SPSO decision report

Case: **202204908, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) during an admission to hospital. At the time of admission, A was taking medication for atrial fibrillation (a heart condition affecting the rhythm and rate of the heart). The medication included a blood-thinner to reduce the risk of blood clots. While A's condition was being assessed, a decision was made to withhold this medication. A developed pain and discolouration in their leg and was unable to weight bear. C complained that there was a delay of 12 hours before medical staff acted upon this. A required a transfer to another hospital by ambulance, where they underwent emergency surgery for clots in the leg. A has been left with deep incisions in the lower leg and their mobility has been significantly reduced.

The board discussed the case at a Morbidity and Mortality meeting, and following review of the circumstances did not think that there was anything from a system perspective that should be changed.

We took independent advice from a consultant physician and geriatrician (specialist in medicine of the elderly). We found failings in record keeping and examination. We found that the board ought to have been alert to the risk of A developing blood clots after the blood-thinning medication was withheld, and should have acted more promptly when A started to deteriorate. We considered that A suffered pain for a longer period because their deterioration was not recognised in a timely manner. Their situation might not have been so serious had their condition been recognised sooner. We also found that the board did not carry out a suitably rigorous analysis of what happened, including review by staff who were not involved in A's care. The board's review failed to identify appropriate learning. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for the failings our investigation has identified. 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:

- Before reaching a decision to stop anticoagulant medication in patients with atrial fibrillation, full consideration should be given to the risks and benefits of doing so. Clear records of patient care should be maintained, with all patient examinations documented. Deterioration in patients should be escalated appropriately including clinical examination where merited. Staff are confident in identifying adverse events and conducting appropriate reviews.

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.