SPSO decision report

Case: **201704247, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C compained about the care and treatment that her husband (Mr A) had received during a number of admissions to Hairmyres Hospital. Mr A had initially been admitted with abdominal pain, and he was found to have a stone in his urinary tract and some thickened loops of small bowel. His pain decreased and, after review by the urologist (a doctor who specialises in the male and female urinary tract, and the male reproductive organs) and general surgeons, he was discharged home.

Mr A was readmitted three weeks later with similar symptoms and required surgery. During his stay he had thromnophlebitis (inflammation of a vein related to a blood clot) in his arm and it was felt that he should have his blood thinned with warfarin (a medication used to thin the blood and prevent blood clots). He was then discharged home, but was readmitted five days later because he had very high Internalised Normalised Ratio (INR - the higher the number, the longer the takes the blood to clot).

Mrs C complained that the board failed to provide reasonable treatment to Mr A.

We took independent advice from a consultant general surgeon. We found that it had been reasonable to discharge Mr A following his first admission. However, when he was readmitted he was prescribed warfarin outside of the guidance for anticoagulation (blood thinning), as thrombophlebitis is not an indication for anticoagulation. The justification for this had not been clearly recorded. We found that, whilst it had not been unreasonable to give Mr A warfarin, the clinical reasons for this should have been clinically documented.

We also found that there was some confusion about the dose of warfarin that Mr A should take at home. We found that Mr A's readmission with high INR could have been avoided by ensuring that his anticoagulation was stable before discharge. We found that the board's anticoagulation guidelines needed to be updated. In addition, we found that a blood sample had gone missing when Mr A was in hospital, and that he had to have this sample retaken. In view of these failings, we upheld Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for the failings in relation to the warfarin he received. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- The use of warfarin or similar medication should have clear and acceptable justification and any exception for clinical reasons should be documented and accessible.
- Review the pathway of blood tests to minimise the risk of losing samples.

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.