SPSO decision report

Case: **201002699, A Medical Practice, Fife NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: not upheld, no recommendations

Summary

Ms C complained about the treatment provided to her late father, Mr A. Mr had a history of heart attacks and strokes, and he also suffered from dementia. His wife had a poor memory. Mr A was prescribed warfarin following a heart attack and when a blood clot had developed on the inner wall of his heart. However, on many occasions, he failed to take the appropriate dosage and did not attend the appointments made to monitor his blood. In August 2010, a decision was taken to stop his warfarin prescription. One month later Mr A suffered a stroke and died.

Ms C believed that the GP concerned did not do enough to ensure that her father took his warfarin, or that he attended all his appointments. She said that more information should have been to her family so that they could have taken appropriate action.

Our investigation determined that by summer 2009, the family were aware of Mr A's erratic ingestion of warfarin and his non attendance at appointments. We also found that the medical practice had reminded him on many occasions to attend and demonstrated that they did everything they could. Confidentiality prevented them from discussing matters directly with the family.

Ms C also believed that some warfarin was better than none and that her father should have been weaned from his prescription. She also said that the GP had not referred her father to a consultant cardiologist as he should. We did not uphold either of these complaints.