Scottish Parliament Region: Central Scotland

Case 200502097: A Medical Practice, Lanarkshire NHS Board

Summary of Investigation

Category

Health: FHS GP; Clinical treatment

Overview

The complainant (Mrs C) raised concerns about the supervision of her medication and that she could not discuss the matter with a GP.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Practice provided inadequate medication supervision *(not upheld);* and

(b) there was communication failure *(not upheld).*

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 14 November 2005 the Ombudsman received a complaint from Mrs C that she had concerns about the level of medication which had been prescribed by her medical practice (the Practice) and that she had been refused permission to speak to a GP.

2. The complaints from Mrs C which I have investigated are that:

(a) the Practice provided inadequate medication supervision; and

(b) there was communication failure.

Investigation

3. In writing this report I have had access to documents supplied by Mrs C; the Practice's complaints correspondence and copies of Mrs C's clinical records. I have obtained clinical advice from one of the Ombudsman's professional medical advisers (the Adviser). 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 can be found at Annex 1. A glossary of terms used in this report is at Annex 2. Mrs C and the Practice were given an opportunity to comment on a draft of this report.

Medical background

4. Mrs C was under the care of the Practice as she had a diagnosis of deep vein thrombosis (DVT) and consequent pulmonary embolism (PE) made in 2002. The medication for this problem was warfarin. She underwent regular blood tests for the warfarin medication. Mrs C's blood was taken for an International Normalised Ratio (INR) test on 27 April 2005. Mrs C rang the Practice for the result to be told the future dosage of warfarin was dependent on the INR result. She was advised of the INR result and that her dosage of warfarin was to be increased. Mrs C then suffered a seizure 11 days later and was admitted to hospital where the level of INR on admission was 9.5. The hospital diagnosis was that Mrs C had suffered a subdural haemorrhage related to a high INR.

(a) The Practice provided inadequate medication supervision

5. Mrs C complained to the Practice about the dosage of warfarin which had been prescribed following the blood test on 27 April 2005. She had been advised by a receptionist on 28 April 2005 as to what dosage a GP had thought appropriate. Mrs C was also given a date in two weeks to have her INR checked again. Mrs C felt the warfarin dosage was too high and, as her INR was unstable, she thought it should have been checked sooner. Mrs C collapsed on 9 May 2005 with a seizure, where it was found her INR level was over 9.5. Mrs C said two consultants had confirmed that Mrs C had been over-prescribed warfarin.

6. The Practice responded to Mrs C's complaint stating that they received the INR result of 2.4 on 28 April 2005. This was too low to protect Mrs C from further DVT or pulmonary embolism, as the target INR was between 2.5 and 3.5. The INR taken on 12 April 2005 was 3.3. This showed Mrs C's INR had dropped by 0.9 in two weeks and, therefore, the warfarin dosage of 3mg was no longer adequate. Had the dose remained unchanged at 3mg and the INR continued to fall, Mrs C would have been at risk of serious complications. For that reason, it was recommended that the warfarin be increased to 3mg and 4mg on alternative days. Over a week, this balanced out to 3.5 mg daily, which was the smallest amount warfarin can be increased by. It would be usual practice to check the INR every two weeks and it would only be checked sooner if it was found to be dangerously high. Rapid changes in INR do sometimes occur but the Practice could not have foreseen that Mrs C's INR would jump to almost 10 in ten days.

7. The Adviser said DVT and PE are serious illnesses and warfarin is the appropriate method of secondary prevention, so as to reduce the possibility of further illness (or death in the case of PE). Warfarin is a medication for which appropriate care has to be taken. The British National Formulary advises that there should be appropriate monitoring of the INR. This testing should be undertaken daily or alternate days in the initial stages of treatment. Thereafter, the dosage should be at longer intervals, increasing to three monthly dependent on the patient's response. There are indications in the records that Mrs C's response to the warfarin was variable. In a patient who has had recurrent DVT's or PE, the accepted target level of INR the practitioner should aim for (by altering the dose of warfarin) is between 2.0 and 3.5 and this is the figure in Mrs C's records. The records show the regular checking of Mrs C's blood at appropriate intervals. There

is also evidence of the variability of response in that Mrs C's INR is reported as being from 1.4 to 5.1. There is also evidence the Practice altered the dosage of warfarin to take account of these variations.

8. The Adviser said the alteration in warfarin dosage was small – on 28 April 2005 from 3mg daily to 3mg and 4mg on alternate days - and this would be seen as evidence of caring practice. Half a mg is the smallest dosage difference that can be arranged. In summary, the Adviser believed the Practice cared appropriately for Mrs C. The fact that Mrs C suffered an intra cerebral bleed – essentially due to a high INR (and thus too high a dose of warfarin) is not the fault of the GPs. They have been shown on the evidence to be taking appropriate and possibly better than average care of Mrs C in relation to checking the dosage of warfarin needed.

(a) Conclusion

9. The advice which I have received and accept is that the Practice appropriately monitored Mrs C's INR levels and prescribed an appropriate dosage of warfarin. Accordingly, I do not uphold this aspect of the complaint.

(b) There was Communication failure

10. Mrs C complained that she was not able to speak to a doctor about her warfarin dosage on 28 April 2005. The person who initially telephoned from the Practice told Mrs C that the doctor did not have time to speak to her. Mrs C persisted and said she felt the dosage was too high. The member of staff said she would speak to the doctor about Mrs C's concerns. The same person telephoned her again and said she had to take the dosage as prescribed earlier.

11. The Practice responded with an apology that Mrs C was unable to speak to a doctor about her concerns and the matter would be discussed at their next staff meeting. A GP from the Practice wrote to Mrs C on 3 October 2005 and explained that the matter was discussed at the Practice and they have taken steps to ensure that all patients requesting access to a doctor will either be telephoned back or offered an alternative time to call when the doctor would be available.

(b) Conclusion

12. Mrs C had legitimate concerns that she had been refused access to speak to a doctor on 28 April 2005. However, when she raised these concerns, the Practice accepted that Mrs C should have had contact with a doctor and apologised. They also invoked procedures which should prevent a repeat occurrence. I am satisfied that the Practice dealt with this issue prior to the complaint to this office and there was no outstanding issue identified by Mrs C which required further investigation. On the grounds that the matter had already been addressed by the Practice, I do not uphold this aspect of the complaint.

30 January 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Practice	The medical Practice where Mrs C was a patient
The Adviser	The Ombudsman's professional medical adviser
DVT	Deep Vein Thrombosis
PE	Pulmonary Embolism
INR	International Normalised Ratio

Annex 2

Glossary of terms

British National Formulary	UK guide for medication prescribing
Deep Vein Thrombosis	Blood clot in the deep leg veins
International Normalised Ratio	Test which shows the result of current warfarin therapy
Intra cerebral bleed	Bleeding in the brain
Pulmonary Embolism	Blood clot in the leg veins which becomes detached and lodges in the lung
Warfarin	Medication to thin blood, to prevent blood clots