mg on alternating days and was advised to alter the dose to 6 mg daily. Miss C stated that in fact her mother had been taking 6 mg and 7 mg on an alternating basis but was told to alter her dose of warfarin to 6 mg each day on 14 August 2000. When her mother called the Practice to query this she was told that the doses were was wrong and the dose was changed to 6 mg one day and 7 mg the next. In either event Mrs A's INR was retested a week later and on 21 August 2000 the test result was 2.8. At this point her dosage was 6 mg per day.

11. Miss C stated that her mother's INR level had again dropped to 1.5 on 14 September 2000, but that her mother was sent home from the Practice and told to return in 4 weeks. Miss C stated that it was while on her way home from another visit to the Practice on 26 September 2000 that her mother's stroke occurred.

12. The Practice disputed these facts as their records indicated Mrs A's last INR result was obtained on 7 September 2000 (a result of 2.8) with a plan to return in 4 weeks. The Practice has no record of any test being conducted or result obtained on 14 September 2000, nor of any visit by Mrs A on 26 September 2000. The GP record for 14 September 2000 indicates that Mrs A phoned to say she had fallen from her bike that day and been seen at Accident and Emergency in RIE. Mrs A was given advice about pain relief and told to call back if there were problems. Mrs A attended the Practice on 19 and 21 September 2000 to have her wounds cleaned. The GP record for 26 September 2000 indicates that Mrs A phoned the surgery and requested a home visit. Mrs A was complaining of a left-sided headache, confusion and nausea. The GP visited and arranged for her to be admitted to the RIE for exclusion of a subdural haemorrhage resulting from her bike accident 12 days previously. It was subsequently diagnosed that Mrs A had

suffered a CVA.

13. The records from the Haematology Department indicate Mrs A's INR level on 7 September 2000 was 2.8. The next test result recorded was submitted from the admissions unit at the RIE on 26 September 2000 following Mrs A's admission for her CVA. The result was 2.2.

14. The Accident and Emergency record from the RIE for 14 September 2000 confirms Mrs A was admitted at 13:51 that day by ambulance following a fall from her bike. The record notes her mitral valve replacement but does not indicate that her INR level was tested that day. The record for 26 September 2000 states that Mrs A woke up that morning with a left-sided headache and found it difficult to speak. She arrived at the hospital at 13:47, by ambulance arranged by her GP.

15. The adviser noted that the discharge letter from the Cardiac Surgeon in November 1998 suggested that the INR level should be between 3.0 and 3.5. The adviser commented that this was a very narrow band which would be very difficult to achieve and maintain in real life. The adviser quoted the appropriate level for this situation as being that given by an authoritative text-book (in use in 1998) as 'between 3.0 and 4.5'. The adviser also noted that by 2000 the likely treatment would not be intra venous heparin but low molecular weight heparin. The adviser commented that while the letter stated Mrs A should be admitted if her INR level fell below 2.0 it does not ascribe a degree of urgency to this. The adviser noted that the Cardiac Unit in England had only admitted Mrs A to hospital when her INR level had continued to be below 2.0, not on the first occasion it dropped below 2.0.

16. The adviser told me that he considers the decision to review the INR level of 14 August 2000 (a reading of 1.5) after a week was a reasonable decision. The adviser noted that there were a number of discrepancies between Miss C's view of events leading up to and including 26 September 2000 and that of the Practice. The adviser is not able to comment on these other than to conclude that in so far as the Practice's view of events is correct he considers that they acted appropriately in monitoring and managing Mrs A's INR levels.

17. In response to my enquiries the Practice provided me with their current procedures for monitoring INR levels. These were introduced in February 2005

and include reference to the target range and specific reference to any guidance issued by the Cardiac Unit for mitral valve replacements. The revised policy reflects the 'Guideline for management of patients on warfarin' issued by the Lothian Clinical Guidelines Team in February 2005. The Practice stated that warfarin monitoring had always been run within the current established guidelines.

18. In response to the draft report Miss C told me she considers that the comments from both the Practice and the adviser are with the benefit of hindsight. Miss C noted that the information from the discharge letter of November 1998 was not noted on Mrs A's INR card and, therefore, while the GP's actions may be considered appropriate by the adviser, decisions were being taken without reference to all the appropriate facts.

(a) Conclusion

19. Where there is a dispute over the facts of the complaint I have sought independent corroboration of the facts in question. The information supplied to me by the RIE supports the view of the Practice. I, therefore, conclude that the dates, events and results contained in the GP record are correct. I accept Miss C's view that, while the actions of the Practice may have been correct, there is no evidence to suggest that they were aware of the contents of the discharge letter of November 1998 and thus consciously chose to override it. I note that GP 2 was of the view that the INR level advised by the discharge letter of November 1998 from the Cardiac Unit should have been noted on the record card (although it was contained in the GP record) and that such a provision is now contained within the revised procedure in use at the Practice. Based on the medical advice I have received, I conclude that the clinical actions of the Practice were reasonable. I do not uphold this aspect of the complaint.

20. I note, however, that the time and manner of resolving this complaint has greatly added to the complexity of it and has, understandably, undermined Miss C's confidence in the quality of the responses. I refer to this problem in complaint (b).

(b) The Practice failed to properly handle the complaint and did not properly follow the NHS Complaints Procedure

21. Miss C wrote to Lothian NHS Board (the Board) on 19 June 2001 to complain about her mother's treatment by the Practice. In accordance with the NHS Complaints Procedure (and with Miss C and Mrs A's consent) the Board forwarded the complaint to the Practice for a response on 6 July 2001. The Practice indicated to the Board that they had passed the complaint to one of their GPs (GP 1) to give a clinical response but that he was on holiday at the time. Mrs A's GP records were then with her new GP and the Board wrote to request these. The records were received by the Board in early October 2001 and forwarded to the Practice on 4 October 2001. The Practice indicated to the Board that a response had been compiled and forwarded to the Medical and Dental Defence Union (MDDUS) on 21 December 2001. The complaint had been passed to another GP (GP 2) who had not met Mrs A but who had been responsible for reviewing her INR test results. GP 2 responded to the Board on 15 February 2002. The response was forwarded by the Board on 22 February 2002. Miss C was not satisfied with the response and wrote to the Board to seek an Independent Review on 18 March 2002. This request was refused by the Convener who referred the matter back to the Practice for further local resolution, specifically to resolve the difference views of the facts between the two parties. Miss C did not consider this to be of any likely benefit as, whatever the facts, she was of the view that the Practice had failed to admit her mother to hospital on 14 August 2000 when her INR was 1.5.

22. At this time GP 2 was absent from work on long term sick leave and when Miss C queried the continued delay with the Board she was advised that the matter had been referred to the MDDUS again by the Practice. This situation persisted for many months and Miss C did not receive a further response from GP 2 until 16 December 2003, some 21 months after the referral back by the Independent Review Convener. In his response GP 2 indicated that the information contained in the discharge letter had not been noted on Mrs A's INR record card and that it should have been. GP 2 also made an offer of a conciliation meeting to look at Mrs A's management and the chronology of events in detail. Miss C remained unhappy and wrote to this effect on 24 February 2004 but accepted the offer of a meeting which was eventually arranged on 27 September 2004.

23. The meeting was not successful as Miss C felt her complaint was addressed to the Practice as a whole but that the matter was only being directed at GP 2 who had never met her mother. Miss C remained concerned that the Practice had not changed its processes to ensure that they were aware of any guidance regarding a particular patient's INR levels or action to be taken in the event of levels reaching non-therapeutic values. Miss C complained again to the Practice on 10 November 2004. GP 1 responded in February 2005 but Miss C found this response contradicted the earlier response of GP 2 and remained unconvinced that the Practice had reacted appropriately to the issues she had raised.

24. At this stage the Practice advised Miss C that nothing further could be achieved by an exchange of letters and she should approach the Board once again to seek an Independent Review of her complaint. This coincided with a change in the NHS Complaints Procedure throughout Scotland which abolished the Independent Review Stage of the Complaints Process. The Board accordingly referred Miss C to this office.

25. In response to my enquiries the Practice provided me with a copy of their current complaints leaflet. This leaflet states that the Practice aim to respond to a complaint within 10 working days (as specified by the NHS Complaints Procedure both current and at the time of these events). The Complaints Procedure in place at the Practice is adequate and meets the guidance issued by the Scottish Executive Health Department.

(b) Conclusion

26. The handling of this complaint was seriously hampered by the Practice's insistence that the matter would only be addressed by GP 2 who was on protracted sick leave. As GP 2 had not met with Mrs A on any occasion there would not appear to be any justifiable reason for this approach and I note that in the event GP 1 did later provide a response. The action suggested by the Independent Review Convener was intended to resolve some of the differences referred to in complaint (a) but in the event only served to add to the areas of dispute and considerably increase the time taken to conclude matters.

27. It is rarely of benefit for a complaint to be allowed to remain at local resolution for several months let alone the several years involved in this case. The revised

NHS Complaints Procedure encourages complaints to be moved along more swiftly, precisely to avoid a number of the complications that arose in this case. The Practice did not respond to this complaint appropriately or in a timely manner and I uphold this aspect of the complaint.

28. I note that both the Board and the MDDUS played a role in the handling of this complaint and I would ask both organisations to consider what might have been done by them to help ensure these matters were addressed more promptly and use such consideration to inform their future practice in dealing with complaints.

(b) Recommendation

29. In light of this conclusion the Ombudsman recommends that the Practice apologise to Miss C for the lengthy delays in responding to her complaint.

26 September 2006

Annex 1

Explanation of abbreviations used

Miss C	The complainant
Mrs A	The aggrieved (Miss C's mother)
GP 1	The GP at the Practice who first responded to the complaint
GP 2	The GP at the Practice who reviewed Mrs A's INR levels and who was the primary respondent to Miss A's complaint
The adviser	Medical adviser to the Ombudsman
The Practice	Mrs A's GP practice in Lothian
MDDUS	The Medical and Dental Defence Union of Scotland – an organisation representing the interests of the doctors and dentists who make up its membership
RIE	The Royal Infirmary of Edinburgh
The Board	Lothian NHS Board

Annex 2

Glossary of terms

CVA	Cerebrovascular accident - sudden loss of consciousness resulting when the rupture or occlusion of a blood vessel leads to oxygen lack in the brain
Heparin	A drug that helps prevent blood clots from forming
Intra venous anticoagulation therapy	Administration directly into a vein of a substance that prevents the clotting of blood
INR	International normalized ratio, a system for reporting the results of blood clotting tests
Mitral Valve	A valve of the heart which regulates blood flow between the chambers
Subdural Haemorrhage	A bleed between the brain and the skull
Warfarin	An anticoagulant drug