SPSO decision report

Case: **201404173, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C developed deep vein thrombosis (DVT, a blood clot in one of the deep veins in the body) after having surgery at Forth Valley Royal Hospital. Mrs C was readmitted to hospital, where the diagnosis was confirmed and she was started on a medication to treat DVT. After she was discharged, Mrs C's GP referred her to an out-patient clinic at the hospital (the Clinical Assessment Unit), as Mrs C's legs were swollen and she was suffering pain. Mrs C was reviewed by a doctor, but not admitted to hospital. Mrs C then received an appointment for a scan at another hospital out-patient clinic (the Day Medicine Unit). When she arrived, the staff were not sure why she was there, and said she did not need a scan. However, a doctor reviewed Mrs C and arranged for her to be seen by a consultant vascular surgeon, who then took over Mrs C's care.

Mrs C complained about her overall care and the confusion about her appointment at the Day Medicine Unit. Mrs C was concerned that her DVT may have developed in her first hospital admission (and been misdiagnosed as an infection), that she may have been discharged too early after her second admission, and that she should have been given a CT scan (computerised tomography scan, which uses x-rays and a computer to create detailed images of the inside of the body) or referred to a surgeon earlier.

The board apologised for a number of failings. The board took a number of actions to address the issues raised by Mrs C's complaint, including developing a ward checklist for checking the use of anti-embolism stockings (specially fitted elastic stockings used to compress the lower leg and reduce the risk of blood clots); developing a patient information leaflet on DVT; arranging for certain types of DVTs to be referred for a CT scan and discussed with a vascular surgeon as a matter of routine; reviewing the patient pathway for the provision of specialist hosiery; and establishing a seven-day service for management of DVTs within the Day Medicine Unit.

After taking independent medical advice, we upheld two of Mrs C's four complaints. We found that, while most of the care and treatment provided was reasonable, the overall approach to Mrs C's care was fragmented, with a number of different doctors and departments involved. This meant that Mrs C received inconsistent information about her condition and care. We also found the board failed to provide the correct anti-embolism stockings and gave inconsistent information about the medication prescription in Mrs C's discharge letter. While we accepted that the action identified by the board in response to Mrs C's complaint was reasonable, we recommended they demonstrate to us that this action is completed within the timeframes they gave.

Recommendations

We recommended that the board:

- demonstrate to us that a consistent pathway for the provision of specialist hosiery has been established;
- review the pharmacy process for checking discharge letters and prescriptions to ensure that any discrepancies in the instructions are clarified appropriately; and
- demonstrate to us that the arrangements for DVT management by the Day Medicine service are in place, including raising staff awareness and updated documentation.