Investigation of a complaint against a GP Practice

Report Reference: 202003438

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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: 202003438

Listed Authority: A GP Practice

SUMMARY

The complainant raised concerns about the care and treatment the Practice provided to her late husband (the patient) during the period June 2015 – August 2022.

The investigation established the Practice's management of the patient's leg pain for the period June 2015 – October 2015 was appropriate and in accordance with good practice. It further established the Practice's management of the patient's care on 14 June 2018 was also appropriate in accordance with good practice. The investigation also established the Practice conducted its consultation with the patient on 1 August 2022 appropriately.

However, the investigation identified examples of poor record keeping by the Practice. While I did not identify maladministration in this regard, I have asked the Practice to reflect on the IPA's observations about record keeping.

I acknowledge the deterioration in the patient's condition was a shock for the complainant and her family. I offer through this report my condolences to the complainant for the loss of her husband. The Practice accept the findings of my report.

THE COMPLAINT

1. The complainant raised concerns about the care and treatment the Practice provided to her late husband (the patient) over several months in 2015, in June 2018 and in August 2022.

Background

2. The patient attended the Practice in 2015 complaining of discomfort and pain in his legs.

3. The complainant telephoned the practice on 14 June 2018 as the patient was unwell and looked a '*strange yellow colour*'. A GP attended the patient in his home. The GP diagnosed the patient with a urine infection and prescribed trimethroprim[1]. The complainant subsequently contacted an Out of Hours (OOH) service. The OOH Doctor diagnosed the patient with '*acute sepsis*' and the patient went into hospital for treatment. The patient was in hospital for 10 days.

4. Three years later in 2021, the patient received a Pulmonary Fibrosis[2] (non-industrial) diagnosis. The patient was due to go on holiday to London on 4 August 2022. Concerned the patient was not well enough to make to journey, the complainant arranged an appointment with the Practice for 1 August 2022.

5. The patient went to London as planned but deteriorated after 24 hours. The patient went to hospital by emergency ambulance. Sadly the patient passed away in hospital on 8 August 2022.

Issues of complaint

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

   Issue 1: Whether the Practice provided appropriate care and treatment to the patient between June 2015 and October 2015 in relation to their leg pain.

   Issue 2: Whether the Practice provided appropriate care and treatment to the patient on 14 June 2018 regarding their urinary symptoms.

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[1] An antibiotic. It's used to treat and prevent urinary tract infections

[2] A form of interstitial lung disease that causes scarring in the lungs

Issue 3: Whether the Practice provided appropriate care and treatment to the patient on 1 August 2022. In particular, this will consider:

- **Advice provided regarding the patient's upcoming travel plans; and**
- **The outcome of the consultation**

INVESTIGATION METHODOLOGY

7. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues the complainant raised.

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 with 47 years' experience (IPA)

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

9. The information and advice which informed the findings and conclusions are included 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. In order 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[3]:

    - The Principles of Good Administration

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

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).

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 recommendations.

THE INVESTIGATION

Issue 1: Whether the Practice provided appropriate care and treatment to the patient between June 2015 and October 2015 in relation to his leg pain.

Detail of Complaint

14. The complainant said the patient attended a named GP at the Practice in early March 2015 '*complaining of discomfort and pain'* in his legs but '*was getting nowhere.'* The patient's chiropodist told him '*there was something serious going on as his toes were turning black.'* The chiropodist said they would write to the Practice about their concerns.

15. The patient attended a different GP by choice, accompanied by the complainant. The GP referred the patient to the local Health and Social Care Trust's Vascular Clinic. The patient underwent a bifemoral by-pass[4] on 24 March 2016.

[4] A form of vascular disease bypass surgery that surgeons perform in your abdomen (belly). It's an open surgery that creates a new route (bypass) for blood to flow around narrowed or blocked portions of your arteries. This improves blood flow to your legs.

16. The complainant felt the named GP failed to identify the seriousness of the patient's condition.

Evidence Considered

Legislation/Policies/Guidance

17. I considered the following guidance:
    - The GMC Guidance.

The Practice's response to investigation enquiries

18. The Practice stated: the patient had long standing issues with both legs, especially his left. The Practice consulted with him in June 2015 when he complained about leg pain - especially in bed, and that it improved when he got up and walked around. The Practice saw the patient again on 10 July 2015 with an infected toe in the left foot that required antibiotics and dressings. It consulted with him again on 27 July 2015 to address pain and swelling in both lower legs. The Practice conducted blood tests and referred the patient to Altnagelvin Area Hospital for a doppler scan[5] to exclude a clot in the left leg. This was negative.

19. The Practice stated: it then saw the patient on 22 September 2015 for suspected cellulitis in his left leg, having previously noted this potential condition on 19 August 2015. The patient underwent a further doppler scan on 6 October 2015 which confirmed impaired blood flow in the left leg. The Practice referred the patient to Vascular Surgery as urgent on 8 October 2015.

Relevant Practice records

20. The investigation considered the patient's GP records from January 2015 to October 2015 inclusive.

Relevant Independent Professional Advice

21. The IPA advised '*there is no specific guidance'* dealing with how to approach and manage leg pain. He advised good practice is for GPs to initially examine how the patient walks. A GP should then talk with the patient to ascertain the nature and location of any pain, as well as its duration and impact on the patient's '*normal functioning*'.

[5] This is a non-invasive test that can be used to measure the blood flow through your blood vessels.

22. The IPA advised it is then good practice for a GP to examine the patient. He advised this may include:

- Observation – noting any difference between the legs such as size, colour, swelling etc. This will also include variation noted from the expected norm.
- Physical examination – manual examination, assessment of movement, assessment of circulation including examining pulses, neurological assessment of sensation to light and firmer touch and also to pain, discriminate between sharp and blunt and assessment and assessment of muscle power and tone.
- Examination may also include examination of movement of the hip to determine whether the pain could be emanating from the hip itself or from the back.

23. The IPA advised if a GP has concerns about potential circulation issues, good practice is to refer the patient to hospital for a Doppler examination, or to a vascular specialist. He advised a GP can start a patient on vasodilator[6] medication in the interim.

24. The IPA firstly advised the patient's history of leg pain appears to have started well before the consultation in June 2015 as the patient's medical records document consultations in January and February 2014 regarding leg pain.

25. The IPA advised the records show the patient presented to the GP on 17 June 2015 stating that he had pain in the left shin that was worse at night. He explained he was not sleeping, and had to get up and walk around, which eased things. He advised the records state '*Legs – NAD (nothing abnormal demonstrated) -? Due to OA spine'.* He explained this means the suspected cause was osteoarthritis of the spine. At this time the GP prescribed Amitriptyline[7] 10mg for the patient to take at night. The IPA advised '*this was a reasonable course of action*' in the circumstances.

26. The IPA advised the patient re-presented on 10 July 2015 with an infection in his left toe with pus coming from the medial (inner) aspect of his small toe. He advised the GP prescribed the patient with antibiotics (flucloxacillin), took a swab, and ordered – blood tests. In addition the nurse arranged to follow up with the patient. The IPA advised '*this was a reasonable course of action'.*

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[6] A medication that opens your blood vessels.

[7] A drug used to treat chronic pain syndrome, anxiety, and insomnia.

27. The IPA advised on 27 July 2015 the patient presented with pain and swelling in the left lower leg with mild pitting oedema. He advised the GP noted pretibial tenderness and pitting oedema. The IPA explained the GP made a tentative diagnosis of cellulitis, with a possibility of deep vein thrombosis (DVT) to be ruled out by a blood test (D-Dimer). He advised the patient underwent a blood test the following day at the surgery and the GP prescribed Rivaroxaban[8]. The patient subsequently underwent the D Dimer in Hospital, which ruled out DVT. The IPA advised the Practice subsequently contacted the patient to advise to stop taking Rivaroxaban.

28. The IPA advised these June/July 2015 consultations all related to problems with the patient's left leg. However, it does not appear from the notes that the patient complained of the same symptoms on each occasion nor that the totality of the symptoms pointed only in the direction of a circulatory issue. He advised it is not uncommon in general practice to see situations of this nature. The IPA advised '*the action taken in response to the 27 July consultation was reasonable.'*

29. The IPA advised on 22 September 2015 the patient presented to the Practice an additional time. He advised the GP records document '*left lower leg looks slightly red – cool to touch – no cellulitis.' The IPA advised the Practice re-prescribed* mild steroid cream. He advised there was insufficient detail in the GP records to enable him to determine if this action was sufficient. However, he ultimately advised that the care and treatment the Practice provided to the patient in 2015 was reasonable and appropriate.

30. The IPA advised on 8 October 2015 the Practice referred the patient to a vascular clinic, upon receipt of a report from a podiatrist in the Western Health and Social Care Trust. The IPA noted a vascular surgeon subsequently diagnosed the patient with chronic occlusive aorto-ileac disease, requiring surgery in December 2015. However he advised '*there is no suggestion or certainty that any signs or symptoms would necessarily have been identifiable several months earlier before the consultation [with the vascular surgeon], as the diagnosis was arrived at by scan'.* The IPA further advised *'I have seen no evidence in the records to suggest that this conclusion should have been reached, or the referral made earlier.'* The IPA ultimately advised *'The GP referred promptly and urgently, which was the correct course of action.'*

[8] A drug used to prevent or treat blood clots.

Analysis and Findings

31. I note the complainant's concern that during the relevant period, the Practice failed to identify the seriousness of the patient's condition. I also note the Practice denied any failures on its part.

17 June 2015

32. Having reviewed the patient's GP records for this consultation, I accept the IPA's advice, set out above, that the care and treatment the Practice provided to the patient was reasonable, appropriate and in line with good practice. In particular, based on the IPA's advice, I am satisfied the GP's examination of the patient was reasonable, given the symptoms the patient presented with. I am also satisfied the GP's decision to prescribe 10mg of Amitriptyline was reasonable. Having considered the IPA's advice, I am satisfied there was no additional action the Practice should have taken at that time.

10 July 2015

33. On this occasion the patient received treatment for an infected toe. Having reviewed the patient's GP records for this consultation, I accept the IPA's advice that the care and treatment the Practice provided was reasonable in the circumstances. In particular, on foot of the IPA's advice, I am satisfied the GP arranged reasonable tests and investigations to determine the cause of the patient's symptoms. I am further satisfied the GP prescribed appropriate medication to treat the infection, and the nurse requested a follow-up appointment with him. Having considered the IPA's advice, I am satisfied there was no further action the Practice should have taken at that time.

27 July 2015

34. On this occasion the patient presented with swelling and mild pitting oedema. I reviewed the patient's GP records for this consultation, and the IPA's advice, which I have set out in detail above. Having done so, I am satisfied the Practice provided reasonable and appropriate care and treatment to the patient. In particular, on foot of the IPA's advice, I am satisfied the GP conducted appropriate investigations to determine a primary, and potential differential diagnosis, of the patient's symptoms. I am further satisfied the GP conducted appropriate further tests the next day to confirm its diagnosis. I am also satisfied the GP's decision to prescribe Rivaroxaban was appropriate in the circumstances.

35. I accept the IPA's advice that the range of concerns the patient presented with in June-July 2015 did not, when considered together, '*point*' towards '*only*' a circulatory concern. On that basis, I am satisfied there was no additional action the Practice should have taken at that time.

22 September 2015

36. I reviewed the patient's GP records for this consultation. The GP recorded '*left lower leg looks slightly red – cool to touch – no cellulitis.'* The GP prescribed a mild steroid cream.

37. I note the IPA's advice that the GP's standard of record-keeping for this consultation was insufficient and this impacted his ability to determine the suitability of the care and treatment the GP provided at this specific consultation. However, I note the IPA was ultimately able to advise that the overall care and treatment the Practice provided to the patient in 2015 was reasonable and appropriate. Insufficient record-keeping has the potential to impact future care and treatment, as subsequent clinicians are unable to determine exactly what took place. However, given the subsequent care and treatment the patient received, and the passage of time since the GP made the record, I am satisfied the GP's record keeping did not impact the patient or cause him injustice on this occasion. In reaching this conclusion, I note the IPA did not identify any impact on, or injustice to, the patient. I am satisfied, therefore, the GP's lack of records was not sufficiently seriously to constitute a service failure, or a failure in care and treatment. Nonetheless, I strongly encourage the Practice to reflect on the IPA's observation regarding the importance of record-keeping in line with GMC Standards.

8 October 2015

38. I note on 8 October 2015 the GP urgently referred the patient to a vascular clinic, following receipt of a letter from a podiatrist. Having reviewed the patient's GP records, I accept the IPA's advice that the care and treatment the GP provided to the patient in doing so was reasonable and appropriate. In particular, I am satisfied the GP's decision to make the referral was appropriate, and that he made it with sufficient urgency, in the circumstances. I accept the IPA's advice there is nothing in the patient's GP records to suggest or infer the GP should have made this referral any earlier. I am also satisfied on this occasion there was no additional action the Practice should have taken at that time.

Summary

39. Having considered all relevant records, including the IPA's advice, I consider the care and treatment the GP Practice provided to the patient from June 2015 to October 2015 was reasonable, appropriate and in line with good practice. I accept the IPA's advice that there is '*no evidence*' to '*suggest*' the GP should have diagnosed the patient's chronic occlusive aorto-ileac disease, or referred or him to a vascular clinic, at an earlier stage. I noted limitations in the GP's record-keeping. However, I am satisfied it did not impact the patient's care and treatment. I also found the patient did not sustain an injustice as a result of this limitation.

40. On this basis I do not uphold this issue of complaint.

Issue 2: Whether the Practice provided the appropriate care and treatment to the patient on 14 June 2018 regarding his urinary symptoms.

Detail of Complaint

41. The complainant said she telephoned the Practice on Thursday 14 June 2018 because the patient was unwell and looked '*a strange yellow colour'.* The named GP attended to the patient at his home. At this stage the patient was '*worse and delirious'.* The named GP said the patient had a urine infection and prescribed trimethoprim.

42. The complainant was '*not happy*' and '*immediately*' visited her local pharmacist for advice. The pharmacist suggested phoning the hospital OOH service. The complainant and the patient attended at 18.30. The attending doctor diagnosed '*acute sepsis'* and '*quickly admitted'* the patient for treatment. The patient was in hospital for 10 days.

43. The complainant felt the named GP failed to identify the seriousness of the patient's condition.

Evidence Considered

Legislation/Policies/Guidance

44. I considered the following guidance:
    - The GMC Guidance.

The Practice's response to investigation enquiries

45. The Practice stated: the complainant contacted the Practice on 14 June 2018 to request a home visit for the patient. The complainant told the receptionist at the time she had asked a pharmacy for advice who told her to phone the GP, which she did at 10.59am. A GP saw the patient later that morning. The patient had been complaining of diarrhoea for two days so the GP prescribed anti-diarrhoea medication. The GP requested a urine sample which the Practice tested the following day (15.06.18). The Practice stated this showed signs of infection and the GP issued a prescription for antibiotics that day. It explained laboratory tests subsequently confirmed this was correct treatment.

46. The Practice stated an OOH GP subsequently saw the patient at 19.20 on 16 June 2018 due to deterioration in his condition. This Doctor referred him to hospital emergency department (ED). The Practice accepted the patient then received a diagnosis of urosepsis[9], which is a potential complication of a urinary tract infection.

Relevant Practice records

47. The investigation considered the patient's GP records dated 14 June 2018.

Relevant Independent Professional Advice

48. The IPA advised during the Practice GP's home visit on Thursday 14 June 2018 the GP noted '*diarrhoea for two days – no vomiting – on examination apyrexial (no high temperature); not dehydrated – abdomen NAD*'. He advised the GP diagnosed the patient with gastroenteritis and prescribed Loperamide[10]. The IPA advised that having reviewed the GP records and the patient's symptoms there is '*no indication*' or '*suggestion*' of urosepsis or a UTI at that time.

49. The IPA advised on the following day, 15 June 2018, the Practice noted '*medication requested – looking for something for urine infection*'. He advised the Practice performed a urine dipstick analysis, which showed '*considerable quantities of blood and protein*'. He further advised microscopy on the same day showed pus cells and organisms in the urine. The IPA advised the GP prescribed Trimethoprim, which was '*timely and appropriate in the circumstances of this case*.'

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[9] A sepsis caused by infections of the urinary tract, including cystitis, or lower urinary tract and bladder infections, and pyelonephritis, or upper urinary tract and kidney infections

[10] A drug that stops diarrhoea from any cause.

50. Regarding the complainant's position the patient appeared '*yellow*' on 14 June 2018, the IPA referred to the OOH records for 16 June 2018. He advised those records state '*skin yellow since patient has started Trimethoprim*'. He advised this suggests the patient may not have been yellow when he saw the Practice GP on 14 June 2018.

51. The IPA advised the OOH examination showed the patient '*looked yellowish*', his temperature was slightly low, his oxygen saturation was at 86% with a clear chest (normal 96%+), blood pressure was 80/60 (normal 120/80) and he was dehydrated. The IPA advised the OOH doctor referred the patient to the hospital ED with potential diagnoses of Urosepsis and/or an UTI. The IPA advised it is not uncommon for sepsis, whether related to urinary tract or otherwise, to be a sudden complication and indeed it is possible, if not likely, that sepsis was not present two days earlier.

52. The IPA advised *'in my examination of the records there is no indication of failure of care nor of following usual practice and procedure.'* This was a short episode of care consisting of one consultation and one phone call. In this instance, although not fulsome, '*I am satisfied that the records are adequate and in line with professional standard guidance.'*

Analysis and Findings

53. Having reviewed all relevant records, including the IPA's advice, I consider the care and treatment the Practice provided to the patient on 14 and 15 June 2018 was reasonable, appropriate and in line with established good practice.

54. On foot of the IPA's advice, I am satisfied the Practice arranged and conducted appropriate tests to explore the symptoms the patient presented with.

55. I acknowledge the patient's symptoms and condition developed and worsened at a quick pace following the Practice's input. However, I accept the IPA's advice this can be a feature of sepsis. I therefore also accept the IPA's advice that the diagnosis the GP made at the time they saw the patient was reasonable and appropriate.

56. I am further satisfied the medication the GP prescribed at the time was appropriate to treat the condition identified at the time.

57. I understand this was a difficult and worrying time for the patient and his family. I can understand why the complainant had questions about the care and treatment the

patient received, given the eventual sepsis diagnosis and the seriousness of that condition, where time is often of the essence. However, based on my above findings, I do not uphold this issue of complaint.

Issue three: Whether the Practice provided appropriate care and treatment to the patient on 1 August 2022.

Detail of Complaint

58. The complainant said the local Trust's Respiratory Unit diagnosed the patient with Pulmonary Fibrosis (non-industrial) in 2021.

59. The complainant said the patient was due to go to London on holiday on 4 August 2022 to visit close relatives. Concerned the patient was not well enough to make the journey, the complainant arranged an appointment with the named GP for 1 August 2022, which she and the patient attended. The patient struggled slowly, with difficulty breathing, to make his way from his car to the surgery room while the complainant went ahead and waited for him.

60. The complainant said the named GP asked the patient why he had come, to which the complainant answered, '*he's here because he wants you to make him feel good about going on holiday.*' The named GP sounded the patient with a stethoscope '*down the neck of his shirt*' and said '*not a crackle.*' She said the patient was fully clothed. The complainant felt the named GP did not sound the patient's lungs, instead sounded the top of his back. The consultation ended thereafter and the patient '*felt he was good to go.*'

61. The complainant said the patient went to London as planned but deteriorated after 24 hours. The patient went to hospital by emergency ambulance. The complainant said a hospital doctor raised a concern about a '*mass*' in the patient's '*lower left lung*' which he described as '*the nasty pneumonia*' which was '*difficult to treat'.* She explained the doctor said the patient had this for quite a while and enquired whether his GP had permitted the patient to take the journey.

62. Sadly the patient passed away in hospital on 8 August 2022. The complainant felt the named GP failed to identify the seriousness of the patient's condition.

Evidence Considered

Legislation/Policies/Guidance

63. I considered the following guidance:
    - The GMC Guidance

The Practice's response to investigation enquiries

64. The Practice stated: the complainant accompanied the patient to an appointment on 1 August 2022. The patient complained about ankle pain and said the diuretic[11] was proving ineffective. The patient complained about dyspnoea[12] on exertion, but no other new respiratory symptoms or fever. The Practice stated that although the complainant was present she did not make any comment on the patient's condition or any concerns she may have had.

65. The Practice stated: the GP performed a brief respiratory examination as this was not the main reason for attending. The GP did not find any abnormality but prescribed the patient a new inhaler, and used a placebo inhaler from his desk drawer to demonstrate how to use if effectively.

66. The Practice accepted the patient stated he was going to London, but denied the complainant made any comment on this at the time or asked any questions about the suitability of travel for the patient. The Practice stated the GP would have addressed any concerns the complainant might have had.

Relevant Practice records

67. The investigation considered the patient's GP records for 1 August 2018.

Relevant Independent Professional Advice

68. Regarding suitability for a flight, the IPA advised there is no specific guidance for GPs on this. However, it is '*well known*' that a plane cabin contains less oxygen than normal air and at a slightly lower pressure. He advised some patients with lung conditions may have difficulty maintaining the oxygen concentration in their blood in this situation which may lead to increased symptoms and feeling unwell. The IPA advised it is possible to have a hypoxic challenge conducted by a respiratory team in

[11] Also known as water pills — are medicines that help you move extra fluid and salt out of your body.
[12] A shortness of breath.

secondary care to determine fitness to fly. He further advised this is not possible in primary care.

69. The IPA advised, whilst doctors should be particularly careful to explain, if asked, the general ramifications of lung conditions when travelling by air, ultimately it must be a decision taken by the individual as to whether they wish to take any risk that might be involved.

70. The IPA advised the notes of the consultation on 1 August 2022 make no specific mention of the patient or complainant asking the doctor for advice about travel. The records state '*ankle pain as before – start co-codamol* [13]'. He advised the GP prescribed this together with Spiriva[14]. The IPA advised there is no record in the notes of any chest or lung examination, although the complainant comments on this in her statement.

71. The IPA advised in view of the complainant's comments about what happened at this consultation which she attended with the patient, it appears that records may not have fully described all the actions taken by the doctor to check on the patient's health. He advised, if the complainant is correct about the chest examination, this indicates the GP listened to the upper part of the patient's chest, as this can be heard as far up as the apex of the lungs.

72. The IPA ultimately advised '*there is no indication that the GP acted less than appropriately.'*

Analysis and Findings

73. I reviewed the patient's GP records. The notes of the consultation on 1 August 2022 make no specific mention of the patient or complainant asking the doctor for advice about travel. The complainant was very certain she raised this with the GP, but there is no evidence to support this position. Given the IPA's observations on limitations in some of the GP records, I am unable to conclude whether this discussion took place. However, just because the records do not align exactly with the complainant's recollection of events does not, in and of itself, mean the standard of record keeping fell below the requirements of the GMC Guidance. Nonetheless, I encourage the

[13] An analgesia containing codeine and paracetamol.
[14] A medication used for lung conditions

Practice to reflect on the IPA's observation that, at times, the Practice's recording keeping could have been better.

74. In any event, I accept the IPA's advice that even if the patient or complainant had asked about it, the GP would not have been able to provide specific medical direction. I accept the IPA's advice only a specialist at secondary care level could conduct tests necessary to comment on air travel. On foot of this advice, I am satisfied it would have been inappropriate for the GP to have provided specific medical direction to the patient about his suitability for travel, even if he had asked about it. Having considered the IPA's advice, there is no evidence to suggest or infer the GP should have made a referral to secondary care as part of this consultation.

75. I considered whether the GP identified the seriousness of the patient's condition. Having reviewed all relevant documentation, I accept the IPA's advice that the GP provided reasonable and appropriate care and treatment to the patient during this consultation that was in line with good practice. I am satisfied that the GP conducted appropriate examinations to address the symptoms the patient presented with. I am further satisfied the GP prescribed appropriate medication and demonstrated how the patient should take it.

76. I appreciate how suddenly the patient's condition deteriorated after he travelled to London. I further appreciate this was within a few days of the patient seeing the GP. It is understandable for the complainant to have questions about the treatment the patient received on 1 August 2022. However, on foot of the above findings, I do not uphold this element of the complaint.

CONCLUSION

77. I received a complaint about the care and treatment the patient received during the period June 2015 to August 2022. I did not uphold the complaint for the reasons outlined in this report.

78. I consider it important to again highlight the IPA identified examples of poor record keeping by the Practice. While I did not identify any injustice to patient or the complainant as result, I nonetheless strongly encourage the practice to reflect on the IPA's observations in this respect, in line with GMC Guidance.

79. I offer through this report my condolences to the complainant for the loss of her husband.

MARGARET KELLY **December 2024**

Ombudsman

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.