# Investigation Report

## Investigation of a complaint against Woodbrooke Medical Practice

**NIPSO Reference: 202000673**

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## 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.

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**Case Reference: 202000673**

**Listed Authority: Woodbrooke Medical Practice**

## SUMMARY

This complaint is about care and treatment Woodbrooke Medical Practice (the Practice) provided to the complainant's late wife, (the patient). The patient attended the Practice on 1 May 2019 with a skin condition. The condition did not improve and the patient attended the emergency department (ED) of the Belfast Health and Social Care Trust's (BHSCT) Royal Victoria Hospital (RVH) on 2 June 2019. The BHSCT referred the patient to the dermatology team at the South Eastern Health and Social Care Trust (SEHSCT). The dermatology team diagnosed the patient with bullous pemphigoid[1]. Doctors subsequently diagnosed the patient with lung adenocarcinoma and she sadly passed away on 29 May 2020.

The complainant said the Practice should have referred the patient to a dermatologist earlier. He believed that the Practice did not manage the patient's steroid medication appropriately. He also believed the Practice should have referred the patient for further testing to aid earlier diagnosis of her cancer. Finally, the complainant thought the Practice could have done more to facilitate the patient's return to hospital in April 2020.

It was evident to me that this was a highly distressing and traumatic time for the complainant and the patient. However, the investigation found the Practice provided appropriate care and treatment to the patient when she presented with a skin condition in May 2019. The investigation found the Practice managed the patient's steroid medication appropriately. However, the IPA advised the Practice should have provided the patient with a steroid card. The Practice have already apologised to the complainant for the lack of a steroid card as part of local resolution. The Investigation also found that the Practice made appropriate referrals for further testing. The Investigation found the Practice acted appropriately regarding readmission to hospital April 2020. Therefore, I did not uphold the complaint.

1 Bullous pemphigoid is a rare skin condition that mainly affects older people. It usually starts with an itchy, raised rash. As the condition develops, large blisters can form on the skin.

## THE COMPLAINT

1. This complaint is about care and treatment the Woodbrooke Medical Practice (the Practice) provided to the complainant's late wife (the patient) between May 2019 and May 2020.

### Background

2. The patient attended the Practice on 8 May 2019 with blisters in her mouth and a boil in her groin. She returned to the Practice on 23 May 2019 with an infected insect bite and damage to skin caused by removing a plaster. The treatment room nurse cleaned and treated the skinned area. The Practice held a telephone triage encounter with the patient on 28 May 2019 regarding the infected insect bite. The patient also attended the surgery on that date to have her dressing changed and bloods taken.

3. The patient attended the Belfast Health and Social Care Trust's (BHSCT) Royal Victoria Hospital ED on 2 June 2019 with a blistering eruption of the skin. The consultant dermatologist diagnosed her with either bullous pemphigoid with mucous membrane involvement[2] or a viral infection[3] such as hand, foot and mouth[4]. The patient transferred to the care of dermatologists in the South Eastern Health and Social Care Trust, (SEHSCT). After her appointment of 10 June 2019, the SEHSCT's consultant dermatologist confirmed a diagnosis of bullous pemphigoid with mucous membrane involvement. She had an appointment with the dermatology team approximately once per month on the following dates, 2 July 2019, 30 August 2019, 11 October 2019, 22 November 2019, 6 January 2020, 17 January 2020, 14 February 2020, 3 April 2020, 9 April 2020 and 1 May 2020. The dermatology team wrote to the Practice after every appointment and asked them to prescribe her steroids to manage the symptoms of her bullous pemphigoid.

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[2] Bullous pemphigoid is a rare skin condition that mainly affects older people. It usually starts with an itchy, raised rash. As the condition develops, large blisters can form on the skin. Blisters develop in the mucous membranes if the patient has the condition with mucous membrane involvement.

3 Viral infection: Infection caused by the presence of a virus in the body.

4 Hand, foot, and mouth disease (HFMD) is a highly contagious infection. It is caused by viruses from the Enterovirus genus.

4. On 23 February 2020, the patient, suffering from shortness of breath, attended the RVH's ED. The BHSCT admitted the patient to hospital. The BHSCT initially treated the patient for community-acquired pneumonia[5]. The BHSCT updated her diagnosis to lung adenocarcinoma on 3 March 2020 after diagnostic testing. The BHSCT drained pleural fluid from the patient to alleviate her symptoms. It discharged the patient on 17 March 2020. The patient met with an oncologist on 26 March 2020. The oncologist informed the patient that she was not suitable for treatment.

5. The patient's condition deteriorated and the complainant contacted her GP on 30 March 2020. The patient had a telephone triage encounter and explained she had a tickly cough for the last two days. The Practice prescribed her co-amoxiclav[6] but agreed with the patient if she experienced any shortness of breath, chest pain, or a high temperature she should attend the ED. The patient contacted her GP again on 2 April 2020 and asked about getting a chest x-ray. The GP noted the patient had a tickly cough. The GP explained if the patient's symptoms worsened or if she had concerns, the Practice could organise a chest x-ray. The patient had another telephone triage on 7 April 2020. The GP noted that the patient had experienced shortness of breath on 6 April 2020 but her breathing had settled and she '*felt great'* apart from an ongoing cough. The complainant said the patient rang the respiratory team who advised possible further antibiotics. The GP noted she advised the patient to seek a review at the hospital if her symptoms worsened.

6. On 13 April 2020, the patient's family called an ambulance as the patient experienced breathing difficulties. The BHSCT admitted the patient to the Covid ward in the Mater Hospital and then transferred her to the RVH. The patient sadly passed away on 29 May 2020.

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5 Community-acquired pneumonia is defined as pneumonia that is acquired outside the hospital. Pneumonia is lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid.
[6] Co-amoxiclav is a similar antibiotic to penicillin. It works by combining amoxicillin with clavulanic acid to kill the bacteria that cause an infection.

**Issues of complaint**

7. I accepted the following issues of complaint for investigation:

**Whether the care and treatment the Practice provided to the Patient between May 2019 and May 2020 was appropriate and in accordance with relevant policies and standards. In particular this will consider:**

- Referral to a dermatologist;
- Management of the patient's steroid medication;
- Diagnosis of patient's cancer; and
- Patient's Readmission to hospital, April 2020

## INVESTIGATION METHODOLOGY

8. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

**Independent Professional Advice Sought**

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

- A GP since 1985 in addition to a number of other educational and quality roles.

I enclose the clinical advice received at Appendix two to this report.

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

**Relevant Standards and Guidance**

11. In order to investigate complaints, I must establish a clear understanding of the standards, of both general application and those 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[7]:

- The Principles of Good Administration; and
- The Principles of Good Complaints Handling

12. 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.

The specific standards and guidance relevant to this complaint are:

- Northern Ireland Cancer Network's Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria, October 2019, (NICaN's guidance); and
- Northern Ireland Primary Care's Antimicrobial Guidelines, Skin & Soft Tissue Infections Cellulitis & Erysipelas, 2019, (NIPC's Guidance).

I enclose relevant sections of the guidance considered at Appendix three to this report.

13. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

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

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

## THE INVESTIGATION

**Detail of Complaint**

15. The complainant said the Practice did not refer the patient to a dermatologist when she presented with a skin condition in May 2019. The complainant believed the Practice should have referred the patient to a dermatology consultant. The complainant said, instead of referring the patient, the Practice made a '*false diagnosis of a hair follicle infection, delaying a proper assessment'*. The complainant said the patient's pain became '*so extreme that she eventually presented to A&E at the end of May 2019'.* The complainant said the Practice should have referred the patient for a specialist assessment before she '*had to attend A&E on 2 June 2019*.

16. The SEHSCT subsequently diagnosed the patient with bullous pemphigoid with mucous membrane involvement and treated her with steroids from June 2019 to May 2020. The complainant said the patient's prolonged use of steroids '*rendered her unable to receive either chemotherapy or immunotherapy'*. The complainant believed the Practice should have raised concerns about the patient's prolonged steroid usage.

17. The complainant said the patient developed a recurring cough from late November 2019, for which the Practice prescribed her two courses of antibiotics. The complainant said the Practice referred the patient for a chest x-ray in February 2020. However, her breathing deteriorated and the BHSCT admitted her to the RVH on 23 February 2020. The BHSCT subsequently diagnosed the patient with lung adenocarcinoma. The complainant said the BHSCT informed him and the patient that '*adenocarcinoma, a common form of lung cancer, does not show up in either chest scans or in blood tests'*. The complainant questioned why the Practice did not refer the patient for a biopsy

as well as a chest x-ray. The complainant said '*an earlier referral for a chest X Ray and a biopsy may have resulted in an earlier diagnosis of adenocarcinoma, which may have been then have been contained before spreading to the pericardium or any other organs'.*

18. BHSCT discharged the patient from hospital on 17 March 2020. Her condition deteriorated and she called the Practice. The Practice diagnosed her with a chest infection and the complainant said the Practice prescribed two courses of antibiotics. The complainant questioned this diagnosis and said a more reasonable diagnosis would have been a build-up of fluid due to her adenocarcinoma. The complainant said the Practice should have referred the patient for specialist assessment '*before she had to be admitted by ambulance for emergency treatment on 13th April 2020'*.

**Evidence Considered**

**Legislation/Policies/Guidance**

19. I considered the following guidance:
    - NICaN's guidance; and
    - NIPC's Guidance;

**The Practice's response to investigation enquiries**

20. In response to our enquires, the Practice also referenced its response to the complainant on 18 May and 18 June 2021.

*Referral to a dermatologist;*

21. The Practice explained the patient telephoned the Practice and spoke to Dr A on 8 May 2019. The patient described a one-week history of cold symptoms, with associated sore throat and blisters in her mouth; she also advised that she had a recent boil in her groin that was settling. The Practice asked her to attend the rapid access clinic at the surgery. The patient saw Dr B who noted '*a 8mm ulcer beneath the right and left side of her tongue, with a resolving boil*

*on her right inner thigh'*. Dr B treated the patient for an aphthous ulceration[8] with topical Difflam[9], Orabase[10] for symptomatic relief; and Fucidin [11] for the boil in her right groin. Dr B advised the patient she should '*re-contact her if her symptoms were not settling or if further lesions developed*'. Dr B noted in the medical record that her condition might require further investigation if her symptoms did not settle.

22. The Practice noted that the patient telephoned the surgery again on 14 May 2019. Dr C spoke to the patient and documented a weeklong history of green nasal discharge (with bloody discharge in her right nostril), a cough with green sputum and a sore throat with associated temperatures, but no breathlessness. Dr C diagnosed a sinus infection and prescribed penicillin[12].

23. The Practice said the patient telephoned on 23 May 2019, she spoke to Dr C and reported her '*right ankle was swollen and red, and her skin had come off when removing a plaster from this area'*. The Practice said the patient related this to recent mosquito bites. She attended the Practice that morning and Dr D reviewed her. He noted the '*skin was removed on her left lower ankle where the plaster had been and that her right ankle was swollen and red'*. Dr D said the patient's temperature was normal and her throat was red. Dr D made a provisional diagnosis of cellulitis secondary to an infected insect bite and prescribed flucloxacillin.[13] The treatment room nurse cleansed and dressed her wounds and arranged a further review on 28 May 2019.

24. The patient telephoned the Practice on 28 May 2019 and reported to Dr D a few '*spots still present in her right groin that were felt by her to be related to an ingrowing hair and had some crusting still present*'. Dr D prescribed fucidin cream again over the telephone. The Practice said the treatment room nurse

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[8] Aphthous ulcers are painful, clearly defined, round or ovoid, shallow ulcers that are confined to the mouth and are not associated with systemic disease.

[9] Difflam Cream works by stopping pain and swelling (inflammation).

[10] Orabase Protective Paste acts like an invisible bandage to produce an environment conducive to healing.

[11] Fucidin, an antibiotic cream, is used in the treatment of primary and secondary skin infections.

[12] Penicillin is widely used to treat a variety of infections.

[13] Flucloxacillin is an antibiotic. It is used to treat: skin and wound infections.

renewed the patient's dressing on the same day. Dr D arranged for blood investigations on 29 May 2019. Dr D reviewed the results on 30 May 2019, and noted they were normal. The patient attended the treatment room for a further review on 31 May 2019 and had her dressings renewed.

25. According to the Practice, the patient telephoned on 4 June 2019 and spoke to Dr A. She told Dr A she had attended the ED, in the RVH on 2 June 2019 due to worsening symptoms. The patient also informed Dr A the BHSCT referred her to a dermatologist in the SEHSCT's Ulster hospital on 3 June 2019 who took a skin biopsy and swab. According to the Practice, the patient reported a sore throat but no temperature. The patient requested an appointment with the treatment room nurse for further dressings. When the treatment room nurse examined the patient on 4 June 2019, she noted '*new, extensive skinned wounds on her buttocks and these were dressed, in addition to those on her right leg and feet*. Dr B also reviewed the patient and diagnosed her with oral thrush, secondary to the recent antibiotics. Dr B prescribed oral Nystatin[14] and noted the patient was under review at the Dermatology Clinic, Ulster Hospital.

26. The Practice said the patient contacted it on 7 June 2019 and spoke to Dr E, to enquire about biopsy results. Dr E told the patient the Practice had not received the results. The treatment room nurse changed the patient's dressing on 7 June 2019. The Practice said it received a telephone call from a dermatology specialist registrar on 10 June 2019. The dermatologist explained skin biopsy results confirmed a diagnosis of Bullous Pemphigoid with Mucus Membrane involvement.

27. The Practice concluded it would '*consider a referral to dermatology for any skin condition that was worsening or not responding to prescribed treatment'*. The Practice said there was a gap of four weeks between the patient presenting with the skin condition and her attending ED. It noted that the doctors assessing the patient '*did not feel a referral was indicated initially'*. It added Dr

[14] Nystatin is an antifungal that works by stopping the growth of fungus; this medication is used to treat fungal infections of the mouth.

B did note on 8 May 2019 if the patient's symptoms did not settle she might require a referral. The Practice added '*On reflection, [the Practice] could have considered referring [the patient] a week earlier after her attendance on 23rd May 2019; however with the history of travel and bites 3 weeks earlier, on review, … at that time it was reasonable to treat for a presumed Cellulitis'*. The Practice apologised if this caused a delay in the patient's diagnosis and for any '*prolongation of pain or suffering she incurred as a result'*.

*Management of the patient's steroid medication*

28. The Practice explained there are recognised risks and side effects with the use of long-term steroid use, the mainstay in the treatment of bullous pemphigoid. The Practice said the consultant dermatologist who called on 10 June 2019 commenced the patient's steroid medication on this date at a dose of prednisolone[15] 30mg daily. Dr D called the patient and left a voicemail advising her to contact the practice pharmacist. The patient contacted the practice pharmacist who advised her on the commencement of a bisphosphonate[16] and supplementations for bone protection, as well, ensuring appropriate gastric protection.

29. The Practice said '*we agree and accept that a steroid alert card should have been issued to [the patient] and have taken action in the practice to ensure this happens in the future'*.

30. The Practice said there is no documentation that it provided advice on the increased risk of infections with prednisolone to the patient. The Practice said it would be standard practice for a patient to receive written information on long-term steroid treatment by the initiating clinician, which in this case, was the dermatologist. The Practice noted that the dermatologist may have given written information directly to the patient.

[15] Prednisolone is a steroid or corticosteroid medicine. It is used to treat a wide range of health problems including allergies, blood disorders, skin diseases, inflammation, infections.
[16] Bisphosphonates are a group of medicines used to treat bone problems, called osteopenia or osteoporosis, which are conditions associated with thin or fragile bones that are at increased risk for fracture.

31. The Practice said a consultant dermatologist informed it in a letter after the patient's 2 July 2019 consultation that she had increased the patient's dosage of prednisolone to 40mg daily. The consultant dermatologist also recommended a reducing dose regime of steroids and noted that she had discussed the steroid sparing medication dapsone with the patient on 2 July 2019. The Practice said the patient attended the treatment room regularly for renewals of dressings. It noted Dr A reviewed the patient at the practice on 25 June 2019.

32. The Practice said the patient remained on a reducing dose of oral prednisolone the specialist dermatology team recommended. The Practice said at her dermatology clinic review on 30 August 2019, the dermatologist counselled the patient and commenced her on dapsone 50mg daily. The Practice noted this drug is used as a steroid sparing agent[17], the aim of which is to allow patients to reduce their long term steroid requirement. The Practice noted that the patient letter on 30 August 2019 stated she received a '*Patient Information Leaflet on Dapsone'*, explaining any common side effects and monitoring requirements. According to the Practice, this letter also advised the patient on the continued gradual reduction of Prednisolone dosing by 5mg every two weeks until reaching a 10mg maintenance dose.

33. Dr D counselled the patient on her medication and on the requirement for weekly blood monitoring by telephone on 2 September 2019. The Practice reviewed the patient again on 16 January 2020 and advised her on her medication.

34. The Practice said the patient attended for regular monitoring of her bloods. The Practice explained the consultant dermatologist commenced the patient on azathioprine[18] on 14 February 2020, as her bullous pemphigoid was still active and symptomatic. A clinic letter on this date noted the patient had read the

[17] Doctors try to keep the dose of steroids as low as possible in to order to reduce the risk of side effects. To assist in keeping the steroid dose as low as possible some people may be considered for additional therapy in order to reduce the need for steroids.

patient information leaflet on azathioprine. The Practice contacted the patient to discuss the commencement of azathioprine, and the monitoring and vaccination requirements.

*Diagnosis of patient's cancer*

35. The Practice said the patient attended on 22 October 2019 with a complaint of breathlessness for several months and a slight cough but no sputum. Dr A also documented the patient's smoking history at that consultation. The Practice said on examination '*her observations were normal and a scattered wheeze was noted*'. The Practice prescribed a salbutamol[19] inhaler for symptomatic relief, and referred the patient for an open access chest x-ray in Lagan Valley Hospital. The Practice said the hospital reported the result of the x-ray on 30 October 2019. The Practice noted '*mild chronic inflammatory changes in both lungs'*.

36. The Practice referred to NICaN's guidance and explained that Dr A did not feel a '*referral for further investigation was clinically required at this stage'*. The Practice noted there were no other contacts from the patient regarding respiratory symptoms until 16 January 2020. The patient telephoned the Practice complaining of a '*cough with green sputum for ten days, with associated breathlessness. At that time she had no reported temperatures or chest pain associated with this'*. The patient attended Dr F, after examination she diagnosed a lower respiratory tract infection, and commenced the patient on augmentin[20]. Dr F advised the patient to '*withhold Dapsone'* and to seek consultant advice from the consultant dermatologist. Dr F advised the patient to attend the ED if her symptoms worsened or to contact the Practice if she did not improve over the next 48 hrs.

37. Dr B telephoned the patient on 22 January 2020 following receipt of a dermatology clinic letter dated 17 January 2020. The dermatologist said in the

[19] Salbutamol is used to relieve symptoms of asthma and chronic obstructive pulmonary disease (COPD) such as coughing, wheezing and feeling breathless.

[20] Augmentin is a prescription medication that's used to treat infections caused by bacteria.

letter that the patient reported she still had a cough with green sputum. The patient attended Dr C on 23 January 2020. According to the Practice, she reported '*feeling a bit better but still had a chesty cough but with no temperature'*. On examination, her chest was clear, and Dr C prescribed clarithromycin[21] and advised the patient to seek further review if her symptoms were not settling.

38. The patient attended Dr B on 11 February 2020 and reported an '*on-going chesty cough with green sputum'*, and that a recent course of antibiotics had helped. Dr B recorded there was no blood in her sputum, but the patient advised that her '*breathing was affected and was wheezy at times'*. Dr B noted the patient's chest x-ray result from October 2019. Dr B examined the patient and prescribed a further course of oral Augmentin for a presumed chest infection. Dr B referred the patient for a repeat chest x-ray. She also advised the patient to make contact for a review if her symptoms were not settling, and that the Practice would consider a referral for spirometry[22]. The Practice said a chest x-ray was indicated at this stage in view of the '*patient having had two recent courses of antibiotics, on immunosuppressive therapy and being a smoker, to exclude a lung lesion, in line with the NICaN guidelines'*

39. The Practice said a clinic letter on 14 February 2020 noted the patient's chest symptoms had settled. The Practice said there was no indication on 11 February when the patient consulted with Dr B '*that an onward referral for further investigation was required while awaiting the chest x-ray result[23]'.* The Practice said the decision regarding the nature of investigation, for example, biopsy would rest with secondary care. However, the Practice said it suspected the result of this x-ray may have led to a '*red flag referral for further investigation and an earlier diagnosis of Adenocarcinoma'*. The Practice concluded '*The GPs are aware that some lung cancers may not be diagnosed*

[21] Clarithromycin is used to treat certain bacterial infections, such as pneumonia (a lung infection), bronchitis (infection of the tubes leading to the lungs), and infections of the ears, sinuses, skin, and throat.
[22] Spirometry is a simple test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath. It is carried out using a device called a spirometer, which is a small machine attached by a cable to a mouthpiece.
[23] The Practice said it assumed the patient did not attend for x-ray before her admission to the RVH on 23 February 2020.

*from a chest x-ray but this is still recommended as a first line investigation in the NICaN guidelines which we follow'.*

*Patient's Readmission to hospital, April 2020.*

40. The Practice noted the patient telephoned the Practice on 30 March 2020 and reported a *'tickly cough for two days'*. The patient reported that she had '*no chest pain and didn't feel particularly breathless'.* According to the Practice, the patient was keen to avoid any deterioration in her symptoms and was currently shielding at home due to the COVID pandemic. Dr G advised her to commence an oral antibiotic Augmentin and advised to contact the dermatology team regarding her steroid medication. He advised that if her symptoms worsened '*she should attend the Emergency Department directly'*.

41. On 2 April 2020, the patient telephoned the Practice and reported 'an ongoing tickly cough, with clear sputum but no change to her breathing'. According to the Practice, the patient stated the 'recent antibiotic had helped and noted that she felt 'markedly improved''. The patient contacted the Practice again on 7 April 2020 and reported feeling breathless the previous day, but noted this had improved, however she had an 'ongoing cough with clear sputum'. The patient also advised she had contacted the hospital respiratory team, who suggested a possible further course of antibiotics. Dr B discussed the options for assessment in light of the current COVID pandemic and it was agreed that there was 'no clinical indication to refer to hospital or to the COVID centre at this stage'. The Practice prescribed clarithromycin, but agreed that the patient defer starting this as her symptoms had improved and she was due to complete her current course of augmentin that day. Dr B advised the patient that if her symptoms were to deteriorate, she should attend the hospital directly for assessment.

42. I enclose a summary of the relevant records at Appendix four to this report.

**Relevant Independent Professional Advice**

43. A General Practitioner (IPA) provided advice on the care and treatment the Practice provided to the patient between May 2019 and May 2020. I enclose the advice the IPA provided at Appendix two to this report.

*Referral to a dermatologist;*

44. The IPA reviewed the treatment the patient received from the Practice from her first consultation on 8 May 2019 about her skin condition to her attendance at the ED, 2 June 2019. The IPA advised the '*early consultations seem proportionate and include clear safety netting. Trying second line antibiotics was not unreasonable'.* The IPA advised '*the whole span of treatment was just under 3 weeks and on 28/5 further investigations were organised appropriately'.* The IPA advised that it would have been '*highly inappropriate'* for the Practice to refer the patient to a dermatologist between 8 May and 2 June 2019.

*Management of the patient's steroid medication;*

45. The IPA advised that, although GPs are responsible for their own prescriptions, they have '*little choice but to follow the instruction of the specialist team because one person (the expert) needs to make the clinical decisions and direct treatment'*. The IPA advised that the plan was to reduce the patient's steroid dose to 10mg daily. However, the IPA advised that the patient's symptoms made it necessary to '*increase the dose (increased by the hospital on 22/11/19 and 3/1/20)'.* The IPA advised dapsone was later introduced in an attempt to reduce the patient's steroid requirement '*but without steroids the pemphigoid would have got considerably worse'*. The IPA concluded there was no safe and problem free alternative to steroids and '*I would not expect any GP to go against the specialist team's recommendations in a case like this'.*

46. The IPA advised that the Practice had admitted to not providing the patient with a steroid card.

*Diagnosis of patient's cancer*

47. The IPA advised there were a number of instances when the patient exhibited symptoms that could have potentially triggered referral for testing. He advised

on 8 May 2019 the '*8mm linear ulcer beneath tongue'*; 14 May 2019,'*bloody discharge from nostril, cough';* 04 June 2019*, 'hoarseness'*. On 2 September 2019 the IPA advised the patient presented with '*chesty cough, green sputum not clearing, slight shortness of breath, scattered wheeze.'* The IPA advised at a review on 22 October 2019 the patient was '*short of breath on exertion, slight cough, continues to smoke 20/day'.*

48. The IPA advised on 16 January 2020 the patient described her symptoms as *'Cough, short of breath on exertion, appetite down'* during a telephone review. Later that day, the IPA advised the Practice examined the patient and noted her chest was not '*clear on examination'.* The IPA advised an examination of the patient showed '*continued symptom of cough'.* The IPA advised on 11 February 2020, the Practice noted '*ongoing chest cough, cigarette smoker'* after reviewing the patient.

49. The IPA advised the Practice should have followed NICaN's guidance when deciding whether to refer patient for cancer testing. The IPA advised *'I am not convinced that, despite the patient being a smoker, the GPs should have treated her symptoms with a high index of suspicion*'. The IPA further advised the chest X-ray gave '*false reassurance as there were no signs of cancer but, as a 20/day smoker, the "mild chronic inflammatory changes" were entirely in keeping with a diagnosis of chronic obstructive pulmonary disease[24] (COPD)'.* The IPA advised the Practice referenced COPD again during the consultation of 11 February 2022.

50. The IPA advised the Practice considered the chest symptoms in the context of a '*review of the pemphigoid and steroid treatment'.* The IPA advised there were two exceptions '*the consultations on 2/9/19 and on 16/1/20 when cough was re-presented and on both of these occasions, the story was of a cough of short duration (2 weeks and 1.5 weeks)'.* The IPA further advised '*it is well recognised that steroid treatment increases the risk of infection'.*

[24] Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties

51. The IPA advised the Practice carried out routine monitoring of bloods because of the patient's dapsone. The IPA advised that the monitoring showed up minor abnormalities and that the Practice and hospital managed these appropriately.

52. In relation to whether the Practice should have referred the patient for a biopsy in the knowledge that a chest x-ray would not show lung adenocarcinoma, the IPA advised '*No'*. He further advised '*Had the GPs considered cancer a likely possibility, they could have asked for a Red Flag referral to a lung specialist'.* The IPA advised the patient's '*cancer advanced very quickly between the chest x-ray in October and her diagnosis in March'.*

53. The IPA advised '*had further investigations (e.g. scans) been ordered by a secondary care doctor[25] in October, it is possible that an earlier cancer might have been detected but there was no evidence of metastases to biopsy at that time'.* The IPA further advised '*this was a difficult diagnosis to make and these cancers[26] often present late'.*

*Patient's Readmission to hospital, April 2020.*

54. The IPA advised the patient's consultation with the Practice on 2 April 2020 was an '*entirely appropriate consultation with no red flags in it and a sensible evaluation of the patient's reason for calling and current physical condition'.* The IPA advised the consultation of 7 April to be '*an entirely appropriate consultation'*. The IPA advised the Practice had given '*safety netting advice'* with reasoning. The IPA advised *'it would be entirely appropriate for a patient known to the hospital under such circumstances to present directly to the Emergency Department'*. The IPA advised that at the time of the consultations towards the end of March - April 2020 admission did not seem necessary to the Practice. The IPA advised that six days passed between the patient contacting

[25] Secondary care refers to services provided by health professionals who generally do not have the first contact with a patient. Primary care services provide the first point of contact in the healthcare system, including general practice.

[26] Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs

the Practice and going to the ED, however the IPA advised the patient did not contact the Practice during that time.

**Complainant's Response to the Draft Report**

55. The complainant believes that it would have been more reasonable for the GP Practice to assume that the patient's symptoms were related to a return of the pleural effusion caused by adenocarcinoma.

56. The complainant believes that the GP Practice should have made an earlier referral to Dermatology and that the Practice misdiagnosed the condition.

57. The complainant explained that he believes the GP Practice should have organised an x-ray on receipt of the patient's second call on 2 April 2020.

58. The complainant was present during each of the patient's calls to the GP Practice and disputes this. He recalled that on each occasion the patient was expressly told not to go to the ED due to the risks presented by Covid-19. It is noted in the patient's medical reports that she had a direct line to the hospital and that she should use it if her symptoms worsened.

59. The complainant explained that the patient had a telephone triage with the Practice on 7 April 2020 with, according to his notes, a further call on 8 April 2020. He said this was after the patient tried unsuccessfully for an intervention from the Respiratory Team. The complainant explained the Team previously advised that the patient should not attend the ED but should instead contact her Primary Care team. The complainant's recollection of the telephone triage on 7 and 8 April 2020 was that the patient was expressly told not to go to the ED due to the risks presented by Covid-19.

60. The complainant explained that the accounts from the GP Practice about the telephone calls which preceded the patient's hospital readmission in April 2020 make no reference to the diagnosis of Stage 4 adenocarcinoma in March 2020. He believes that the advice and treatment provided appears to disregard the

most likely cause of the symptoms, that is pleural effusion caused by adenocarcinoma.

61. The complainant explained that no accurate diagnosis was made during four examinations of the patient by the Practice during May 2019. Due to the extreme pain she was experiencing, the patient attended the ED on Sunday 31 May 2019, without a referral by the Practice. The complainant does not believe that further investigations were organised appropriately by the Practice. The patient's family did not provide any additional information or evidence that would cause me to not accept the IPA's advice.

62. The complainant raised a question about the introduction of the steroid card. He queried if it had been in place at the time of the patient's illness, would the Practice and the Dermatology team have been in more regular dialogue with each other. This cannot be determined, and I have no additional information which would be able to either confirm or deny this.

63. The complainant noted his surprise that the report found no record of any interaction between the patient and the Practice between 22 October 2019 and 10 January 2020. The complainant explained that apart from the ongoing treatment for Pemphigoid, the patient had a pronounced cough late in the evenings throughout December 2019. The complainant believed the patient contacted the GP before 16 January 2020. The medical notes from the Practice document several consultations with the patient between 22 October 2019 and 10 January 2020. However, they refer to ongoing blood tests, her skin condition, and other tests the patient had. The complainant stated there was an opportunity for the Practice to refer the patient for an X-ray on 16 January 2020, or 23 January 2020, rather than the eventual referral on 11 February 2020. I appreciate the complainant's concern. However, I cannot find any evidence that would lead me to find that the Practice should have referred the patient earlier than February 2020.

**Analysis and Findings**

*Referral to a dermatologist*

64. The complainant said the Practice could have referred the patient to a dermatologist sooner. Records show that the patient presented to the Practice with a mouth ulcer and a boil in her groin on 8 May 2019. The Practice treated these with difflam and fucidin respectively. The patient presented to the Practice with a sore throat on 14 May 2019 and the Practice prescribed penicillin. The Practice prescribed flucloxacillin to the patient on 23 May when she presented to the Practice with torn skin. The Practice recorded the symptoms as cellulitis. The Practice took a blood sample on 29 May 2019 and sent it for analysis. The IPA concluded '*early consultations seem proportionate and include clear safety netting. Trying second line antibiotics was not unreasonable'.* The Practice referred to NIPC's Guidance, which document offering *'an antibiotic for cellulitis'*. The Practice noted on 8 May that the patient would be reviewed if symptoms were not settled or if further lesions appeared. The Practice did accept it could have referred earlier but did not believe it necessarily should have.

65. The IPA advised on 28 May 2019 further investigations were organised appropriately. The IPA advised it would have been '*highly inappropriate'* for the Practice to refer the patient to a dermatologist between 8 May 2019 and 2 June 2019 when she attended the ED. I accept this advice. I acknowledge the complainant's comment that he finds it hard to accept the IPA's advice. I appreciate how difficult it is for the complainant to receive this advice. However, I cannot find any evidence that would lead me to question the advice provided. Having weighed up the evidence, I do not uphold this element of the complaint.

*Management of the patient's steroid medication*

66. The complainant said the patient's continuous use of steroids meant the patient was unable to receive either chemotherapy or immunotherapy. The complainant also said the patient's steroid usage weakened her immune system. I note the IPA's advice '*Although responsible for their own prescriptions, GPs have little choice but to follow the instruction of the specialist team because one person (the expert) needs to make the clinical decisions and direct treatment'.*

67. The IPA advised that the GP did not provide the patient with an information leaflet on prednisolone or a steroid card. I note the Practice informed the complainant and apologised to him in its letter of 18 May 2020. The Practice informed us it introduced a steroid policy since this complaint. The National Patient Safety Alert issued by the Health & Social Care Board on 13 August 2020, recommends that all eligible patients prescribed (or initiated on) steroids, where necessary, are issued a Steroid Emergency Card. This was outlined in the "Guidance for the prevention and emergency management of adult patients with adrenal insufficiency". The GP Practice developed its own steroid policy in line with this alert. This involves issuing patients on high dose and long-term steroid medications a blue card to indicate their steroid medication to medical staff should they become ill or incapacitated. Although this would not have brought any notable benefit for the patient in this case, I welcome this learning.

68. I am satisfied the Practice prescribed steroids as directed by the dermatology team. I accept the IPA's advice that without steroids, the symptoms of the patient's pemphigoid would have increased in severity. Based on the evidence available to me, I do not uphold this element of the complaint.

*Diagnosis of patient's cancer*

69. The complainant believed the Practice could have referred the patient for further testing that would have identified her cancer. The Practice explained how it treated the patient's respiratory symptoms. It explained it referred the patient for two chest x-rays in October 2019 and February 2020. The results of the October 2019 x-ray gave no cause for concern. The Practice noted the x-ray in February 2020 may have generated a red flag referral had the patient attended[27]. The Practice referred to NICaN's guidance and noted the patient's symptoms did not meet the threshold for referral. I accept the IPA's advice '*I am not convinced that, despite the patient being a smoker, the GPs should have treated her symptoms with a high index of suspicion'*.

[27] There is no record of an x-ray taken in February 2020 in the patient's records and the Practice assume that she did not attend her appointment.

70. The NICaN guidelines suggest doctors refer patients urgently for a chest x-ray if a patient presents with any of the symptoms it lists. The IPA advised the patient exhibited a number of the listed symptoms (dyspnoea, chest signs; hoarseness and cough) and explained that the Practice referred the patient for a chest x-ray in October 2019 and February 2020. However, the patient did not attend for x-ray before her ED attendance on 23 February 2020.

71. I accept the IPA's advice that the Practice followed NICaN guidelines. I note the Practice referred the patient for two x-rays. I note that the Practice closely monitored the patient's bloods, and I am satisfied the care and treatment the Practice provided to the patient was appropriate. Based on the evidence available to me, I do not uphold this element of the complaint.

*Patient's Readmission to hospital, April 2020.*

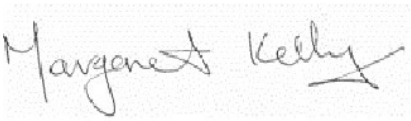
72. The complainant believed the Practice could have been more proactive in readmitting the patient to hospital in April 2020. I note the patient had two consultations with the Practice between her discharge from hospital on 17 March 2020 and her re-admittance to hospital via the ED on 13 April 2020. I note that the Practice did not feel a re-admittance to hospital was necessary and instead treated the patient's symptoms with antibiotics. I note the Practice advised the patient to attend the ED if her symptoms worsened. I accept the IPA's advice that the two consultations with the Practice were '*entirely appropriate'*. The IPA also advised that '*safety netting advice was given with reasoning.'*

73. I am satisfied the consultations with the Practice were reasonable and it provided appropriate safety netting advice. I sympathise with the patient and acknowledge the stress she experienced by being admitted to hospital via the ED. Based on the evidence available to me, I do not uphold this element of the complaint.

## CONCLUSION

74. This complaint is about the care and treatment provided to the patient between June 2019 and May 2020. I do not uphold this complaint for the reasons outlined in this report. I note the Practice acknowledged and apologised for the lack of a steroid card. I note it has since introduced a steroid policy and I welcome this learning.

75. I recognise the distressing situation the complainant was in with his wife suffering. I am aware the patient sadly passed away in May 2020. I offer through this report my condolences to the complainant for the loss of his wife.



**MARGARET KELLY**
**Ombudsman** **21 February 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.