SPSO decision report

Case: **202210656, A GP Practice in the Grampian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the decision to stop the anticoagulant (blood thinning) medication given to their late parent (A) and a lack of communication with the family around this decision. The practice instructed to stop the medication due to an unexplained bleed. Following this stoppage, A died from a stroke. A's family contacted the practice to discuss their concerns about the medication but they were unable to speak to a clinician in a timely manner.

We took independent advice from a GP adviser. We found that there were clear indications for A to be on anticoagulant medication and that it was unreasonable that the medication was stopped without a replacement in place. The decision to stop the medication was not fully informed. We noted that the practice did not undertake timely blood tests or communicate with A's family and the relevant specialists. We also found failings around the administration of blood tests.

The practice carried out a Significant Adverse Event Review (SAER), which we found was not in line with relevant national guidance. We upheld C's complaint

Recommendations

What we asked the organisation to do in this case:

- Apologise to the family for the failings identified in this report. 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:

- Significant Adverse Event Reviews should be reflective and learning processes that ensure failings are identified and any appropriate learning and improvement taken forward. SAERs should be held in line with relevant guidance.
- Appropriate blood tests should be carried out in line with relevant guidance when anticoagulant medication is stopped or replaced. Test results should be appropriately actioned.
- Contacts to the practice from patients or their carers should be adequately assessed to ensure that they are appropriately escalated and, where necessary, there is discussion with the appropriate member of staff, including clinicians.
- Patients should be fully assessed prior to the stopping of anticoagulation medication with appropriate consideration given to the risks. Full information should be sought, including where appropriate communication with relevant specialists and the family members prior to any decision being reached. Where this information is received in the GP's absence, arrangements should be in place for this to be picked up by another clinician.

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.