SPSO decision report

Case: **201900702, Ayrshire and Arran NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C, an advocate, made a complaint on behalf of her client (Ms B). Mrs C complained about the care and treatment provided to Ms B's late partner (Mr A). Mr A had attended Ayr University Hospital after rupturing his patella tendon. He underwent surgical repair of his ruptured patella tendon and was discharged home the following day. Over the next few weeks, there was delay and a lack of clarity over how Mr A was to access follow-up care and treatment. His GP informed him that they had not received a copy of the discharge letter in the post and Mr A did not know who was to arrange a follow-up appointment at his local orthopaedic (specialism in the treatment of disease and injury of the musculoskeletal system) department, which was located in a different NHS Board area from the hospital where he received surgery.

These matters were resolved after discussion with the orthopaedic consultant who treated Mr A. However, Mr A suddenly became very unwell some days after his surgery and died following a cardiac arrest. The cause of Mr A's death was later recorded as a pulmonary embolism (a condition when a blood clot breaks off and ends up blocking a blood vessel in a person's lungs), resulting from deep vein thrombosis (a condition that happens when a blood clot forms in a deep vein, usually in the leg) in his calf.

Mrs C complained that Mr A had not been prescribed with chemical thromboprophylaxis (drugs to prevent thrombosis) on discharge and that his discharge was not handled reasonably or appropriately. In particular, she complained that he was discharged without an appropriate post-operative medical review, and that there was a delay in the hospital issuing the discharge letter and arranging an appointment with Mr A's local orthopaedic department.

The board acknowledged that there was a failure to follow the instructions of the orthopaedic consultant who had operated on Mr A and outlined what steps they intended to take to prevent this happening again. However, they concluded that the choice to discharge Mr A without recommending or prescribing chemical thromboprophylaxis was acceptable.

We took independent advice from an orthopaedic consultant. We found that, given Mr A's individual circumstances, the relevant guidance supported chemical thromboprophylaxis being prescribed to him on discharge. Therefore, we upheld this aspect of the complaint. However, we agreed with the board's position that there was no strong evidence to suggest chemical thromboprophylaxis would have prevented Mr A's pulmonary embolism.

In respect of Mr A's discharge from hospital, we found that patients who live outwith the board area should be given two copies of their immediate discharge letter, one for their own records and one to pass onto their GP. The board were unable to say whether this happened in this case. We concluded that it was likely that the board's policy on providing immediate discharge letters to people who live outwith the area was not followed on this occasion.

The board were also unable to confirm whether Mr A was provided with instructions about how to arrange a follow-up appointment with his local orthopaedic department or whether this was to be arranged by the orthopaedic department. We noted that, once the orthopaedic consultant who carried out the surgery became aware of this uncertainty, they appear to have acted promptly to resolve this. However, we considered that the lack of clarity prior to this to be a failing on the part of the board.

We considered whether it was appropriate for Mr A to be discharged without a review by the orthopaedic consultant. We confirmed that it is normal practice for a patient to be reviewed by a health care professional prior to discharge, and that a nurse-led discharge is commonplace in Scotland. Therefore, we considered it reasonable for Mr A to be discharged without being reviewed by a consultant.

Overall, we concluded that Mr A's discharge from hospital was not carried out in a reasonable and appropriate manner. As such, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms B for failing to provide Mr A with chemical thromboprophylaxis and discharge him reasonably and appropriately. 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:

- Patients from outwith the health board area should be discharged in line with the existing policy and provided with two copies of their discharge letter. Patients should be made aware whether on-going appointments are to be arranged by the discharging department or by the patient and their GP.
- Staff should be aware of when it is appropriate to utilise chemical thromboprophylaxis after surgery of this type.

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.