SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201004354, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the treatment her mother (Mrs A) received at the Victoria Infirmary. Mrs A was admitted to hospital by emergency referral from her GP with a history of recurrent falls, drowsiness and reduced mobility. Mrs A was initially treated for a presumed infection based on abnormalities in her bloods and her presenting condition. However, no clear source of infection was identified. She was identified as being at risk of blood clots and was put on anticoagulant medication.

Nursing staff observed that Mrs A's right leg was swollen. A doctor reviewed the swelling and did not consider it to be significant. Mrs A's leg was found to be swollen again eight days later. A Doppler ultrasound (a type of ultrasound for monitoring blood flow) was carried out, which showed no signs of thrombosis. A CT scan showed that Mrs A had a mass in her pelvis. Biopsies were ordered, but because of the location of the mass and the quality of the material gathered, it took some time to obtain the eventual diagnosis of cancer of the B-cells. This diagnosis was made around a month later and three days after Mrs A's death. A post-mortem was carried out which concluded that Mrs A's death was the result of a pulmonary blood clot, caused by Deep Vein Thrombosis (DVT) in the right calf, due to a large tumour.

Mrs C complained that the board failed to take prompt or effective action to investigate the cause of her mother's swollen leg. She considered that this led to a failure to identify DVT. She also complained that delays to the biopsy results meant that there was no opportunity to treat her mother's cancer. Mrs C raised further concerns about delays to providing family members with test results and poor administration of medication.

Whilst we found that the board did not regularly assess Mrs A's risk of blood clots during her admission, we were satisfied that this would not have had a detrimental impact on her treatment. We considered that there were

opportunities for further Doppler ultrasounds to be carried out, but were ultimately satisfied that it was reasonable for the board not to undertake these tests in the circumstances.

There was no evidence of DVT following the Doppler ultrasound and we found that Mrs A's mass (which was likely to cause leg swelling) and the fact that she was already receiving anticoagulant medication indicated that there were alternative causes for her swelling other than DVT. We did not find that the board unduly delayed providing family members with test results.

Similarly, the evidence presented to us showed that it was difficult to obtain biopsy samples from Mrs A's mass and, once obtained, the diagnosis of cancer of the B-cells was complex, requiring specialist opinion. We were satisfied that the biopsies were ordered, and their results reported, as quickly as possible. With regard to the provision of medication, we found that cough medicine prescribed for Mrs A was taken to a different patient in error. We also established that Mrs A was prescribed the wrong dose of anticoagulant medication and that doses may have been missed on more than one occasion. Whilst we were unable to confirm that doses were definitely missed, we considered that the lower dose provided would have increased Mrs A's risk of developing blood clots.

Recommendations

We recommended that the board:

- apologise to Mrs A's family for the failure to properly prescribe and record certain anticoagulant drugs;
- remind staff of the importance of recording and signing for all administered medication; and
- draw clinical staff's attention to the guidance in the Therapeutics Handbook for Thromboprophylaxis for Medical Patients (guidance on the administration of anticoagulant drugs to patients with an increased risk of blood clots).