**Scottish Parliament Region: Lothian**

**Case 201004092: A Medical Practice, Lothian NHS Board**

**Summary of Investigation**

***Category***

Health: Family Health Service - General Practice; clinical treatment; diagnosis

***Overview***

The complainant (Mrs C) raised a number of concerns about the inadequate care and treatment her late mother (Mrs A) received from her GP Practice (the Practice).

***Specific complaints and conclusions***

The complaints which have been investigated are that the Practice:

(a) failed to refer Mrs A to Liberton Day Hospital (the Hospital) following their 17 August 2010 consultation (*not upheld*);

(b) failed to monitor the fluid on Mrs A's lungs (*upheld*); and

(c) failed to treat cellulitis adequately by only prescribing antibiotics, not arranging for attention by a district nurse and failing to follow up Mrs A's condition, given her history of cellulitis (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Practice | *Completion date* |
|---|---|
| (i) ensure that patients are appropriately monitored and the outcomes recorded during the course and administration of diuretics; | 14 March 2012 |
| (ii) conduct a Significant Event Analysis on this case; and | 28 March 2012 |
| (iii) provide Mrs C with a full apology for the failures identified within this report. | 14 March 2012 |

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

## Main Investigation Report

### Introduction

1. Mrs C said that her late mother, Mrs A, had initially consulted her GP (GP 1) and he did not follow up her case or refer her to Liberton Day Hospital (the Hospital). Mrs C stated it was left to another GP (GP 2) to do this. Mrs C also said that GP 1 was later called out to Mrs A's home to attend to the cellulitis on her leg, however, he only gave her antibiotics, did not arrange for a nurse to visit Mrs A about her leg and did not follow up her case during the following weeks, despite Mrs A having a history of cellulitis that had taken years to clear up.

2. Mrs C stated that if GP 1 had followed up Mrs A's case after she presented herself at the medical practice (the Practice) (and could hardly speak to him because of shortness of breath), Mrs A 'may well still be with us', although not for a great deal more time, but 'certainly her last few days on this earth would have been far less stressful for her'. Mrs A died, aged 89, on 14 October 2010 after she was transferred from the Hospital to Edinburgh Royal Infirmary, the day after she had attended the Hospital for an out-patient assessment and was subsequently admitted. Mrs C complained to the Practice on 17 October 2010 about the care and treatment they had provided to Mrs A and received a response from the Practice dated 11 January 2011. Mrs C was unhappy with the response and complained to this office on 31 January 2011.

3. The complaints from Mrs C which I have investigated are that the Practice:

(a) failed to refer Mrs A to the Hospital following their 17 August 2010 consultation;
(b) failed to monitor the fluid on Mrs A's lungs; and
(c) failed to treat cellulitis adequately by only prescribing antibiotics, not arranging for attention by a district nurse and failing to follow up Mrs A's condition, given her history of cellulitis.

### Investigation

4. In conducting the investigation my complaints reviewer obtained and examined Mrs A's GP records (the Records) and the complaint correspondence from the Practice. My complaints reviewer sought advice from one of my independent professional advisers, a General Practitioner (the Adviser).

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

**(a) The Practice failed to refer Mrs A to the Hospital following their 17 August 2010 consultation**

6. Mrs C stated that, in her view, Mrs A was disregarded from the first day she entered the Practice and if she had been sent to the Hospital to be monitored, her life would have been more tolerable towards the end.

7. The Adviser reviewed the case file and the Records which centred on the Practice management of Mrs A between August 2010 and October 2010. He noted that Mrs A presented to GP 1 on 17 August 2010 and had complained of breathlessness on exertion and that some investigations were subsequently arranged.

8. The Adviser noted from the Records the entry dated 17 August 2010 of SOBOE (shortness of breath on exertion), which had been noted as 'worse in recent weeks'. There was no note of the severity of the symptom nor were there details of how this had changed. In addition, there was a note that Mrs A had had cellulitis over the preceding two weeks, with swelling of the right leg (see complaint (c)). The medication was recorded. Blood tests were ordered and these were performed two days later. A chest x-ray was requested. In the examination part of the consultation it was noted that Mrs A was not short of breath and the pulse was 130 regular. There was no note of blood pressure, weight or oxygen saturation. The Adviser noted a systolic murmur was present.

9. The Adviser stated that blood tests initially completed were appropriate and carried out in a timely manner.

10. The Adviser stated that he did not believe that an immediate referral to the Hospital on 17 August 2010 was warranted.

11. I have noted that in GP 1's letter, dated 7 December 2010 to Mrs C, he stated that when he visited Mrs A at her home on 17 September 2010, he offered to admit her to a hospital on that day; however, she declined this as she preferred to wait for the Hospital referral appointment. The Adviser stated GP 3 had recorded on 12 October 2010 that Mrs A had been unwilling to enter a

hospital. The Adviser confirmed that patient consent would be required for these hospital admissions.

*(a) Conclusion*

12. I have taken account of the Adviser's considerations and, according to the Records I have seen, I am satisfied the symptoms Mrs A presented to the Practice on 17 August 2010 did not justify a referral to the Hospital. For this reason, I do not uphold this complaint.

**(b) The Practice failed to monitor the fluid on Mrs A's lungs**

13. Mrs C stated that Mrs A had been prescribed diuretic tablets and was not monitored to see how much water was draining from her lungs or to see if these tablets were working. Mrs C also stated that GP 1 did not seem to understand the distress these water tablets caused Mrs A, as she already had bladder problems and these made it worse. Furthermore, Mrs A had mobility problems due to rheumatoid arthritis and had a previous hip replacement, so getting to the toilet on time was difficult.

14. The Adviser stated that the Records reflect no biochemical monitoring after 19 August 2010 and no radiological monitoring after 17 August 2010.

15. The Adviser noted that a further review of Mrs A was undertaken by GP 2 on 31 August 2010 and a referral to the Hospital was made in a timely manner. The Adviser stated that diuretic therapy was also increased for one week by GP 2 at this time. However, while he stated it was reasonable to increase the diuretic, he noted the lack of follow-up monitoring.

16. The Adviser added that it was not clear from the Records whether this consultation was at home or in the Practice. The presenting complaint was entered as 'significantly SOB [short of breath] on exertion' and the Adviser noted that Mrs A's history suggested she was unable to sleep lying flat (known as orthopnoea). The examination notes record bilateral ankle oedema, and the term overweight was entered, however. the weight was not specified, nor was there any change in weight noted since August. Adviser 1 stated no note was made of pulse, blood pressure or oxygen saturation. The systolic murmur was noted and lung auscultation revealed 'reduced air entry, fine creps (crepitations)'. According to the Adviser, these symptoms and signs are consistent with heart failure and pulmonary oedema and he noted the diuretic furosemide was increased for one week. Again no follow-up plan was noted

and no further blood tests were ordered. A referral was agreed for the Hospital and this was actioned on 2 September 2010.

17. The Adviser stated that Mrs A was seen by GP 1 on 17 September 2010 – again it was not noted if the consultation was at home or at the Practice and the diuretic was again increased. It was noted that Mrs A's right leg was now leaking fluid (see paragraph 11).

18. The Adviser concluded that, in the absence of weight measurements and serial examination findings, the monitoring of Mrs A was deficient.

*(b) Conclusion*

19. Mrs C was concerned that the effect on Mrs A's lungs of the prescribed diuretic tablets had not been adequately checked. I have taken account of the Adviser's considerations as detailed above. In the absence of recorded evidence that adequate monitoring of the effects of the diuretic tablets and adequate monitoring Mrs A had taken place, I uphold this complaint.

*(b) Recommendation*

| 20. I recommend that the Practice: | *Completion date* |
|---|---|
| (i) ensure that patients are appropriately monitored and the outcomes recorded during the course and administration of diuretics. | 14 March 2012 |

**(c) The Practice failed to treat cellulitis adequately by only prescribing antibiotics, not arranging for attention by a district nurse and failing to follow up Mrs A's condition, given her history of cellulitis**

21. Mrs C stated that when GP 1 was later called out to tend to the cellulitis on Mrs A's leg, he only gave her antibiotics. He also did not get a district nurse to visit her to look at her leg and did not follow up her case in the following weeks.

22. In GP 1's response to Mrs C's complaint he stated that, during his home visit on 17 September 2010, Mrs A had developed another episode of cellulitis of her right leg and he had prescribed an antibiotic for this. He also stated that he would normally only ask the district nurse to visit if a patient had developed a leg ulcer as well as cellulitis, as this would require dressings.

23. The Adviser stated that at the consultation of 17 September 2010 it was noted in the Records that Mrs A's legs were oedematous and leaking and that no action was specified for this other than a prescription for antibiotics.

24. Given this, the Adviser stated that, in his view, the Practice should have considered district nursing care for Mrs A's cellulitis and oedema.

25. The Adviser concluded that, overall, the Practice management of Mrs A was deficient in a number of areas. For example, there was no medication review and the notes made at consultations on 17 and 31 August 2010, 17 September 2010 and 12 October 2010 lacked the recording of key examination findings. No measure of blood pressure was recorded in any of these consultations. The Adviser stated that the severity of Mrs A's symptoms was poorly recorded.

26. Also, following Mrs A's consultation on 17 August 2010 there was no record of a plan to review Mrs A or was there advice on future action to be taken if her symptoms did not resolve. In this regard the Adviser stated that the lack of a follow-up plan constituted a deficiency in Mrs A's care and that an early review following the investigation should have occurred.

*(c) Conclusion*

27. The Adviser stated that the Practice failed to provide Mrs A with the attention of a district nurse or to follow up her condition appropriately, given her history of cellulitis. Given the evidence outlined above and having taken all relevant factors into account, I uphold this complaint.

*(c) Recommendations*

| 28. I recommend that the Practice: | *Completion date* |
|---|---|
| (i) conduct a Significant Event Analysis on this case; and | 28 March 2012 |
| (ii) provide Mrs C with a full apology for the failures identified within this report. | 14 March 2012 |

29. The Practice have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Practice notify him when the recommendations have been implemented.

**Annex 1**

## Explanation of abbreviations used

| | |
|---|---|
| Mrs C | The complainant |
| Mrs A | The late mother of Mrs C |
| GP 1 | A doctor at the Practice |
| The Hospital | Liberton Day Hospital, the hospital Mrs A was initially referred to |
| GP 2 | A doctor at the Practice |
| The Practice | The medical practice which Mrs A attended |
| The Records | Mrs A's GP records |
| The Adviser | The professional medical adviser to the Ombudsman |
| GP 3 | A doctor at the Practice |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Biochemical monitoring | Checking levels of chemicals related to the effects of diuretics, for example, kidney function, sodium and potassium levels |
| Diuretic | Drug which promotes increased urinary output |
| Cellulitis | Inflammation of connective tissue |
| Crepitation | A dry sound |
| Lung auscultation | Breath sounds |
| Oedema | Presence of fluid in tissues which can be seen in limbs and in lungs |
| Orthopnoela | Shortness of breath when lying flat |
| Radiological monitoring | Checking the serial x-ray examinations, for example, chest, so that resolutions of previously detected abnormalities can be detected |
| Rheumatoid arthritis | A chronic systemic inflammatory disorder which principally attacks joints |
| Systolic murmur | A heart murmur heard during contraction of the heart |