SPSO decision report

Case: **201911563, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment given by the board to their late parent (A). They made a formal complaint to the board to which the board replied two and a half months later. They were unhappy with the reply and wrote again.

A had been admitted to Ayr Hospital where they were diagnosed with sepsis. They had previously had a heart valve replacement and were taking Warfarin (blood-thinning medication) on a long-term basis for which they required regular International Normalised Ratio checks (INR; checks used to monitor the effectiveness of the medication), especially when they were taking antibiotics.

C believed that during A's admission they were not properly cared for, that inadequate tests and investigations were carried out and that their previous medical history was not taken into account. Staff showed no sense of urgency when A's condition deteriorated.

C noted that A was allowed to deteriorate to the extent that they could not be treated and that they died as a result.

The board's view was that on admission, all of A's symptoms and history were taken into account and that they were treated reasonably, promptly and appropriately throughout.

We took independent advice from a consultant physician and cardiologist (specialises in dealing with disorders of the heart), who identified that A's INR levels were not checked in accordance with the board's standard Warfarin prescription, given that A had been prescribed new medication following the diagnosis of sepsis. When A's INR levels were subsequently checked again, they were found to be rapidly rising before being brought under control two days later. However, A's INR levels were again recorded as being too high within days, at which time A began to display symptoms of delirium. A scan of A's brain was arranged and that confirmed A had suffered a cerebral haemorrhage (bleeding from a ruptured blood vessel in the brain). A later died. Whilst it could not be said with certainty when the bleeding started, we found that the INR levels were likely to have contributed to the brain haemorrhage that A suffered prior to their death. We found that the failure to check and closely monitor A's INR levels was unreasonable and therefore, upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Formally apologise to C for their failure to follow standard Warfarin prescription guidance. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Relevant staff should be aware of and apply Standard Warfarin Prescription guidance.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.