SPSO decision report

Case: **201706036, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C's husband (Mr A) underwent minor surgery at Victoria Hospital. He was discharged the same day, but died of a blood clot in the lungs two weeks after his surgery. Mrs C complained that the aftercare provided to Mr A was unreasonable. Specifically, she was concerned that Mr A should have been kept in overnight after the surgery, and she felt that when he came home from hospital he was not breathing properly.

We took independent advice from a surgeon. We found that a risk assessment tool had not been filled in. If it had been, it would have shown that Mr A had a number of risk factors for blood clots. This in turn should have led to the consideration of the use of a variety of preventative measures including Flowtron boots (boots to prevent blod clotting), TED stockings (stockings used to try and prevent blood clots) and heparin (a medication which reduces the ability of the blood to clot), though we noted that these measures may not have changed the eventual outcome. Inconsistencies in the documentation meant that it was unclear if Flowtron boots or TED stockings had been used to prevent venous thrombo-embolism (VTE, or blood clots in the veins), however it was clear that heparin was not considered. We found that it was reasonable not to keep Mr A in hospital overnight, and did not consider that this would have changed the outcome. We found that there were likely to be other reasons for Mr A's breathlessness after the surgery, and did not consider that the blood clot would have been present so soon after surgery.

On balance, we considered that the aftercare provided to Mr A was unreasonable and we upheld Mrs C's complaint.

The board said that this complaint had alerted them to inconsistencies in practices, and confirmed that they were undertaking a review with a view to standardising and ensuring guidelines were followed. We asked for evidence of this and we also made some recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the poor record-keeping, and for failing to consider the use of heparin after Mr A's surgery. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Staff should ensure that patients' documentation is completed at every stage of their admission. The General Surgery VTE/Risk Assessment Tool should be completed for all patients.
- Staff in the day surgery unit should be clear about the board's policy for dealing with the presence of risk factors for VTE in day case surgery. (While the board are reviewing this matter, interim measures should be in place to ensure that appropriate steps are being taken when risk factors are present).

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.