15 November 2023

Complaint reference:
23 001 921

Complaint against:
Nottinghamshire County Council
Skegby Family Medical Practice

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's final decision

Summary: We found fault with the care provided to Mrs C by a GP Practice and a care home acting on behalf of the Council. This leaves her daughter, Ms B, with significant uncertainty as to whether the outcome of Mrs C's care might have been different with appropriate care. The Practice and Council will apologise to Ms B and pay her a financial sum in recognition of the impact of this fault on her. They will also explain what action they will take to prevent similar omissions occurring in future.

The complaint

1. The complainant, who I will call Ms B, is complaining about the care and treatment provided to her mother, Mrs C, by Sutton Court Care Home (acting on behalf of Nottinghamshire County Council) and Skegby Family Medical Centre (the Practice).
2. Ms B complains that the care home and Practice failed to take appropriate action when her mother became unwell in January 2022. She says care home staff failed to report that Mrs C had suffered two falls. Furthermore, Ms B says a GP failed to properly examine her mother and did not take account of the impact of her falls when misdiagnosing her with a Urinary Tract Infection.
3. Ms B says this poor care resulted in Mrs C eventually being admitted to hospital with severe pneumonia, by which point it was too late to treat her successfully.

The Ombudsmen's role and powers

4. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship **(Health Service Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A(1), as amended)**.
5. If it has, they may suggest a remedy. Our recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.
6. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. **(Health Service Commissioners Act 1993, section**

18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended)

How I considered this complaint

7. In making my final decision, I considered information provided by Ms B and discussed the complaint with her. I also considered relevant records provided by the care home (via the Council) and Practice. This included the clinical records and care notes. I also took account of relevant legislation and guidance. Furthermore, I obtained clinical advice from a suitably qualified and independent clinician. I invite comments from all parties on my draft decision statement and considered the responses I received.

What I found

Relevant legislation and guidance

General Medical Council

8. The General Medical Council (GMC) produces guidance for doctors entitled 'Good Medical Practice (2013)'. This describes the professional values and behaviours expected of a doctor.

9. The guidance is categorised is separated into four care domains. Domain 1 relates to knowledge, skills and performance. Section 15 says a doctor must provide a good standard of practice and care. This means they must:

- "adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary examine the patient
- promptly provide or arrange suitable advice, investigations or treatment where necessary
- refer a patient to another practitioner when this serves the patient's needs."

10. Section 16 says a doctor must:

- "prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs
- provide effective treatments based on the best available evidence
- take all possible steps to alleviate pain and distress whether or not a cure may be possible."

National Institute of Health and Care Excellence

11. The National Institute of Health and Care Excellence (NICE) publishes guidance for doctors regarding the treatment of Urinary Tract Infections (UTI).

12. The NICE guidance requires a doctor to take a comprehensive clinical history. This should include a record of when the symptoms began and how they have changed. In older women, the doctor should also exclude any other causes of delirium.

13. The NICE guidance sets out that a urine sample should be taken and tested for all women with a suspected UTI who are older than 65 years.

14. In addition, NICE produces a risk tool flowchart for doctors regarding sepsis. This prompts doctors to consider whether a person with an infection may be suffering from sepsis. This says that:

- "If the person presents with signs or symptoms that indicate infection, even if they do not have a high temperature.
- Be aware that people with sepsis may have non-specific, non-localised presentations (for example, feeling very unwell).
- Pay particular attention to concerns expressed by the person and their family or carer.
- Take particular care in the assessment of people who might have sepsis if they, or their parents or carers, are unable to give a good history (for example, people with English as a second language or people with communication problems)."

Fundamental Standards of Care

15. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the fundamental standards that registered care providers must achieve. The Care Quality Commission (CQC) has guidance on how to meet the fundamental standards.

16. Section 20 of the guidance relates to the duty of candour. This sets out that "as soon as reasonably practicable after becoming aware that a notifiable safety incident has a occurred a registered person must;

- notify the relevant person that the incident has occurred…
- …and provide reasonable support to the relevant person in relation to the incident, including when giving such notification."

Background

17. In January 2022, Mrs C was resident in the care home.

18. On 6 January, Mrs C suffered a fall. She was found by a care worker on the floor of her bathroom. The care worker checked her for injuries but found only a small graze on her wrist. A nurse took Mrs C's clinical observations shortly afterwards and these were within the normal range.

19. A member of staff spoke to a GP at the Practice later that day. The GP noted that Mrs C was reported to be "a little chesty today" but that her observations were normal. The GP advised that Mrs C would be for review the following day if her condition did not improve.

20. A member of care home staff spoke to Ms B to advise her of the fall and the GP's input.

21. On 8 January, Mrs C suffered a further fall. She was again found on the floor. The care worker who found her checked her for visible injuries and found nothing. However, she noted that Mrs C sounded "chesty" and was "not being herself". A nurse took Mrs Y's observations and found she had a raised temperature.

22. By 9 January, Mrs C's temperature had reduced.

23. On the morning of 10 January, a member of staff noted that Mrs C appeared confused and was hot. However, she noted that Mrs C's room was hot and that

this may have been a factor. Mrs C's temperature appeared normal when taken by a nurse.

24. Ms B took Mrs C out later that morning for a visit. She found Mrs C chesty and coughing up phlegm. Ms B said Mrs C did not eat or drink and simply slept. Ms B was sufficiently concerned to advise care home staff that Mrs C should see a doctor. I found no record of this conversation in the care home's records.

25. In the meantime, the care home arranged for Mrs C to be referred to the local community falls team.

26. On Tuesday 11 January, Mrs C suffered a further fall and was again found on the floor of her bathroom. She had sustained no obvious injuries and her clinical observations were normal.

27. A nurse discussed Mrs C with the GP that day. She queried whether Mrs C was suffering from a possible UTI due to her poor mobility and incontinence. The GP did not examine Mrs C. He recorded "? uti" and prescribed antibiotics to treat this.

28. In the early morning of 13 January, Mrs C was found on her knees in her room, with her head on her bed. Mrs C said she could not remember how she came to be there. She appeared unhurt on examination. A member of care home staff reported the incident to Ms B later that day.

29. On 15 January, a member of staff called the NHS 111 service. She noted that Mrs C "looks quite grey/yellow, and breathing appears quite slow, she keeps rolling her eyes and looks generally unwell." This call resulted in an ambulance being sent to the care home.

30. The attending paramedics found Mrs C had low oxygen saturation levels. However, her other observations remained within normal ranges. Nevertheless, the paramedics transported Mrs C to hospital due to her breathing difficulties.

31. Mrs C was subsequently diagnosed with pneumonia and sepsis and treated with intravenous antibiotics. She died in hospital on 25 January.

32. Ms B subsequently complained to the Practice. When she did not receive a satisfactory response, she escalated her concerns to NHS England.
NHS England obtained advice from an independent clinician. This found the care offered by the GP had fallen below an acceptable standard.

33. The Practice declined to comment on NHS England's findings. This led Ms B to approach the Ombudsmen.

My analysis

Care Home

34. Ms B complained that the care home and Practice failed to take appropriate action when Mrs C became unwell. She said the GP did not properly examine Mrs C and simply prescribed antibiotics to treat a UTI.

35. In his response to the complaint, the GP said he had spoken to the care home on 6 January, when Mrs C was described as "chesty". The GP said he asked the care home to let the Practice know if Mrs C had not improved by the next day. The GP said he next spoke to the care home on 10 January when "care home staff felt that [Mrs C] had a Urinary tract infection. He went on to say that staff felt they would be unable to obtain a urine sample because of symptoms associated

with her long-term health conditions. Therefore, the GP said he prescribed antibiotics to treat a UTI.

36. The care records show that Mrs C was first noted to be “chesty” on 6 January. At that’s stage, the GP gave clear advice to the care home to contact the Practice again if her condition had not improved.

37. It is clear Mrs C remained unwell by 8 January, when she was noted to again to be “chesty” and had a raised temperature. Despite this, there is no evidence to suggest the care home contacted the Practice again to request further GP input. There was clear evidence to show Mrs C remained unwell by 8 January. This should have prompted care home staff to request further input from the Practice.

38. By 10 January, Ms B was sufficiently concerned about Mrs C’s condition to request that she be seen by a GP. Although I found no record of this conversation in the care home’s records, I am satisfied it took place as described by Ms B. This is because a note in the care home’s records from the following day refers to the conversation. Again, this should have prompted the care home to contact the Practice. I found no evidence that it did so at that stage.

39. The evidence I have seen shows the care home failed to advise Mrs C’s family when she fell on 8 and 11 January. This was contrary to the requirements of the CQC fundamental standards and represented fault by the Council (as the care home was acting on its behalf). This caused Ms B unnecessary distress.

40. Furthermore, the care home should have contacted the Practice when Mrs C’s condition had not improved following the consultation on 6 January. It did not do so until 11 January. This failure represented further fault by the Council.

41. It is not now possible to determine whether the outcome of Mrs C’s care would have been different if the care home had sought clinical input sooner than it did. This means Ms B is left with uncertainty.

42. In its response to my draft decision statement, the Council provided evidence of significant work it has done since 2021 to support care homes to recognise early signs of patient deterioration. This includes the introduction of a specialised training programme (Restore2) and accompanying toolkit that provide clear guidance for care staff on how to recognise, and respond to, deterioration. I am satisfied these tools, properly applied, would reduce the risk of similar problems occurring for other residents.

43. However, it is unclear whether the care home had accessed these tools at the time of Mrs C’s care. I have addressed this in my recommendations below.

Practice

44. On 11 January, the care home sought further input from the Practice as Mrs C’s condition had deteriorated.

45. The NICE guidelines and GMC guidance place a clear duty on doctors to properly assess patients and provide care accordingly.

46. The clinical record for the consultation on 11 January contains no clinical history for Mrs C, nor any record of her status at that time. There is no evidence in the clinical record to suggest the GP examined Mrs C and nothing to support a diagnosis of UTI. As a result, there was no clinical evidence base on which to prescribe antibiotics to treat a UTI. Furthermore, there is no evidence to show the GP considered whether Mrs C may be suffering from sepsis.

47. The care provided by the GP fell below the standards set out in the GMC and NICE guidance. This was fault by the Practice.

48. I am unable to say whether the outcome of Mrs C's care would have been different even if she had received appropriate treatment. Nevertheless, the Practice missed an opportunity to properly examine Mrs C and prescribe appropriate medication to treat her chest infection. This means Ms B is left with significant uncertainty as to whether there would have been a different outcome if Mrs C had received the proper care.

Agreed actions

Council

49. Within one month of my final decision statement, the Council will write to Ms B to apologise for:

- the care home's failure to inform her that Mrs C had experienced falls on 8 and 11 January; and
- the care home's failure to promptly seek further clinical input when Mrs C's condition had not improved by 8 January.

50. The Council will also pay Ms B £400 in recognition of the distress this caused.

51. Within two months of my final decision, the Council will also explain what action it will take to support the care home to put in place appropriate tools (such as the Restore2 training/toolkit) for care staff in how to recognise, record, and promptly respond to, deterioration in a resident's condition.

Practice

52. Within one month of my final decision statement, the Practice will write to Ms B to apologise for:

- its failure to properly examine Mrs C and prescribe appropriate medication to treat her chest infection.

53. The Practice will also pay Ms B £1,000 in recognition of the distress and uncertainty this caused.

54. The Practice will also explain what action it will take to ensure GPs are aware of the importance of properly examining patients and making evidence-based prescriptions.

55. The Council and Practice will provide the Ombudsmen with evidence that they have completed the above actions within the stated timescales.

Final decision

56. I found fault with regards to the care provided to Mrs C by the Practice and care home (acting on behalf of the Council).

57. I consider the actions the Council and Practice have now agreed to undertake represent a reasonable and proportionate remedy to the injustice arising to Ms B from this fault.

58. I have now completed my investigation on this basis.

Investigator's decision on behalf of the Ombudsmen