Northern Ireland
Public Services
Ombudsman

Investigation of a complaint against a GP Surgery

Report Reference: 202002854

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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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Appendix 1 – The Principles of Good Administration

Case Reference: 202002854

Listed Authority: A GP Surgery

SUMMARY

This complaint was about care and treatment a GP Surgery provided to the complainant's brother (the patient).

The patient attended a GP appointment on 7 March 2022 with *'numbness'* in his left arm. The GP diagnosed the patient with a trapped nerve and prescribed Ibugel[1]. The patient telephoned the Surgery the following day, on 8 March 2022, and reported to a receptionist that the numbness in his arm had worsened and his left leg was '*trailing*'. A GP provided advice to the patient (through the receptionist) and prescribed diazepam[2]. The patient attended hospital on 9 March 2022 where tests indicated he suffered five strokes[3] over the previous seven days. The complainant's concerns related to actions the Surgery took on 7 and 8 March 2022. He believed that had the Surgery taken appropriate action, it may have minimised the damage caused to the patient's leg control.

The investigation found GP A failed to document his consultation with the patient on 7 March 2022. In the absence of this record, I could not be satisfied GP A conducted appropriate tests prior to reaching this diagnosis. The investigation also found GP A failed to carry out additional observations, including a blood pressure check, to rule out stroke. The investigation also established that by not speaking directly to the patient, GP B did not adequately assess the patient's condition and take account of his history. I considered these failures in care and treatment.

I recommended the Surgery apologise to the complainant and patient for the injustice they sustained. I also recommended actions for the Surgery to take to prevent recurrence of the failings identified.

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[1] Ibugel is an anti-inflammatory painkiller applied to, and absorbed through, the skin.

[2] Commonly used to treat a range of conditions, including anxiety, seizures, alcohol withdrawal syndrome, muscle spasms, insomnia, and restless legs syndrome.

[3] If the blood flow to the brain is interrupted, brain cells can get damaged because they aren't getting the oxygen supply they need. A stroke can affect a person in different ways, depending on which part of the brain hasn't received the blood supply. This can affect speech, as well as thinking and movement.

THE COMPLAINT

1. This complaint was about care and treatment the Surgery provided to the complainant's brother (the patient) in March 2022.

Background

2. On 7 March 2022 the patient telephoned the Surgery and reported *'numbness and loss in left arm' for 4/7*[4] *no shoulder pain neck a little sore*'. Later that day he attended a face-to-face appointment with a locum GP (GP A) who examined him, diagnosed a trapped nerve[5], prescribed ibuprofen gel, and gave him exercises to do.

3. At 17.45 on 8 March 2022 the patient telephoned the Surgery and spoke to the receptionist. He advised her of '*worsening arm numbness'* and a *'trailing left leg'*. The receptionist spoke to GP B who prescribed the patient diazepam. The patient agreed to take the diazepam but said he was *'in a bad way'*. Following a further conversation with GP B, the receptionist advised the patient that the GP felt diazepam should help. She also advised that if things did not '*settle down'*, the patient should contact the Surgery the next day or he may need to attend ED.

4. Later that day the patient called an ambulance which took him to the South West Acute Hospital's ED. On 9 March 2022 tests indicated that the patient had suffered five strokes in seven days.

5. On 27 April 2022 the complainant raised concerns with the Surgery regarding care and treatment it provided to the patient on 7 and 8 March 2022. The Surgery responded to him on 23 May 2022.

Issue of complaint

6. I accepted the following issue of complaint for investigation:

[4] For four days.
[5] A pinched nerve occurs when too much pressure is applied to a nerve by surrounding tissues, such as bones, cartilage, muscles or tendons. This pressure can cause pain, tingling, numbness or weakness.

Whether the care and treatment provided by the GP Practice to the complainant between 7 March 2022 – 8 March 2022 was adequate, appropriate and in accordance with guidance and relevant standards.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

    - **A General Practitioner (GP)** MBBS BSc FRCGP ILM5 MSc (med ed)- a senior GP with a special interest in regulatory medicine and complaints.

    I enclose the IPA's advice at Appendix three to this report. I outlined my consideration of the advice in my analysis and findings below.

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

Relevant Standards and Guidance

10. To investigate complaints, I must establish a clear understanding of the standards, both of 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[6]:

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[6] These principles were established through the collective experience of the public services ombudsmen affiliated to the

- The Principles of Good Administration

11. 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:

    - The General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance);
    - The General Medical Council's Good practice in prescribing and managing medicines and devices, published April 2021 (the GMC Prescribing Guidelines);
    - The National Institute for Health and Care Excellence (NICE): Stroke and transient ischaemic attack (NG 128), May 2019 (NICE Guideline);
    - National Health Service FAST Advice, undated (FAST Advice);
    - The National Institute for Health and Care Excellence (NICE) Clinical Knowledge Summary Neck pain - cervical radiculopathy: Scenario: Management (NICE CKS), 2018; and
    - The British Medical Journal's and Pharmaceutical Press British National Formulary 83, March to September 2022 (BNF).

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

12. 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.

13. 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

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recommendations. I have carefully considered the responses I received.

THE INVESTIGATION

Whether the care and treatment provided by the GP Practice to the complainant between 7 March 2022 – 8 March 2022 was adequate, appropriate and in accordance with guidance and relevant standards.
In particular, this will consider:

- **The care and treatment the Practice provided to the patient on 7 March 2022; and**
- **The care and treatment the Practice provided to the patient on 8 March 2022**

Detail of Complaint

14. The complainant raised a concern that GP A and GP B did not take appropriate actions based on the symptoms the patient reported on 7 and 8 March 2022. The complainant believed GP A did not carry out a blood pressure check on the patient. He also believed that GP B's assessment of the patient '*by a third party was totally unprofessional'.*

15. The complainant said that had both GPs correctly diagnosed the patient, he may have received earlier treatment. He believed this may have minimised the damage caused to the patient's leg control and significant mental distress he experienced.

Evidence Considered

Policies/Guidance

16. I considered the following policies and guidance:
    - The GMC Guidance;
    - The GMC Prescribing Guidelines;
    - NICE Guidance;
    - NICE CKS;
    - NHS FAST Advice (NHS); and
    - BNF.

The Surgery's response to investigation enquiries

17. The Surgery stated it held a face-to-face meeting with the complainant and the patient in the Surgery on 8 June 2022. It shared details of the failings it identified in its in processes through the investigation of the complaint. The failings were that GP A omitted to record the face-to-face consultation he had with the patient on 7 March 2022. Also that GP B did not speak directly to the patient on 8 March 2022. This may have helped reduce any errors in communication or lack of clarity.

18. The Surgery said GP A wrote to both the complainant and the patient and apologised for any distress he caused.

19. The Surgery stated that both GPs considered stroke as a possible diagnosis. GP B also shared appropriate safety netting advice with the patient regarding attending the local ED if necessary.

20. The Surgery stated it did not document in the records that it advised the patient his symptoms could be stroke related.

21. The Surgery stated it held a Practice Meeting on 8 June 2022 and undertook a Significant Event Analysis (SEA)[7]. This identified possible procedural failings:

    - A missed opportunity to document the consultation with Dr A;
    - Concerns with improved communication with patients seeking advice on the emergency line between 5.30-6 pm; and
    - Explanations provided to those patients advised to attend the ED.

22. The Surgery stated GPs see patients between 17.30 and 18.00 and also carry out telephone triage between those times. It now prioritises these calls. It also updated the automated telephone message to advise patients to call 999 if they experience symptoms of a stroke.

[7] Significant Event Analysis (SEA) is a technique used in general practice to reflect on and learn from individual cases to improve the quality of acre overall. It is usually undertaken to prevent recurrence of an adverse event. SEA involves taking a proactive approach and using the information accrued during and after a significant event to introduce new measures to try to prevent one occurring in the first place.

Relevant Practice records

23. I enclose extracts from the relevant medical records at Appendix four to this report.

Relevant Independent Professional Advice

24. The IPA provided advice about the care and treatment the Surgery provided to the patient. I enclose the full IPA received at Appendix two to this report.

Analysis and Findings

Care and Treatment provided on 7 March 2022

25. The patient telephoned the Surgery on 7 March 2022 complaining of numbness and loss of feeling in his left arm. He attended an appointment with GP A later that day.

26. I am surprised and concerned that GP A did not create a record of his consultation with the patient on 7 March 2022. I refer to Standard 20 of GMC Guidance which requires clinicians to '*make records at the same time as the events you are recording or as soon as possible afterwards'.* The absence of this record prevents me from establishing what symptoms the patient reported, details of GP A's examination, the diagnosis reached and reasons for it, and the treatment provided. Furthermore, a lack of appropriate records limits the availability of clinical information for staff who subsequently become involved in the patient's ongoing care and treatment. This is particularly relevant in this case, given that the patient contacted the Surgery the following day. I consider that by not documenting a record of the consultation on 7 March 2022, GP A did not act in accordance with Standard 20 of the Guidance. I consider the absence of this record a failure in the care and treatment of the patient.

27. As outlined, the absence of this record prevents me from establishing what symptoms the patient reported to GP A. In his response to investigation enquiries, GP A said he recollected the patient presented with '*numbness and pain to the left arm and left side of neck, and an altered feeling in the fingers*.' This somewhat agreed with the patient's reported symptoms. Therefore, I am satisfied the patient presented with numbness and loss of feeling in his left arm.

28. The IPA advised that given these reported symptoms, it was reasonable for GP A to consider stroke as a diagnosis. I refer to the NICE Guidance relating to rapid recognition, symptoms, and diagnosis of stroke. It states that in people with a sudden onset of neurological[8] symptoms, clinicians should employ a validated tool such as FAST (Face Arms Speech and Time) to screen for a diagnosis of a stroke or TIA[9].

29. In his response to investigation enquiries, GP A recollected that he did consider FAST during his consultation with the patient. He said the patient was '*FAST negative and had pain'*, which was '*not usually a sign of a stroke'*. However, the patient did not recollect GP A asking him the four questions FAST advice recommends. He recalled that GP A only asked him to remove his jacket and felt his arm. In the absence of an appropriate record, I cannot be satisfied GP A appropriately considered FAST guidance.

30. The complainant also raised a concern that GP A did not take the patient's blood pressure. The IPA advised clinicians should be aware that a person may have ongoing focal neurological[10] deficits despite a negative FAST test. Therefore, to exclude stroke, the NICE guidance recommends clinicians should consider other examinations. One of these is to assess vital signs including blood pressure, heart rate, oxygen saturation, and temperature. The IPA advised that given the patient's symptoms, and because GP A said he considered the FAST test, he should *'at least'* have carried out a blood pressure and pulse check to support the low risk of stroke.

31. I note in its correspondence with the patient, the Surgery informed him it did not consider a blood pressure check necessary given he reported shoulder pain. However, the Surgery stated to this office that GP A considered FAST Guidance (and therefore, risk of stroke) during the consultation. Therefore, in this case, I would have expected GP A to carry out additional observations,

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[8] A neurological disorder is any disorder of the nervous system.
[9]A Transient Ischaemic Attack (TIA) is the disruption in blood supply resulting in a lack of oxygen to the brain. This can cause sudden symptoms similar to a stroke, such as speech and visual disturbance, and numbness or weakness in the face, arms and legs.
[10] Focal Neurological deficit - impairments of nerve, spinal cord, or brain function that affects a specific region of the body, e.g. weakness in the left arm,

including a blood pressure check, to rule out stroke. However, there is no evidence to suggest he did so. I consider that by not doing so, GP A failed to act in accordance with NICE guidance. I am satisfied this represents a failure in care and treatment provided to the patient.

32. For the reasons outlined, I have identified failures in the care and treatment the Surgery provided to the patient on 7 March 2022. I uphold this element of the complaint. I am satisfied these failings caused the patient to sustain the injustice of a loss of opportunity to have his symptoms correctly diagnosed and to receive medical treatment in a timely manner. I also consider it caused the patient to experience uncertainty and concern.

Care and treatment provided on 8 March 2022

33. The complainant said the patient telephoned the Surgery's urgent call line at 17.45 on 8 March 2022 and spoke to a receptionist. The receptionist, in turn, spoke directly with GP B and subsequently relayed information obtained from the GP to the patient.

34. The Surgery provided a telephone recording of the patient's conversation with the receptionist. The symptoms the patient reported to the receptionist during their conversation included '*no power in the left arm; trailing the left leg'* and that he felt '*that something was not just right'.* The receptionist subsequently spoke to GP B. However, GP B did not document her interaction with the receptionist. Therefore, I cannot determine what information the receptionist provided to GP B or what advice GP B asked her to pass onto the patient.

35. I again refer to Standard 20 of GMC Guidance which requires clinicians to '*make records at the same time as the events you are recording or as soon as possible afterwards'.* I consider that by not documenting a record of the advice provided on 8 March 2022, GP B did not act in accordance with Standard 20 of the Guidance. I consider the absence of this record a failure in the care and treatment of the patient.

36. In its response to enquiries, the Surgery advised that GP B considered a stroke diagnosis for the patient. However, the records do not evidence this. The IPA

advised that instead, GP B '*favoured*' muscular pain as '*the most likely cause'* for the patient's symptoms.

37. It is of concern to me that given the symptoms reported, and if GP B did consider stroke as a diagnosis, she did not, at minimum, speak to the patient on the telephone. Instead, she asked a receptionist to pass on her advice.

38. I refer to Standard 15 of GMC Guidance which says you must provide a good standard of practice and care. Standard 15 (a) states if you assess diagnose or treat patients you must '*adequately assess the patient's conditions, taking account of their history and where necessary examine the patient'*.

39. I consider that by not speaking directly to the patient, GP B did not take the opportunity to adequately assess the patient's condition and take account of his history. Therefore, based on the evidence available, I cannot be satisfied GP B acted in accordance with Standard 15 of the GMC Guidance. Given the absence of a record of GP A's consultation the previous day, I consider it was especially important for GP B to speak with the patient. I am satisfied this represents a failure in GP B's care and treatment of the patient. I uphold this element of the complaint.

40. While not part of this complaint, the IPA identified a concern regarding the Surgery's prescription of diazepam for the patient on 8 March 2022. She advised that GMC Prescribing Guidelines classifies diazepam as a controlled drug[11]. Therefore, if GP B felt the patient had a diagnosis of muscular pain, she should have reviewed the patient directly. I would ask the Surgery to take this into consideration when prescribing such medication in future.

41. I consider the failures identified caused the patient to sustain the injustice of a loss of opportunity to have his symptoms properly considered on 8 March 2022. This loss of opportunity extends to GP A and B making an earlier diagnosis and therefore the patient potentially receiving more timely treatment for his strokes. Although it is not possible for me to determine whether the patient would have had a different outcome, had the failures not occurred, I acknowledge the

[11] Controlled drug – Controlled medicines are prescribed only when other medicines (that are not controlled) cannot help with a medical problem.

uncertainty the complainant and the patient will always have in relation to this.

CONCLUSION

42. I received a complaint about care and treatment the Surgery provided to the complainant's brother on 7 and 8 March 2022. The investigation found GP A failed to record his consultation with the patient on 7 March 2022. The investigation also found GP A failed to carry out additional observations, including a blood pressure check, to rule out stroke. I consider these to be failures in care and treatment.

43. The investigation also found that GP B should have spoken to the patient to inform her diagnosis when he telephoned the Surgery on 8 March 2022. I consider this a failure in care and treatment.

44. I am satisfied these failings caused the patient to sustain the injustice of the loss of opportunity to be properly diagnosed and treated in a timely manner. I also consider they caused the complainant and patient to experience uncertainty and upset.

45. I welcome that the Surgery carried out a Significant Event Analysis which identified several procedural failings. I am pleased it recognised the need for direct telephone advice with a GP in the event of an emergency call of a clinical nature. I am also pleased the Surgery put in place a new auto-attendant message for suspected strokes between the hours of 17.00- 18.00. I note this message includes a GP mobile number for emergency advice.

Recommendations

46. I am pleased the Surgery provided the complainant with a written apology. I note it focused primarily on the clarity of the advice provided to the patient about attending ED. However, this investigation identified additional failings in the care and treatment provided to the patient. Therefore, I recommend that within **one month** of the date of this report, the Surgery provides the patient and complainant a written apology, in accordance with NIPSO's 'Guidance on issuing an apology' (August 2019), for the injustice caused as a result of the

failures identified.

47. I also recommend, for service improvement and to prevent future reoccurrence, that the Surgery:

- Shares the findings of this report with relevant staff to allow them to reflect on the failings identified;
- Provides training to relevant staff on the importance of documenting consultations, and advice provided to patients regarding their care and treatment, in accordance with GMC Guidance; and
- Provides training to staff on the importance of assessing patients in accordance with Standard 15 of the GMC Guidance and the NICE Guidance.

48. I recommend the Surgery implements an action plan to incorporate these recommendations and provides me with an update within **three** months of the date of my final report. The Surgery should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

MARGARET KELLY
Ombudsman **July 2024**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.