Investigation of a complaint against a GP Surgery

Report Reference: 202001459

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS

Page

Case Reference: 202001459

SUMMARY

I received a complaint about the actions of the Practice in relation to the care and treatment General Practitioners (GPs) provided to the complainants' late wife and mother (the patient).

The investigation examined the details of the complaint, the GPs' response and relevant local and national guidance. I also obtained independent professional advice from a General Practitioner.

The investigation found there were failures in the care and treatment the Practice provided to the patient in relation to the following matters:

- the follow up with the patient after her discharge from the Royal Victoria Hospital in December 2020;
- conducting at least one face to face consultation following telephone consultations on 8 and 9 April 2021;
- making alternative arrangements to have the patient's bone profile repeated as Craigavon Area Hospital requested on her discharge; and
- the provision of Enoxaparin prescriptions to the patient on 7 and 15 July 2021.

The investigation did not find a failure in the care and treatment in relation to the following matters:

- the Practice's follow-up actions after the patient's June 2021 discharge;
- the monitoring of the patient's potassium levels;
- the notification of blood results taken on 5 May 2021;
- the consultations/contact with the Practice on 10 and 11 May 2021; and
- the Practice's actions following the patient's consultation on 21 May 2021.

I am satisfied the failures in care and treatment identified caused the patient to sustain the injustice of frustration and upset. She also lost the opportunity for a

referral to secondary care, and further investigation into her symptoms at that time, having potential raised calcium levels identified and symptoms managed sooner, and to continue with prescribed medication. I also consider the complainants experienced the injustice of frustration and upset. However, I do not consider that the failing of not following up with the patient after her discharge in December 2020 caused the patient to experience an injustice.

I recommended that the Practice provides the complainants with a written apology because of the failures in care and treatment I identified. I also made further recommendations for the Practice for service improvement and to prevent future recurrence of the failings identified.

THE COMPLAINT

1. I received a complaint about the actions of the Practice in relation to the care and treatment General Practitioners (GPs) provided to the complainants' late wife and mother (the patient) from 9 December 2020 to 22 July 2021.

Background

2. In December 2020 the patient underwent a right upper lobectomy[1] VATS[2] procedure for squamous cell carcinoma[3] of her lung in the Royal Victoria Hospital (RVH). The RVH discharged the patient to the care of the Practice on 9 December 2020. In the months following her discharge, the patient had telephone and face-to face consultations with GPs due to new symptoms. The patient attended Craigavon Area Hospital (CAH) Emergency Department (ED) on 29 March 2021 at the request of Dr W. She also attended CAH ED on 10 May 2021 and 2 June 2021 because of symptoms she was experiencing. On 4 June 2021, the patient attended CAH for an ultrasound scan. Following this scan clinicians admitted her and subsequently diagnosed the patient with recurrence of her primary lung cancer. On 22 July 2021, the patient left the Practice and registered with another GP surgery. The patient sadly passed away on 15 August 2021.

Issue of complaint

3. The issue of complaint accepted for investigation was:

Issue 1: Whether the Practice provided appropriate care and treatment to the patient between 9 December 2020 and 22 July 2021.

[1] Surgical removal of a lobe of an organ such as the thyroid gland, lung, liver, or brain.

[2] Video-assisted thoracic surgery.

[3] Cancer that begins in squamous cells. Squamous cells are thin, flat cells that look like fish scales, and are found in the tissue that forms the surface of the skin, the lining of the hollow organs of the body, and the lining of the respiratory and digestive tracts.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues raised by the complainants. This documentation included information relating to the Practice's handling of the complaint.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - General Practitioner, MBBS BSc FRCGP ILM5 MSc (med ed), with 12 years' experience working as a GP and qualified as a doctor for 17 years.

6. The information and advice which informed my findings and conclusions are included within the body of this report. The IPA provided me with 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[4]:

    - The Principles of Good Administration

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

[4] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council (GMC) Good Medical Practice, as updated April 2014 and April 2019 (the GMC Guidance);
- National Health Service England (NHS England), Standards for the Communication of Patient Diagnostic Test Results on Discharge, March 2016[5] (NHS results on discharge guidance); and
- Guidelines and Audit Implementation Network (GAIN), Guidelines for the Treatment of Hyperkalaemia[6] in Adults, August 2014 (GAIN guidelines).

9. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied I took into account everything that was relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainants and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the Practice provided appropriate care and treatment to the patient between 9 December 2020 and 22 July 2021.

The investigation of this issue considered a number of the complainants' concerns which have been addressed separately.

Detail of Complaint

Follow-up actions of the Practice following notification of patient discharges on 9 December 2020 and 11 June 2021

[5] Although produced by NHS England this guidance has been endorsed by the Royal College of Physicians.
[6] An increase in the level of potassium in the blood.

11. The complainants raised concerns that the patient did not receive any communication from the Practice following her discharge from the RVH on 9 December 2020 following her cancer surgery. They also raised concerns she did not receive any communication from the Practice, following her discharge from CAH on 11 June 2021 when diagnosed with a recurrence of her lung cancer. The complainants said the Practice did not initiate any house calls, district nurses or palliative care and the family were left on their own with no guidance or support.

Evidence Considered

Policies/Guidance

12. I considered the following policies/guidance:
    - the GMC Guidance; and
    - the NHS results on discharge guidance.

The Practice's Response to investigation enquiries

13. The Practice explained that *'...in "normal" times the GPs would try and make contact with patients who had recently been diagnosed with cancer. Unfortunately at that time we were in the height of the Covid pandemic and the doctors were not only working in the Surgery but also the doing shifts in the Covid Centres and carrying out Covid vaccinations…We can only apologise again for a GP not making contact with [the patient]. [Dr V] had received a further letter from [the patient's] surgeon in January requesting that she be referred for a chest x-ray 6 weeks post-surgery. From the clinical notes [Dr V] had noted on the x-ray reporting system that her Respiratory Consultant, [Dr Z] had already requested this and it was carried out on 15th March 2021...The chest x-ray concluded that no significant lung lesion was seen and the report had been sent to…[Dr Z] and the Surgery was not informed of the result.'*

14. The Practice also provided information on changes to its service. *'…We wanted to improve communication by making sure new cancer patients had a designated GP that they could contact, which is more important in the present climate with Practices running a telephone triage system to contact patients.*

Prior to us being able to re-establish our Palliative Care meetings we had continued to have close contact with our District Nursing and Palliative Care colleagues to discuss patients. They also have a designated mobile number that they can contact the Surgery through when they need to speak to a GP urgently about a patient. We have also increased our Palliative Care Meetings from quarterly to monthly. The purpose of the service improvements is to reinforce the areas where there has been a change in usual procedures and highlight this to all members of the Practice team and is not a case that these services were never happening.'

Relevant Independent Professional Advice

15. The IPA advised '*The pandemic has highlighted long-standing issues of continuity of care, however it is considered good practice to follow up patients who have been recently discharged from hospital, especially a patient having undergone such an invasive procedure and with lung cancer…'*

16. In relation to the patient's December 2020 discharge the IPA advised *'…The hospital requested the GP to arrange an urgent CXR [chest x ray] within six weeks post discharge and ASAP…Whilst GP and primary care colleagues were re-deployed and were asked to support Covid vaccination hubs, I would expect the practice to respond and act upon a request to carry out an urgent CXR 6 weeks post discharge and arrange this and contact the patient to advise them that this had been done…The outpatient consultant also reminded the practice of the same when the patient went to the OPA [out patient appointment] on 20.1.2021…Even if the discharge letter was not completely clear as to who should request or orgnaise [sic] the CXR, there should have been some sort of follow-up or contact with the patient by the GP.'* The IPA further advised that '*There was a delay for the patient to have her repeat urgent CXR…' however the result was found to have 'no significant abnormality seen' in 21/3/2021.'*

17. In relation to what actions would have been considered reasonable following the patient's discharge in June 2021 the IPA advised '*It would be reasonable for the GP practice to contact the patient, arrange a follow up consultation and have a structured cancer care review to improve personalised care for people*

with cancer in primary care. This ensures that patients diagnosed with cancer have a good quality, robust and personalised review to identify and address their needs and for this review to consider emotional, practical and financial concerns they may have. This facilitates the achievement of personalised care for people living with cancer.'

18. She further advised that post discharge in June 2021 '…*the patient's daughter was seen in the surgery…and a medication review and reconciliation was carried out, advising her of the medication changes and how to take medication….'* The diabetic nurse was asked to follow-up with the patient and an appointment arranged for the patient to have further follow up blood testing in two weeks' time. The IPA advised '*…these actions were appropriate, however I would have expected the practice to carry out a meds reconciliation and to inform the patient of medication changes post discharge routinely…As the patient has not had a structured cancer care review carried out, it would have been appropriate to carry this out in order to have a more holistic view of the patients' ongoing needs, and whether a referral to the district nurse team or palliative care team would have been required. This is not made obvious from the medical records or associated discharge records.'* The IPA also advised that there should be '…*a regular named GP for the patient to be a point of contact for any concerns or queries and to co-ordinate care.'*

19. The IPA also identified learning for the Practice in relation to reviewing *'…the way it follows up patients who are newly diagnosed with cancer, or have a recurrence of cancer and have regular cancer care reviews.'*

Complainants' response to draft report

20. The complainants said they understood the full enormity of the Covid 19 pandemic and *'…the pressures that the Practices would have been under…'* However, they strongly believed that this should not excuse the fact that the patient did not get the minimum standard of care required from Practice staff including receptionists, nurses and doctors, especially when she was an end of life cancer patient.

Practice's response to draft report

21. The Practice disagreed with the IPA's comments that '*There was no follow up on the part of the Practice following the patient's discharge in December 2020…'* and explained that it had *'…a system within the GP surgery where every hospital discharge letter is reviewed by a GP and by a clinical pharmacist who carries out a medicines reconciliation for that patient. In this case the patient was discharged on 9/12/20 and the next day 10/12/20 the practice pharmacist…completed a medicines reconciliation for this patient…'* The Practice also reiterated its comments that normal practice, prior to Covid 19 would have been to *'…contact a patient either by phone or arranging an appointment in the surgery following a recent cancer diagnosis…'* and again emphasised its reasoning for not doing in this instance.

22. The Practice also commented on the IPA's advice in relation to the arranging of the patient's chest x-ray post discharge from RVH. It highlighted that in the discharge letter, the chest x ray documentation and plan for follow up in 6 weeks time was documented in the section of the investigations and results, and no action was requested of the GP. It further commented that *'…the discharge letter indicated to us that the hospital was organising their own chest x ray as follow up… There was no reason for us to believe that had not been requested until we received a letter on 1st Feb 2021 indicating that the patient was reviewed by Royal Victoria Hospital Cardiothoracic unit…and mentioned that the patient had not yet had the x ray…'* However, Dr V *'…acted immediately…'* and noted on the x-ray reporting system that the patient's Respiratory Consultant, [Dr Z] had already requested the chest x-ray and no further action was needed to avoid duplication of this request. The Practice also said that the correspondence from the Royal Victoria Hospital was an acknowledgment to RVH's own discrepancy in not requesting the chest x ray and disagreed with the IPA's advice that *'…the outpatient consultant also reminded the practice of same when the patient went to the OPA on 20/1/2021…'* It explained this letter was *'…not a 'reminder' but instead a first request and the hospital team admitting that they had not done it and request us do this for them at that point in time…'* The Practice reassured this office

that it would *'…act on requests from secondary to carry out a task – either by agreeing to do the task or letting secondary care know that we are not able to do the task.'* The Practice also noted that any delay for the patient to have a repeat urgent chest x-ray was no fault of the Practice.

23. In relation to the patient's June 2021 discharge the Practice disagreed with the IPA's comments that she *'…would have expected the practice to carry out a meds reconciliation and to inform the patient of medication changes post discharge routinely…'* and arrange a *'…follow up appointment to manage the patient's deranged urea and electrolytes…'* It explained that *'…On the 15th June 2021 the practice pharmacist…completed a detailed medicines reconciliation…'* regarding the patient's discharge letter which the Practice received on 14 June 2021 *'…Later that afternoon, the GP practice based pharmacist met with the patient's daughter in person in the GP surgery to review medications following discharge...*' It also explained that the practice pharmacist also initiated a further clinical on 16 June 2021 after the patient made a medication request. The Practice further explained that on review of the patient's discharge letter it was requested to repeat a bone profile and not to test urea and electrolytes.

Analysis and Findings

December 2020 discharge.

24. I considered the Practice records including the discharge letter from RVH on 9 December 2020 and the Consultant, specialist nurse and holistic needs reviews.

25. I note and accept the Practice's comments that the clinical pharmacist carried out a medicines' reconciliation for the patient on the day following her discharge on 10 December 2020. I also acknowledge that prior to Covid 19 it would have been normal practice to contact a patient following a recent cancer diagnosis and note the Practice's reasoning for this not occurring when the patient was discharged. I also considered and accept its comments about arrangements for the patient's chest x-ray and the follow-up letter regarding the six weeks

post surgery chest x-ray and that the x-ray reporting system documented *'…[Dr Z] had already requested this and it was carried out on 15th March 2021...*'

26. I acknowledge that the RVH discharge letter of 9 December 2020 requested that a chest x-ray be carried out within six weeks and that it records there is no action required by the GP. Therefore, I understand and accept why the Practice did not action a chest x-ray and agree with the Practice that the delay in arranging the patient's chest x-ray was not within its control. However, I accept the IPA's advice '…*there should have been some sort of follow-up or contact with the patient by the GP…'* and *'…it is considered good practice to follow up patients who have been recently discharged from hospital, especially a patient having undergone such an invasive procedure and with lung cancer…'*

27. I acknowledge the pressures GPs were under at the time of the patient's discharge in December 2020 because of Covid-19. Nonetheless I consider it would have been appropriate for a GP to have followed-up with the patient to address any concerns the patient may have had. I am satisfied that the Practice's failure to contact the patient following her discharge on 7 December 2020 is a failure in the patient's care and treatment. Therefore, I uphold this element of complaint.

28. I note the IPA's advice that when the chest x-ray was completed there was *'…no significant abnormality seen…'* As a result of the chest x-ray results and given that the patient had other reviews completed in the RVH I do not consider the patient sustained an injustice due to this failure.

June 2021 discharge.

29. I acknowledge and accept the Practice comments that the practice pharmacist completed a medicine reconciliation on the morning of 15 June 2021 following receipt of the patient's discharge letter on 14 and that it was requested to repeat a bone profile for the patient and not test her urea and electrolytes as. I also considered the Practice records and noted a discussion with the patient's daughter on 15 June 2021, with the practice pharmacist, about the patient's medication and, a telephone consultation between the patient and Dr Y about

the patient's recent admission to CAH. I note this telephone consultation took place on 21 June 2021 after the patient was discharged on 11 June 2021.

30. I acknowledge that Dr Y contacted the patient on 21 June 2021; however I also note the IPA's advice that '…*As the patient has not had a structured cancer care review carried out, it would have been appropriate to carry this out in order to have a more holistic view of the patients' ongoing needs, and whether a referral to the district nurse team or palliative care team would have been required. This is not made obvious from the medical records or associated discharge records.'*

31. Given the available evidence I am satisfied GPs did follow up with the patient after her discharge from CAH in June 2021. However, I am concerned that this took 11 days. I would therefore ask the Practice to reflect on the comments of the IPA as set out at paragraph 20 above.

32. I wish to acknowledge and welcome the service improvements, for example Palliative care meetings now held monthly and patients with a cancer diagnosis having a designated GP contact, identified by the Practice because of the issues raised by the complainants.

Detail of Complaint

Monitoring of Potassium levels

33. The complainants raised concerns that the Practice did not appropriately monitor the patient's potassium levels.

Evidence Considered

Policies/Guidance

34. I considered the following policies/guidance:

- Gain guidelines.

The Practice's Response to investigation enquiries

35. The Practice stated *'…The patient was sent a letter dated 3rd March 2021 advising the patient of an appointment with the nurse for blood tests prior to*

diabetic clinic telephone review. On the 29th March 2021 having reviewed the blood tests…' the patient was *'…contacted…and advised her to attend the A+E department as she had hyperkalaemia.'* The patient was *'…advised by the Doctor in A+E to hold her Ace Inhibitor…'* Dr W also advised the patient *'…she should also hold her Metformin….'* Following a further blood test, for her urea and electrolytes, on 1 April 2021 Dr W *'…noted that it was normal…and advised the patient that she could restart her Metformin but to continue to hold her Ace Inhibitor….'*

36. In response to urea and electrolytes result on 10 October 2019 being 0.1 outside the range given on the result document and that no further treatment was given the Practice explained that *'…the GPs currently use the "Gain Guidelines for Treatment of Hyperkalaemia in Adults"… which states that mild hyperkalaemia is when the potassium is >5.5-5.9. [The patient's] was 5.4 hence the comment no treatment required.'*

Relevant Independent Professional Advice

37. The IPA advised that blood test monitoring potassium on *'…9/6/2017 showed a potassium level in the normal range. The potassium was also found to be normal in 7/6/2018 and 14/6/2019. However in 10/10/2019 the potassium was 5.4…Using the Gain guidelines, there would not have been an indication to repeat the potassium blood test in 10/10/2019 when the potassium was 5.4… I agree with the practice response…On 25/3/2021, the potassium was found to be 5.6 and the patient was referred to A&E for further investigations… It would have been appropriate to carry out monitoring of routine potassium levels once a year…'*

38. The IPA also advised that that from 10 October 2019 the Practice did not appear to have monitored the patient's potassium again until 25 March 2021 but *'…The patient was being followed up by the hospital and was admitted for surgery, and it is likely that her blood tests for monitoring would have been carried out, including a urea and electrolyte blood test with monitoring of potassium…however it was not reviewed or mentioned by the hospital.'*

Analysis and Findings

39. I note the dates the Practice carried out blood tests, the subsequent results, and actions of the GPs. I note the IPA's advice that it would be appropriate to carry out potassium monitoring once a year and the GAIN guidelines that set out the levels of potassium at which action should be taken. From the records I note that in 2020 the RVH monitored the patient's potassium levels and the Practice informed the patient, of a high potassium result taken on 24 September 2020. The Practice advised the patient to attend the ED.

40. Given the available evidence I am satisfied that the Practice monitored the patient's potassium levels appropriately and actioned any abnormal results as set out in the GAIN guidelines. Therefore, I do not uphold this element of complaint although I hope this provides some reassurance to the complainants.

Detail of Complaint

Consultations on 8 and 9 April 2021

41. Following telephone consultations on 8 and 9 April 2021, the complainants said the Practice failed to see to the patient. They believed that the Practice should have followed up telephone assessments with the patient with a face to face appointment, given the symptoms she was experiencing and her recent history of surgery.

Evidence Considered

Policies/Guidance

42. I considered the following policies/guidance:

- the GMC Guidance

The Practice's Response to investigation enquiries

43. The Practice explained that *'[Dr X] had a telephone consultation with [the patient] on the 8th April 2021. During this consultation [the patient] informed Dr X that she had recently attended A+E with hyperkalaemia…and that the A+E doctor had told her to stop her Ramipril medication. She believed that since stopping this blood pressure medication she had been feeling fatigued and that she had developed a dull headache. She denied any fever, she had no*

associated nausea or vomiting with this headache and she described the headache as a dull headache of gradual onset. She described occasional blurring of her vision with the headache but she denied any slurred speech, weakness or loss of sensation… Dr X's consultation note [the patient] did not describe any cough, chest pain or respiratory symptoms…Following this consultation [Dr X] booked an appointment with the treatment room nurse to have her blood pressure checked that day. The result was minimally raised…therefore [Dr X] booked her for a follow-up telephone consultation with [Dr W] the next day for review of her blood pressure medication and follow-up of these symptoms… [Dr X] felt this would ensure better continuity of care for [the patient] rather than offering an appointment with herself that day, as she had not been involved with her recent care at that time…This consultation with [Dr W] took place by telephone on 9th April…'

44. In response to the concern that Dr X had only considered Covid-19 as a possible cause for the patient's symptoms the Practice explained *'… When triaging any patient on the telephone a GP is currently required to assess the likelihood of Covid-19 infection before bringing the patient to the GP surgery…[The patient] informed [Dr X] that she was tested for covid-19 when at A+E on 29th March 21 and this test was negative, as she had no respiratory symptoms [Dr X] felt comfortable with offering her an appointment that day with the nurse without having to wait on a swab test for Covid-19…'* The Practice stated Dr X *'…did verbally advise [the patient] to consider getting a Covid 19 swab to exclude Covid 19 as a cause for these symptoms. However, after her telephone consultation with [the patient] her opinion was that these new symptoms had started after her blood pressure medication had been discontinued and that they were most likely blood pressure related. [Dr X] was sorry if she had given the impression that she was focused on Covid 19 and for any resultant miscommunication, as it was not her intention to give this impression to [the patient].'*

Relevant Independent Professional Advice

45. In relation to the consultation on 8 April 2021, the IPA advised *'A history was taken and most red flags symptoms of headache were considered and*

excluded. The patient attended the practice to have her blood pressure checked. Given that the patient recently had been investigated and treated for raised potassium, it would have been advisable to examine her, carry out a fundoscopy (a procedure where we look at the back of the eyes and blood vessels in the eyes) examination, a neurological examination and repeat her blood tests including potassium, as this can cause a migraine and headache symptoms…' She advised the patient had *'…her blood pressure checked…'* and *'…was added onto [Dr W's] acute list for the 9th April 2021…I would recommend that [the patient] have her symptoms examined by a clinical member of the team…'*

46. In relation to the consultation on 9 April 2021 the IPA advised that Dr W *'…carried out a telephone consultation with the patient, and advised to have her blood pressure checked in four weeks time with a view to restarting her medication.'* She further advised on whether the patient should have had any ongoing referrals following this consultation *'Whilst Covid precautions were put in place, carrying a face to face consultation and examination may always put things in a different light…It is difficult as there is no documentation of the patient having suffered a cough, or experiencing chest symptoms but rather a different symptoms of a new headache, with red flags symptoms mostly excluded. As the patient felt unwell with her symptoms of a new headache, it should have been a red flag to offer her a face to face appointment which may have led to a referral to secondary care or further investigations into how she was feeling sooner.'*

Complainants' response to draft report

47. The complainants disagreed with the Practice's record of the telephone consultation on 8 April 2021 and reiterated that the patient did describe a cough as they had witnessed the telephone call and were worried about the symptoms the patient was experiencing. The complainants understood that Dr X had apologised if she give the impression that Covid was the only diagnosis she was considering. However, they still felt let down and believed the Practice should have assessed the patient face to face, especially given her cancer surgery. They hoped that going forward the Practice would show more

empathy and care, especially to cancer patients, when they make contact feeling unwell and are giving the priority they deserve.

Practice's response to draft report

48. The Practice wished to clarify the IPA's advice that stated *'…The patient presented with symptoms of 'fatigue, blurring of vision and dull headache' on 8th April 2021…'* It said *'…It is factually incorrect that the patient 'presented' with blurring of vision, as this was a symptom only reported when [Dr X] had carried out her clinical history screening questions.'* Following a review of the patient's ED records the Practice disagreed with the IPA's comments that the patient was treated for hyperkalaemia. It also raised a query in relation to *'…migraine and headache symptoms…'* as a symptom of hyperkalaemia and the patient's normal U+E result of 1 April 2021. It said that if, as a Practice, it was not aware that hyperkalaemia could cause the symptoms the patient presented with, it would be understandable that both Dr X and Dr W would take reassurance from the recent normal U+E test. It also said the Dr W did not feel clinical examination was required following his assessment of the patient on the 9 April 2021 as the patient was not reporting any concerning symptoms regarding headache, blurred vision or fatigue. The Practice also restated that there was no documentation indicating the patient reported a cough either to Dr X or Dr W, to reception staff or, during her nurse appointments. The Practice also raised concerns about the term red flag used by the IPA in relation to the offer of a face to face appointment.

Further IPA obtained

49. The IPA clarified the use of the word treatment in relation to the patient's visit to the ED on 29 March 2021. She advised *'…When I used the word 'treatment'…it referred to 'no further action needed.'* The IPA further advised that '…*Hyperkalaemia may present with no symptoms or cardiac related symptoms, but also muscle weakness and flaccid paralysis; depressed or absent tendon reflexes…'* In relation to the term red flag used to describe the offering of a face to face appointment to the patient the IPA advised *'…This was not a red flags with regards to medical terminology, but echoing language used by the complainant.'*

Analysis and Findings

50. I considered the Practice's records and note the Practice's comments that on 8 April 2021 following this telephone consultation Dr X booked an appointment for the patient to have her blood pressure checked the same day and as '…*The result was minimally raised…[Dr X] booked her for a follow-up telephone consultation with [Dr W]… [Dr X] felt this would ensure better continuity of care for [the patient] rather than offering an appointment with herself that day, as she had not been involved with her recent care at that time.'* I acknowledge that Dr X's record from 8 April 2021 did not document that the patient described '...*any cough, chest pain or respiratory symptoms…'* and this differs from the complainants account of the patient's symptoms who said she was also suffering from a dry cough.

51. I note the IPA's advice that '…*Given that the patient recently had been investigated and treated for raised potassium, it would have been advisable to examine her, carry out a fundoscopy…examination, a neurological examination and repeat her blood tests including potassium….'* I also note her advice about the patient's consultation on 9 April 2021 '*It is difficult as there is no documentation of the patient having suffered a cough, or experiencing chest symptoms but rather a different symptoms of a new headache, with red flags symptoms mostly excluded. As the patient felt unwell with her symptoms of a new headache, it should have been a red flag to offer her a face to face appointment which may have led to a referral to secondary care or further investigations into how she was feeling sooner.'*

52. I acknowledge the pressures the Practice was experiencing at the time because of Covid-19, and the explanation the Practice provided about continuity of care in paragraph 44 above. However, given the advice of the IPA that the patient was experiencing new symptoms I am satisfied that the patient should have had at least one face to face consultation following the telephone consultations on 8 and 9 April 2021 and consider this a failure in the patient's care and treatment. As a consequence of this failure, I consider the patient experienced the loss of opportunity for a potential referral to secondary care

and further investigation into her symptoms at that time. Therefore, I uphold this element of complaint.

53. I wish to acknowledge and pass on the Practice's comments that '…*[Dr X] was sorry if she had given the impression that she was focused on Covid 19 and for any resultant miscommunication, as it was not her intention to give this impression to [the patient].'*

Detail of Complaint

Timely provision of blood results taken 5 May 2021

54. The complainants said the patient had to wait six days to have a telephone consultation about blood test results taken on 5 May 2021. Given the patient's history of cancer they considered this time scale unacceptable.

Evidence Considered

Policies/Guidance

55. I considered the following policies/guidance:

- the GMC Guidance.

The Practice's Response to investigation enquiries

56. The Practice explained *'[The patient] attended for her bloods to be taken on the 5th May 2021...The blood results were not all processed and available until the 8th May 2021 which was a Saturday. [The patient's] blood tests were viewed Monday 10th May 2021 and an appointment assigned for the next available appointment slot the following day.'*

Relevant Independent Professional Advice

57. The IPA advised that *'…usually general blood tests requested results can take around 7 days to be sent, processed and the results returned to the clinician who has requested them in primary care…There is no specific national guidance regarding the timeline within which results should be reported by to the patient. However the guidance [NHS results on discharge guidance]…recommends that every test result received by a GP practice for a patient should be reviewed and where necessary acted on by a responsible*

clinician even if this clinician did not order the test.' The IPA went on to advise that upon receipt of the blood tests results the Practice *'…reviewed the blood test results and arranged a telephone appointment to review the results with the patient…This timescale was appropriate, given the results that were found, and a plan to repeat the blood tests were made in within two weeks.'*

Analysis and Findings

58. The Practice's records document that the patient had a blood test carried out on 5 May 2021. I note the Practice arranged a telephone consultation to discuss the blood results with the patient on 11 May 2021 however, she contacted the Practice about the results and other symptoms on 10 May 2021. I also note the patient was advised of the appointment slot already arranged but was offered the opportunity to speak with the on-call GP if she wished. A telephone consultation took place with the patient on 11 May 2021 to discuss the blood results.

59. I note the Practice comments that all the blood test results were available from 8 May 2021, a Saturday. The Practice viewed the results on Monday 10 May 2021 and *'…an appointment assigned for the next available appointment slot the following day.'* I considered the IPA's advice that the timescale for reporting on the blood test was '…*was appropriate, given the results that were found…'* I accept the advice of the IPA. Therefore, I do not uphold this element of complaint.

Detail of Complaint

Consultations/contact with Practice on 10 and 11 May 2021

60. The complainants said the Practice did not offer the patient an appointment with a GP on 10 May 2021, and the patient's telephone consultation on 11 May 2021 did not fully address her symptoms. They further queried whether a red flag referral had been made, to the respiratory team of CAH, for the patient on 11 May 2021.

Evidence Considered

Policies/Guidance

61. I considered the following policies/guidance:

- the GMC Guidance.

The Practice's Response to investigation enquiries

62. The Practice explained when the patient *'…contacted the surgery on the 10th May 2021 she was informed an appointment had already been put in place for her the following day the 11th May 2021, however, staff were informed that if [the patient] felt she needed to speak to a doctor that day she could be added to the urgent triage list…at this point there was no documentation of a cough, in regards to her fatigue her blood count was normal and an appointment was in place the following day, and a red flag referral had already been completed in regards to her loose motions.'* The Practice explained that *'…Following the consultation 11th May 2021 an urgent letter was sent to [the patient's] respiratory consultant [Dr Z] outlining [the patient's] bowels symptoms and that a red flag referral to the surgeons had been completed. It also highlighted [the patient's] recent blood tests and that she had recently attended A&E…'* Dr Y also explained *'…Since the Covid-19 pandemic all GP appointments including urgent appointments are firstly telephone triaged by a GP and subsequent face to face appointments are allocated as appropriate…'* The patient's ED record documented *'…the doctor in A&E has recorded no cough, but following assessment treated her with an antibiotic…'*

Relevant Independent Professional Advice

63. In relation to the patient's contact with the Practice on 10 May 2021 the IPA advised that the Practice *'…offered the patient a review with the oncall GP that day but the patient declined and said that she would go to hospital as she is feeling unwell…'* She also advised that it was reasonable for the Practice to offer to place the patient on the triage list with a view to review the patient face to face.

64. In relation to 11 May 2021 the IPA advised that during the telephone consultation on 11 May 2021 the records document *'…that the patient went to A&E and diagnosed with a chest infection and given antibiotic treatment. [Dr. Y] has written that a referral has been made to the surgeon, and that she will*

inform [Dr Z] regarding the events…The referral letter was marked as urgent and this is appropriate with the information recorded in the medical records. It would have been the discretion of the hospital to escalate this further.' The IPA further advised that after the patient's ED attendance on 10 May 2021 *'…there is no evidence that the practice proactively followed up the patient…other than the routine appointment already made to discuss the patient's blood test result.'*

Complainants' response to draft report

65. The complainants disagreed with the Practice's response to investigation enquires and re-enforced that the patient did have a cough when she contacted it. They also said it was because of the new cough and the patient's lung surgery that they were so concerned. The complainants said the Practice did not tell the patient she could be placed on the tirage list. The patient wanted to avoid the ED as she knew she was vulnerable to Covid 19 and that is why she rang the Practice first. If the Practice had told her that she could have been triaged and a doctor see her she would have done this rather than going to the ED.

Practice's response to draft report

66. The Practice disagreed with the IPA's comments *that '…there is no evidence that the practices proactively followed up the patient…other than the routine appointment already made to discuss the patient's blood test result.'* It highlighted that the patient had a telephone appointment at 09:58 with Dr Y on 11 May 2021, and whilst this was pre planned it *'…also served as appropriate follow up following the patient's A+E attendance a day previous day…'* The Practice also believed that a *'…separate, specifically 'proactive' phone call…would likely confuse a patient as to why they were receiving two separate telephone reviews on the same day regarding essentially the same thing.'* The Practice further explained that all ED documentation is reviewed by a GP and *'…if there is specific follow up required this generally will be actioned and arranged by the GP +/- practice based pharmacist…'*

Analysis and Findings

67. I note the interactions between the patient and Dr Y. I also note the Practice's comments that on 10 May 2021 the Practice offered the patient a place on its urgent triage list, but she declined this offer. I acknowledge and accept the Practice's comments that it did follow up with the patient following her attendance in the ED on 10 May 2021. I further note Dr Y, following the telephone consultation on 11 May 2021, sent an urgent referral letter to the patient's respiratory consultant. I accept the IPA's advice that it was reasonable for the Practice, on 10 May 2021, to offer to place the patient urgent triage list which may have led to a face to face consultation. I also accept her advice that the actions regarding Dr Y's referral letter on 11 May 2021 were also appropriate.

68. I acknowledge the comments of the complainants and how these differ from the Practice's comments and patient records. While I have no reason to disbelieve the complainants, I have no evidence to suggest that the patient's records are incorrect. Therefore, based on the available evidence I am satisfied that the patient's interactions with Dr Y on 10 and 11 May 2021 respectively, were appropriate. Therefore, I do not uphold this element of complaint.

Detail of Complaint

Consultation on 21 May 2021

69. The complainants said the Practice did not appropriately investigate a lump on the patient's back during her consultation on 21 May 2021. The complainants believed the Practice requested a chest x-ray to further investigate the patient's chest infection rather than the lump on the patient's back. They believed the chest x-ray should have been red flagged given the patient's symptoms and cancer history.

Policies/Guidance

70. I considered the following policies/guidance:

- the GMC Guidance.

The Practice's Response to investigation enquiries

71. The Practice explained the patient *'…had contacted the surgery regarding concerns of a lump… During the consultation it was ascertained and documented that [patient] felt this was a new discomfort. It was discussed with [the patient] that muscle damage and scarring can occur around operation sites and clarified during the examination that this was a new lump. She was informed that the lump needed further investigation…'* The Practice explained also *'…During that consultation discussion was made regarding her recent antibiotics from A&E. [The Patient] stated she had a slight cough with some clear phlegm. She denied any haemoptysis[7] or shortness of breath. She was examined that morning at the surgery. On examination her Oxygen saturation in room air was 98%, her heart rate was 96 beats per minute and respiratory rate was 14 breaths per minute. Her chest was clear on examination. [The patient] commented that she felt her cough was coming from a postnasal drip and sinuses. [The Patient] was prescribed a course of Doxycycline which is a second line antibiotic for a chest infection as diagnosed by A&E but would also cover for sinusitis. A chest x-ray was requested highlighting the above findings and…a further urgent letter was sent to Dr Z highlighting these concerns also.'*

Relevant Independent Professional Advice

72. During this consultation the IPA advised that Dr Y *'…examined the patients' chest, carried out oxygen saturations, respiratory rate and pulse examination. [Dr. Y] had documented that '2cm hard prominence superior to scar R side tender towards lateral chest wall. Chest clear.'* She further advised that Dr Y *'…referred the patient for a CXR, prescribed alternative antibiotics, wrote to the chest physician to advise them of this new development… discussed analgesia with the patient and offered alternative and appropriate analgesia, and advised the patient to return to the practice if there were any concerns.'* The IPA also advised the actions of Dr Y '…*were appropriate and she shared communication of the new symptoms and findings with the secondary care team.'*

73. In relation to the chest x-ray referral the IPA advised *'It is unclear if the CXR referral was made in relation to the chest findings- which were chest clear- so it*

[7] the coughing up of blood or bloody sputum from the lungs or airway.

is likely that this referral was due to the new chest wall findings and symptoms. It is appropriate that [Dr. Y] sent further information regarding change of symptoms for the patient. As the patient had an appointment for the respiratory team in early June 2021, it seems appropriate to wait this period of time for a review by the secondary care team…It is difficult to answer if the CXR should have been red flagged, as the chest examination demonstrated that there were no new chest findings and based on this, the clinical indication is an urgent referral which was actioned.'

74. In relation to the update referral to the respiratory consultant [Dr Z] the IPA advised *'…the referral was made as soon as the patient presented with symptoms and sent as soon as possible, It would then have been up to the discretion of the secondary care team as to when an appointment would have been offered.'*

Complainants' response to draft report

75. The complainants wished to clarify advice provided by the IPA in relation to the patient's appointment on 21 May 2021. They stated the advice reads as if the nurse made the appointment for the patient. However, this was not the case as the patient had an appointment that morning with the nurse, discovered a lump and before the appointment rang the doctor to ask for the appointment.

Analysis and Findings

76. I considered the patient's records and note that, on 21 May 2021, Dr Y made a referral for a chest x-ray marked as *'Urgent'* as well as a referral update letter to Dr Z [respiratory consultant] marked as *'Urgent'.* I accept the IPA's advice that Dr Y's actions *'…were appropriate…'* and it is likely that the referral for a chest x-ray *'…was due to the new chest wall findings and symptoms.'* I also accept the IPA's advice that it is difficult to say if the chest x-ray should have been red flagged; however based on the clinical examination the indication was that an urgent referral was required, which was actioned.

77. Given the available evidence I am satisfied that Dr Y's action of an urgent chest x-ray and onward referral to the patient's respiratory consultant were appropriate. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

Monitoring of bloods, including calcium levels, post hospital discharge in June 2021

78. The complainants said the Practice was not able to obtain blood from the patient on 28 June 2021 or 5 July 2021 as requested in her discharge letter from CAH dated 11 June 2021. The complainants believed if the Practice had taken bloods sooner, then the patient's high calcium levels would have been detected earlier. They said the patient's family had been left with extreme stress due to the uncertainty of whether the patient's symptoms, as a result of high calcium, could have been better controlled.

Policies/Guidance

79. I considered the following policies/guidance:

- the GMC Guidance.

The Practice's Response to investigation enquiries

80. Following the patient's discharge on 11 June 2021 the Practice advised it *'…had been requested to check the patient's phosphate level not her calcium level in 2 weeks following phosphate supplements. An appointment had been given to [the patient] on the 28th June. Unfortunately the Nurse was unable to obtain bloods…due to poor venous access which was most likely due to [the patient] needing intravenous fluids, contrast for radiological investigations and blood tests during her recent inpatient stay. A further appointment had been rescheduled the following week in the hope access would be better. Unfortunately the Nurse was not able to get venous access again having been able to on previous occasions when she attended the surgery. As this was a hospital requested blood test there is a hospital phlebotomy service that patients can access through the Consultant that has requested the bloods and the patient was signposted to this service by the nurse. The Surgery was unaware of the [patients'] difficulties in obtaining this service. [The patient] had a telephone review with her Oncologist the following day and possible*

treatment options were outlined to the patient. There had been no mention at that time with regards blood monitoring.' The Practice explained that *'…Nursing staff were informed verbally following the meeting held by us on the 14th September 2021 that if they were having difficulty talking [sic] a blood to either ask another nurse or a GP to perform this task…'*

Relevant Independent Professional Advice

81. The IPA advised that following discharge on 11 June 2021 CAH required the Practice *'…to repeat the patients [sic] bone profile 2 weeks after discharge, specifically mentioning to check phosphate level…'* She also advised that a bone profile test normally includes *'…Adjusted calcium, Albumin and ALP, and in most laboratories, phosphate needs to be requested separately.'*

82. In relation to the Practice attempts to obtain blood the IPA advised *'…Following the 28th June 2021, it is documented that the patient was advised to drink more water and a second appointment was made. Following the 5th July 2021, it is documented that the patient will contact the respiratory consultant's secretary to try and get a blood test carried out at the hospital when she is next there. It would have been reasonable to ask the patient to come back after the first attempt to take a blood test- but perhaps in a shorter time frame, meaning the next 24-48 hours to repeat the blood test. It is also reasonable to ask the patient to go to A&E or the hospital for a blood test if the surgery had been unable to carry out a blood test on the first attempt, given that a repeat blood test was requested by the hospital within 2 weeks. It is not reasonable for the surgery to expect the patient to contact the consultant to arrange an appointment for a repeat blood test.'*

83. In relation to the monitoring of calcium levels the IPA advised *'…The practice has coded 'hypercalaemia'[8] on 4th June 2021' in the patient's medical records, but there is no record of a calcium level being monitored…the practice should have tried to repeat the blood test to monitor this. If the patient could not have blood tests taken at the practice, then the practice should have made*

[8] A condition when the calcium level is above normal in the blood. This causes excessive thirst, frequent urination, headache, fatigue, nausea, vomiting, constipation and palpitation.

alternative arrangements to have a repeat test carried out for the patient, as it had been requested by the hospital also.'

84. The IPA also advised *'Symptoms of raised calcium include muscle weakness, constipation, anorexia and nausea, fatigue, dehydration, lethargy, cardiac arrhythmias, shortened QT interval, coma and pancreatitis...From the new practice that the patient registered at, symptoms such as constipation and anorexia are listed. The patient then saw her oncologist at the hospital on 4th August 2021 with these symptoms, and the next record of a raised calcium level was on 13/8/2021…When the [new] practice was made aware of the raised calcium on 13.8.2021, a plan was put in place to help with managing the symptoms of this. If this had been picked up sooner, then it may have helped her end of life period and symptoms she was experiencing of raised calcium be tolerated better, and possibly relieved.'*

Complainants' response to draft report

85. The complainants said the Practice did not tell the patient about the hospital's phlebotomy service but, it simply told her to contact the hospital. They said when the patient asked who she should contact, the Practice told her to contact the Consultant's secretary. The complainants also disagreed with the Practice's response to investigation enquires that they were unaware that the patient was having difficulties in obtaining the phlebotomy services. They said the patient had rung and told the receptionist that she still had not got the bloods sorted and was told she had to organise this herself. The complainants also said that the lack of empathy and care shocked them and hoped the Practice would do better for future patients.

Practice's response to draft report

86. The Practice raised concerns about how the IPA presented her advice in relation to the actions listed in the discharge summary and explained that several of the actions would have been the responsibility of secondary care teams. The Practice also disagreed with the IPA's comments that there was no record of a calcium level being monitored. It explained that the patient had raised calcium on admission to hospital which was normal on discharge and the

Practice were asked to repeat a bone profile to check her phosphate level in 2 weeks following treatment for a low phosphate on discharge from hospital. The Practice felt that the documentation about the unsuccessful attempts to have the bloods taken by a practice nurse on 28th June and 5th July 2021 was record of an attempt to monitor the calcium level (as part of the bone profile). The patient stated that the patient did not present with symptoms of hypercalcaemia to it and felt unable to comment on the IPA 's comments about any impact to the patient as it did not have access to the records of the patient's new GP. However, if the patient presented with hypercalcemia symptoms this may have been what trigged the new GP to take a calcium level.

Further IPA obtained

87. The IPA provided some additional clarification in relation to her comments about the patient's discharge summary. '*…Knowing [the patient's] complex medical history with different secondary care teams and consultants involved, in some practices where this is possible, such patients may be allocated to a' named GP', who may know about the patient's care, and be the main point of contact…*' The IPA also advised *'…It is recognised that the practice did try repeatedly to attend to monitor the patient's blood test level and I agree that they did try. However as they were unsuccessful and unable to manage taking blood for this patient. Perhaps in the future the practice could have a specific protocol for this in case such a situation happens again.'*

Analysis and Findings

88. I note the CAH discharge letter, dated 11 June 2021, asked the Practice *'…to report bone profile in 2 weeks to check [patient's] phosphate level…*' I also note the IPA's advice that as part of a bone profile the patient's calcium levels would also have been monitored. I note and accept the Practice's comments that a number of the actions listed in the patient's discharge summary were to be actioned by the secondary care teams.

89. I examined the Practice's records and note that the Practice tried to obtain blood samples from the patient on 28 June 2021 and 5 July 2021. I further note on 5 July 2021 the records document that '…*[Patient] will contact [Dr Z's]*

secretary regarding getting bloods taken at next hospital visit.' I also note that the patient had an oncology telephone consultation on 6 July 2021. I also note the complainants' comments that the patient was not told about the hospital's phlebotomy service but rather told to contact her Consultant's secretary.

90. I note the Practice's comments that it *'...had been requested to check the patient's phosphate level not her calcium level in 2 weeks following phosphate supplements…'* and as venous access was not possible on two occasions the patient was signposted to hospital phlebotomy service accessed through the consultant who had requested the bloods. *'…[The patient] had a telephone review with her Oncologist the following day and possible treatment options were outlined to the patient. There had been no mention at that time with regards blood monitoring.'*

91. While I acknowledge the Practice's comments that CAH asked it to monitor the patient's blood for potassium level, I accept the IPA's advice that as part of a bone profile the patient's calcium levels would also have been monitored. I also note the IPA's advice that, it would have been reasonable to ask the patient to return to the Practice after the first attempt '…*but perhaps in a shorter time frame, meaning the next 24-48 hours...It is also reasonable to ask the patient to go to A&E or the hospital for a blood test if the surgery had been unable to carry out a blood test on the first attempt, given that a repeat blood test was requested by the hospital... It is not reasonable for the surgery to expect the patient to contact the consultant to arrange an appointment for a repeat blood test.'*

92. At the time of discharge in June 2021 the patient had been under the care of a General Medicine Consultant, a Respiratory Consultant and had an onward referral to a Consultant Oncologist. Given the patient's diagnosis of the reoccurrence of her primary lung cancer I consider that it would have been unreasonable to expect the patient to know which Consultant had requested the repeat bone profile. I also acknowledge the comments of the Practice blood monitoring was not mentioned at the patient's oncology consultation. However,

I note this review was to discuss possible treatment options in relation to the cancer reoccurrence.

93. I acknowledge both the complainants' and Practice's comments in relation to what the Practice told the patient about how she should go about getting further bloods taken. I accept the patient was not fully aware of phlebotomy service and would ask the Practice to reflect on how it conveys such information to patients. Given the available evidence I accept that the Practice did not make sufficient efforts to make alternative arrangements to have the patient's bone profile repeated as CAH requested in her discharge letter to the Practice on 11 June 2021. I consider this a failure in the patient's care and treatment. I note the patient had a blood sample taken on 12 August 2021 which showed a raised calcium level. However, I cannot conclude that if an earlier blood sample had been taken that the patient's calcium levels would have been raised at that time. Nevertheless, I consider the patient lost an opportunity to have any potential raised calcium levels identified and symptoms managed earlier. This will also have caused her upset and frustration. I also consider that the complainants sustained the injustice of upset and frustration. Therefore, I uphold this element of complaint.

94. I welcome the Practice's comments that following the complaint made to it *'…Nursing staff were informed verbally following the meeting held by us on the 14th September 2021 that if they were having difficulty talking [sic] a blood to either ask another nurse or a GP to perform this task…'*

Detail of Complaint

Provision of Enoxaparin[9]

95. The complainants said Practice reception staff refused to provide the patient or her daughter with a prescription of Enoxaparin on 7 and 15 July 2021 even though CAH detailed it within her discharge letter, dated 11 June 2021. The complainants also said the Practice told both the patient and her daughter to contact CAH as the Practice did not issue Enoxaparin.

[9] Used to prevent and treat deep vein thrombosis.

Policies/Guidance

96. I considered the following policies/guidance:

- the GMC Guidance; and
- the NHS results on discharge guidance.

The Practice's Response to investigation enquiries

97. In relation to the Enoxaparin the Practice stated it *'…carried a patient audit search…The search did not show anyone having accessed [the patient's] notes during this time so we are unable to clarify further how this happened. Our Practice Pharmacist on the 15th June had spoken to the [patient's daughter] as she was confused with the change in medication following her mum's discharge from hospital. The Pharmacist had gone through the medication and had them available on the [patient's] medication page to be printed when required. We have had new members of reception staff joining our team and it may be that they were not aware of this medication. Our receptionists are asked to speak to a senior member of the reception team, GP or Pharmacist if there [sic] are unsure of any medication. We understand how this caused further upset to [the patient] and her family.'* The Practice also commented that in a Practice meeting on 14 September 2021 reception staff were reminded that Enoxaparin is prescribed at the Practice and if not sure about medication to be prescribed they are to ask another member of the reception team, Practice Pharmacist or GP. The Practice also explained that telephone calls requesting prescriptions are not recorded.

Relevant Independent Professional Advice

98. The IPA advised that Enoxaparin was *'…initially listed in the discharge letter from the hospital in June 21…'* The Practice was advised of the prescription *'…on the 15th June 2021, after a medicines reconciliation was carried out…The medical records appear to have been updated but the medication does not appear to have been issued. This had an impact on the patient as she had been prescribed it following a new diagnosis of a DVT [Deep Vein Thrombosis] and this is the treatment for it, otherwise without this medication, there is a risk*

that further clots can develop and a risk of death if untreated or inadequate treatment.'

99. The IPA further advised that *'All staff should have an induction as part of their onboarding in a new role and in the practice. This will include how to manage prescription requests and how to escalate this to appropriate members of the practice team if a member is unsure or working outside their scope of practice, competence and expertise. Non clinical staff should not be making clinical decisions regarding prescriptions, as this is beyond their scope of practice.'*

100. In relation to the recording of prescription requests from patients the IPA advised that it *'…is reasonable to expect this, so there is a clinical trail in the patient's medical records, and so an audit can be carried out to ensure relevant checks and monitoring has been carried out at each point.'* She further advised that there is nothing in the medical records as to why the patient or her daughter were told the Practice did not prescribe Enoxaparin.

Complainants' response to draft report

101. The complainants disagreed with the Practice's response to investigation enquires as to why the Practice had not prescribed the patient or her daughter the patient's prescription of Enoxaparin. While the complainants acknowledged that new reception staff may have started in the Practice, they said patient and her daughter had both been patients of the Practice for over 30 years and, the dealings they had over the prescription were not with a new member of staff. The complainants also wished to clarify that the discussion with the Pharmacist on 15 June 2021 took place at the request of the patient's daughter.

Practice's response to draft report

102. The Practice wished to clarify that it did not refuse to prescribe Enoxaparin but rather redirected the patient back to secondary care for this medication. The Practice said this was in line with regional guidance in relation to the prescribing of Enoxaparin which is 'Amber list' medication which indicates that *'…responsibility for prescribing may be transferred from secondary to primary care when agreed shared care arrangements for the patient have been*

established between specialist and GP…' It went on to explain that '*...Unfortunately the Practice did not receive this shared care arrangement, therefore the patient was directed back to secondary care to continue prescribing this medication…'* The Practice also re-iterated its comments that *'…All reception staff receive induction training and supervision in regards to the ordering of prescriptions. Any concerns about prescriptions can be escalated to a senior receptionist, Practice Pharmacist or General Practitioner.'*

Further IPA obtained

103. The IPA advised that she agreed that enoxaparin was an amber medication and that shared care protocols were available online. *'…If the practice know it is a shared protocol, then it would be reasonable for the practice to go back to the hospital to get a shared protocol…'*

Information provided by Southern Health and Social Care Trust.

104. The Southern Health and Social Care Trust [the Trust] were asked to provide information in relation to the information provided to the Practice in respect of the patient's Enoxaparin medication. It explained that '*On the discharge letter, the Enoxaparin was prescribed with additional information specifying it was an Amber List Medicine. General Practitioners and Community Pharmacy Services have access to the shared services protocol on the internet**...**It is not routine practice to send a copy of the shared care services protocols along with the discharge letters…there was no communication from the GP Practice regarding the provision of shared care arrangement or a request for any further information about the patients Enoxaparin medication…'*

Analysis and Findings

105. I note Enoxaparin was listed on the patient's discharge letter dated 11 June 2021 from CAH to the Practice and, under 'additional information' it was documented as an Amber List Medicine I also note the Practice's comments that the Practice Pharmacist had the medication available on the [patient's] medication page and that a patient audit search '…*did not show anyone having accessed [the patient's] notes during this time so we are unable to clarify further how this happened…'* While I acknowledge the Practice's comments

that there is no record of the patient or her daughter's telephone call with the Practice on 7 and 15 July 2021, I have no reason to disbelieve the complainants that these calls occurred. I also note the Practice's comments that at this time it '…*had new members of reception staff joining our team and it may be that they were not aware of this medication…'* I also acknowledge the complainants' comments that neither the patient nor her daughter dealt with new members of staff in relation to the prescription for Enoxaparin.

106. I further note the Practice's comments that it did not receive shared care arrangement from CAH for the prescribing of the patient's Enoxaparin. However, given the IPA's advice, the information supplied by the Trust and that the Shared Care Guideline is readily available online, I am satisfied the Practice, if it required further clarification in relation to prescribing the patient's Enoxaparin, could have contacted CAH directly before the patient made any requests for this medication.

107. I note the IPA's comments about induction training for new staff and that this should '…*include how to manage prescription requests and how to escalate this to appropriate members of the practice team if a member is unsure or working outside their scope of practice, competence and expertise…'* I also note that she considered it *'reasonable'* to expect a record of patients' prescription requests to enable future audits. I considered the IPA's comments about the potential impact to the patient including the risk that further clots may develop. Given the available evidence I accept the Practice did not provide the patient with a prescription of Enoxaparin on 7 and 15 July 2021 and consider this a failure in the patient's care and treatment. As a consequence of this failure, I consider the patient experienced the injustice of frustration and upset as well as the loss of opportunity to receive prescribed medication. I also consider the complainants experienced the injustice of frustration and upset. Therefore, I uphold this element of complaint.

108. I refer to the IPA's advice in relation to recording patients' prescription requests and I would ask the Practice to reflect on and consider the learning the IPA

identified in relation to documenting information about prescriptions and medications.

CONCLUSION

109. I received a received a complaint about the Practice's actions in relation to the care and treatment it provided to the patient from 9 December 2020 to 22 July 2021.

110. The investigation established failures in the care and treatment in relation to the following matters:

- Following up with the patient after her discharge from the RVH in December 2020;
- Conducting at least one face to face consultation following telephone consultations on 8 and 9 April 2021;
- Making alternative arrangements to have the patient's bone profile repeated as requested by CAH on her discharge; and
- The provision of Enoxaparin prescriptions to the patient on 7 and 15 July 2021.

111. I do not consider that the failing of not following up with the patient after her discharge in December 2020 caused her to experience an injustice. However, I am satisfied that the other failures in care and treatment identified, caused the patient to experience the injustice of frustration and upset. She also lost the opportunity for a referral to secondary care, and further investigation into her symptoms at that time, having potential raised calcium levels identified and symptoms managed sooner, and to continue with prescribed medication. I also consider the complainants experienced the injustice of frustration and upset.

112. The investigation did not establish a failure in the care and treatment in relation to the following matters:

- Follow-up action by the Practice after the patient's June 2021 discharge;
- The monitoring of the patient's potassium levels;
- The notification of blood results taken 5 May 2021;
- The consultations/contact with the Practice on 10 and 11 May 2021; and
- Actions following patient's consultation on 21 May 2021.

Recommendations

113. I recommend that the Practice provides the complainants with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the maladministration/failures identified within **one month** of the date of this report.

114. I further recommend for service improvement and to prevent future recurrence the Practice:

i. Discusses the findings of this report with the GPs and other staff members involved in the patient's care;
ii. Carries out a review of the face to face appointment system currently offered to patients and identifies if any improvements can be made to current Practice policy/guidance. Any findings should be provided to this office;
iii. Carries out a review of the induction training for reception staff to ensure it includes how to manage prescription requests and how to escalate this to appropriate members of the Practice team if a member is unsure about requests. Provide evidence that this review has been completed and updates made as necessary; and
iv. Reviews how it makes arrangements for patients should repeat blood monitoring be unable to be undertaken at the Practice.

115. I recommend that the Practice implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence

to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

116. Throughout my examination of this complaint, I recognised the pain and trauma the patient and her family experienced over the patient's recurrence of her primary lung cancer. The effect of losing a much loved mother and wife in such circumstances is very evident in the correspondence I received. I hope this report goes some way to address the complainants' concerns which I reached only after my full consideration of the facts of this case.

MARGARET KELLY
Ombudsman **11 August 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.