Investigation of a complaint against Tramways Medical Practice

Report reference: 202400471

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

The role of the Ombudsman

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

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

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

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

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

Reporting in the public interest

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

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

TABLE OF CONTENTS

Page

Case Reference: 202400471
Listed Authority: Tramways Medical Practice

SUMMARY

The complaint concerned the care and treatment Tramways Medical Practice (the Practice) provided to the patient in April 2023. The patient is the complainant's father.

The complainant said the GP should have acted sooner, once it was aware of her father's condition and existing medical history, rather than waiting six days to repeat a blood test.

The investigation found the Practice acted appropriately and in accordance with relevant procedures and standards. In particular, it determined the GP appropriately assessed the patient when he first reported his symptoms, and also provided him with appropriate advice, taking into account his medical history. The investigation further found the GP acted in accordance with NICE guidance upon receipt of the patient's blood test results on 6 April 2023 and provided appropriate safety netting advice. It also found the GP acted appropriately after receipt of the follow up blood test results on 13 April 2023.

Although I did not uphold the complaint I hope the complainant is reassured that the care and treatment her father received was appropriate.

THE COMPLAINT

1. This complaint was about care and treatment Tramways Medical Practice (the Practice) provided to the patient in April 2023. The complainant is the patient's daughter.

Background

2. The patient had a history of diabetes[1] and congestive heart failure[2]. He contacted the Practice on 5 April 2023 and told the GP he had been feeling hot and cold the previous day and had experienced diarrhoea throughout the night.

3. The GP arranged a home visit later that afternoon, and also arranged for a nurse to attend the patient to take blood, urine and stool samples.

4. The Practice received the sample results on 6 April 2023, which showed a drop in kidney function. The GP arranged for follow up blood tests to be completed on 12 April 2023.

5. The results from the follow up blood test showed a further deterioration in the patient's kidney function. The GP then arranged for the patient to go to hospital by ambulance as an urgent transfer.

Issue of complaint

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

Issue 1: Whether the care and treatment the Practice provided to the patient between 5 and 13 April 2023 was appropriate, reasonable and in line with relevant standards.

INVESTIGATION METHODOLOGY

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

[1] A condition that causes a person's blood sugar level to become too high.
[2] A condition where the heart is unable to pump enough blood to meet the body's needs. The condition tends to get gradually worse over time.

Independent Professional Advice Sought

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

    - General Practitioner Mb ChB DCH.MRCGP with over 30 years' experience in General Practice and a member of the Royal College of General Practitioners.

    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. 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

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 Good Medical Practice, updated April 2014 (the GMC Guidance);
    - The National Institute for Health and Care Excellence Clinical Knowledge Summary for Acute Diarrhoea, revised November 2023 (NICE CKS Acute Diarrhoea);

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

- The National Institute for Health and Care Excellence Clinical Knowledge Summary for Hypertension: Angiotensin-converting enzyme inhibitors, revised December 2023 (NICE CKS Hypertension);

I enclose relevant sections of the guidance considered at Appendix three 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 recommendations. I gave careful consideration to the comments I received in preparing this final report and made amendments where I considered it appropriate.

THE INVESTIGATION

Issue 1: Whether the care and treatment the Practice provided to the patient between 5 and 13 April 2023 was appropriate, reasonable and in line with relevant standards.

Detail of Complaint

14. The complainant said her father became ill on 5 April 2023. A Practice GP assessed him that day and conducted blood tests. The following day, the GP advised him to withhold taking his regular medication as it may affect his kidneys.

15. The complainant said blood results showed a dip in renal function, but her father did not meet the threshold of Acute Kidney Injury (AKI)[4]. The GP ordered repeat blood tests for 12 April 2023.

16. The complainant said that after receiving the results of the repeat blood tests on 13 April 2023, the GP informed the patient he needed to attend the Emergency Department by ambulance. The complainant considered the Practice was aware

[4] Acute Kidney Injury is where the kidneys suddenly stop working properly. It can range from minor loss of kidney function to complete kidney failure.

her father had a history of health problems and it should have acted sooner, instead of waiting six days before conducting further blood tests.

The Practice response to investigation enquiries

17. The Practice stated a GP saw the patient appropriately, at a home visit, on 5 April 2023. It explained the GP gave advice regarding existing medications, which was in line with NICE guidelines.

18. It stated it acted on blood results appropriately on 6 April 2023 as no AKI was identified at the time. It explained it requested repeat bloods as early as possible following the Easter Bank Holiday. The GP then identified the AKI upon reviewing the updated results, and arranged an urgent ambulance to transport the patient to the ED.

19. The Practice also stated it advised the patient on separate occasions to attend an ED if any concerns arose, or if the patient deteriorated over the Bank Holiday weekend.

Documentation and records I examined

20. I completed a review of the copy documentation the complainant provided, and those the Practice provided in response to my investigation enquiries. I outlined my consideration of this evidence in my analysis and findings below.

Relevant Independent Professional Advice

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

Analysis and Findings

22. I reviewed the patient GP records. I note he was a 75 year old man, who was taking medication for diabetes and congestive heart failure. He contacted the Practice on the morning of 5 April 2023 because he wasn't feeling well and had experienced diarrhoea during the night. He confirmed he had no abdominal pain, no cough, sore throat or runny nose, and had been passing small amounts of urine.

23. The IPA advised the GP arranged to visit the patient the same day and examined him at home because the medications he was taking for his existing conditions could put him at risk with the illness he was experiencing.

24. The IPA advised the GP checked the patient's temperature, pulse, blood pressure, oxygen saturation, blood sugar and urine. The GP also completed physical examinations of the patient's chest, heart and abdomen, and for any swelling.

25. The IPA advised the GP recommended the patient continue checking his blood sugars regularly, and to withhold taking his regular medications while he was experiencing diarrhoea. The GP also arranged for a nurse to attend the patient to take bloods and samples of urine and stool for lab analysis.

26. The IPA advised *'the GP took a full history and did a thorough examination to the GMC guidance'*. He also advised the examination took into consideration the implications dehydration from diarrhoea could have on the patient's existing medical conditions. Having reviewed the patient's GP records, I accept this advice.

27. The complainant raised concerns that the GP who treated her father was a locum and therefore was not familiar with him or his existing medical conditions. However, I note the IPA has confirmed the GP acted in accordance with GMC guidance, which all GPs are required to adhere to. Additionally, GP practices are entitled to engage the services of locum GPs where required. As such, I am satisfied that the GP being a locum did not adversely affect the care and treatment provided.

28. The IPA advised the GP's diagnosis at the time was diarrhoea, probably infective in origin. NICE CKS Acute Diarrhoea guidance states GPs should determine the onset, duration, frequency and severity of symptoms, and enquire about the presence of red flag symptoms. GPs should also attempt to ascertain the underlying cause of the diarrhoea and assess for complications, such as dehydration, and perform an abdominal examination.

29. The IPA advised the GP appropriately assessed the patient and provided him with appropriate advice for his condition at the time. He considered an emergency admission was not indicated at that time, and the GP appropriately considered the patient's medical history in making that decision. I accept this advice. I am satisfied, therefore, that the care and treatment the Practice provided to the patient on 5 April 2023 was reasonable, appropriate, and in line with relevant standards.

30. The GP records show the GP contacted the patient at 09.13 on 6 April 2023 and advised him to continue withholding his regular medication as he was still experiencing episodes of diarrhoea.

31. They show the Practice received the patient's blood and sample results on 6 April 2023. His stool and urine samples were clear. The IPA advised the most clinically relevant result from the patient's blood test was his estimated glomerular filtration rate (eGFR)[5], which was 26. He advised the patient's previous eGFR measurements were 30 in September 2021, 28 in April 2022, 31 July 2022, 31 in September 2022 and 30 in October 2022.

32. The GP records show that upon receipt of the lab results, the GP telephoned the patient, who reported he was feeling better and had no further diarrhoea since the morning. The GP advised him his bloods showed there was "*a slight deterioration in renal function from baseline*". He was advised that as long as he had no more episodes of diarrhoea, he could restart his existing medications. The GP also arranged for a follow up blood test for 12 April 2023.

33. The complaint said the GP should not have waited six days before completing further blood tests. She also said the GP did not take her father's already poor kidney function into consideration when making this decision.

34. I considered the NICE CKS Hypertension guidelines, and note GPs are advised if the eGFR decreases by less than 25%, '*recheck levels in a further one to two weeks'*.

35. The IPA advised the GP acted in accordance with NICE guidance since the patient's eGFR decreased 14% from his normal baseline, and the GP arranged follow up blood tests for six days' time.

36. In terms of the patient's reduced baseline kidney function, I sought further advice from the IPA. The IPA advised the patient's eGFR measurements had previously reduced to 25 as a result of a gallbladder stone, but had since stabilised at around 30. The IPA advised renal function can go down when a patient is actively unwell, and the purpose of retesting bloods was to ensure renal function had returned to 'normal' for the patient. The IPA further advised the patient was clinically stable at the

[5] A measure on how well the kidneys filter blood.

time the blood tests were first returned and there was no indication at the time that he needed hospital treatment.

37. Having reviewed the GP records and NICE guidelines, I accept the IPA's advice. I am satisfied, therefore, that the care and treatment the Practice provided to the patient on 6 April 2023 was reasonable, appropriate, and in line with relevant standards.

38. The GP records show the GP spoke with the patient's daughter on 12 April 2023, who advised the diarrhoea had stopped but the patient had vomited the previous night and that day. The GP advised if the symptoms worsened he should attend the ED.

39. The lab contacted the Practice on 13 April 2023 at 13:06 to advise the patient's eGFR had dropped from 26 to 12. I note the GP telephoned the patient and spoke to him and his daughter to advise of the result and arranged for an urgent ambulance at 13:15.

40. The IPA advised the care and treatment the GP provided that day was correct and appropriate. The IPA further advised there were no additional steps the Practice should have taken in the circumstances. Having reviewed all the relevant evidence and standards, I accept this advice. I am satisfied, therefore, that the care and treatment the Practice provided to the patient on 12 and 13 April 2023 was reasonable, appropriate, and in line with relevant standards.

41. I appreciate the complainant disagreed with the Practice's approach regarding the care of her father, and how distressing it must have been for her. However, having reviewed all relevant evidence, including the IPA's advice, I have not identified any failings in the care and treatment the Practice provided to the patient, which was in line with relevant standards.

42. The complaint is therefore not upheld.

CONCLUSION

43. I received a complaint about the actions of Tramways Medical Practice and the care and treatment it provided to the patient in April 2023. I did not uphold the complaint for the reasons outlined in this report.

44. I was saddened to learn the patient died a few days after his admission to hospital. I offer through this report my condolences to the complainant for the loss of her father. I hope this report provides the complainant with some reassurance regarding the care and treatment that was provided to her father by the Practice.

MARGARET KELLY
Ombudsman **September 2025**

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.