SPSO decision report

Case: **201503218, A Medical Practice in the Dumfries and Galloway NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained to us about the system that the medical practice used for reporting on warfarin (a drug used to prevent blood clots) blood tests. Her mother (Mrs A) had been discharged from hospital and a blood test was taken on a Friday. Ms C was told to phone the practice later that day for the result. Ms C did so and was told by a receptionist that the results would not be ready until Monday and that her mother should continue on the same dosage of medication (one tablet daily) in the meantime. On the Monday, the practice phoned Ms C and advised her that her mother's medication should be reduced to one tablet every other day. In the meantime, Mrs A had developed speech problems and had difficulties swallowing, eating and drinking. Ms C felt that the dosage of medication that her mother was taking over the weekend had caused Mrs A's deterioration.

We took independent advice from a GP adviser and concluded that whilst the dosage of medication taken over the weekend had not harmed Mrs A (and was not the cause of her deterioration), the system of reporting warfarin blood test results was not entirely in accordance with local guidelines and that it was not clear whether the receptionist had spoken to Ms C on the instructions of a clinician. We upheld the complaint.

Recommendations

We recommended that the practice:

- apologise to Mrs A for the delay in informing her of the warfarin blood test result;
- review their warfarin blood test results procedure for Fridays to ensure that it is in accordance with board guidelines; and
- ensure that where medical information is being communicated to a patient by a receptionist that it is on the instructions of a clinician.