Scottish Parliament Region: Mid Scotland and Fife

Case 200700972: A Medical Practice, Fife NHS Board

Summary of Investigation

Category

Health: FHS GP, Clinical treatment

Overview

The complainant (Mrs C) raised concerns that the Medical Practice (the Practice) inadequately monitored her husband (Mr C)'s blood clotting therapy, which led to him requiring frequent hospital admissions.

Specific complaint and conclusions

The complaint which has been investigated is that, between January 2005 and June 2007, the Practice inadequately monitored and failed to take appropriate action in relation to Mr C's blood clotting therapy (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 2 July 2007 the Ombudsman received a complaint from Mrs C about her concerns that the Medical Practice (the Practice) inadequately monitored her husband (Mr C)'s blood clotting therapy, which led to him requiring frequent hospital admissions. Mrs C had complained to the Practice but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Mrs C which I have investigated is that, between January 2005 and June 2007, the Practice inadequately monitored and failed to take appropriate action in relation to Mr C's blood clotting therapy.

Investigation

3. In writing this report I have had access to Mr C's GP clinical records and the complaints correspondence with the Practice. I obtained advice from one of the Ombudsman's professional medical advisers, who is a practicing GP (the Adviser), regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mrs C and the Practice were given an opportunity to comment on a draft of this report.

Medical background

5. Mr C has a past medical history of cerebrovascular accident (CVA) (lack of oxygen to the brain) and atrial fibrillation (irregular heart rhythm). During the period February 2005 to June 2007, Mr C was admitted to hospital on 20 occasions with symptoms which were, in the main, related to chest pain. Of these, there were ten instances where Mr C was discharged within 24 hours of admission. To help maintain Mr C's health, he was prescribed warfarin (medication to prevent blood from clotting), which is appropriate for patients with atrial fibrillation. It is important that the warfarin dosage is monitored, as too high a dosage can increase the risk of internal bleeding and insufficient warfarin could increase the risk of a blood clot. The normal testing procedure for a patient on warfarin is for their international rationalised ratio (INR) level to be checked (time taken for blood to clot) and, dependent on the level, the warfarin would be increased, remain the same or decrease.

Complaint: Between January 2005 and June 2007, the Practice inadequately monitored and failed to take appropriate action in relation to Mr C's blood clotting therapy

6. Mrs C wrote to the Practice informally on four occasions between 8 August 2006 and 24 March 2007 with her concerns about the Practice's monitoring of Mr C's INR levels. Mrs C explained that Mr C had spent some time in hospital following a transient ischemic attack (TIA) (a disturbance of the blood and oxygen supply to the brain like a stroke but, unlike a stroke, it resolves fully within 24 hours). Mrs C said hospital staff told her the cause of the TIA was due to Mr C's persistent sub-therapeutic levels of warfarin over a period of time. Mrs C said hospital staff had also said that, in view of Mr C's erratic INR levels, more frequent testing should have taken place. Mrs C mentioned that she had brought up the subject of Mr C's low INR levels on many occasions with the Practice but had been told that, as long as he was on warfarin, there was no danger. Mrs C also said that she informed the Practice that Mr C had been seen at the warfarin clinic at the hospital and advice was given that the INR level required to be in the therapeutic range (target 2.5) and if there had been problems then a hospital referral should be made. Mrs C remained dissatisfied with the Practice's responses to her concerns and made a formal complaint to the Practice on 22 May 2007 about the monitoring of Mr C's INR levels.

7. A General Practitioner at the Practice (the GP) responded to Mrs C on 22 August 2006, 18 May 2007 and on 31 May 2007 following her formal complaint. He explained the computer programme which the Practice used to monitor INR levels and that, in Mr C's case, the levels were checked weekly which was more frequent than recommended. The GP continued that it was accepted that Mr C would be less likely to suffer medical problems if his INR levels were stable and within the therapeutic range. He commented that, in view of Mr C's complex medical history, the instability of Mr C's INR levels would be only one of a number of factors which had contributed to his recent TIA. The GP explained that, even with careful monitoring, INR levels can become unstable for no obvious reason and when that happens it is best to adjust the warfarin dosage gradually. The GP continued that the Practice was well aware of the problems encountered in controlling Mr C's anti-coagulant levels but it remained unclear why they were so unstable. He said the Practice had monitored Mr C's INR levels in accordance with recommended guidelines and proposed reasonable changes based on the available information.

8. The Adviser reviewed Mr C's GP records and, in particular, he focussed on the period Mr C's INR levels were checked from 12 April 2005 to 8 May 2007. The levels were checked most frequently by the Practice but there were also notes of the readings taken during hospital admissions and attendance at the hospital INR clinic. The levels were checked generally on a weekly basis and ranged from 1.2 to 7.0. The target level for patients with atrial fibrillation ranged from 2.0 to 3.0. Out of 95 recordings, 39 were within the target range, 31 were below and 25 were above. The Adviser told me that he thought the Practice had adequately monitored Mr C's INR levels and that, when the level was outwith the target range, the warfarin was adjusted appropriately. The Adviser told me that Mr C's INR levels were erratic and difficult to control and that applied whether it was the Practice or the hospital who were responsible for the monitoring. The Adviser felt that the Practice had monitored Mr C's INR levels to an acceptable standard.

Conclusion

9. Mrs C complained that the Practice had inadequately monitored Mr C's INR levels and that they should have taken appropriate action to ensure that the level remained within the therapeutic range. However, the advice which I have received is that Mr C's INR levels were difficult to control but that the Practice had taken appropriate action in an attempt to gain some stability. I have also taken into account that, even when Mr C was under the care of the hospital, his INR levels were difficult to control. Accordingly, in all the circumstances, I do not uphold this complaint.

Recommendation

10. The Ombudsman has no recommendations to make.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Practice	The Medical Practice where Mr C was a registered patient
Mr C	Mrs C's husband
The Adviser	One of the Ombudsman's professional medical advisers
INR	International rationalised ratio
TIA	Transient ischemic attack
The GP	A GP at the Practice