SPSO decision report

Case: **202004911, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C attended Aberdeen Royal Infirmary after being referred by their GP for left leg pain and swelling behind the knee. Investigations revealed the presence of a Baker's cyst (fluid-filled swelling at back of knee) and C was discharged home with no further treatment planned. The pain continued to bother C over the weekend and they sought further medical opinion and returned to the hospital six days later. This time a deep vein thrombosis (DVT, blood clot in a vein) was diagnosed and C was discharged home on blood thinning medication. C believed that the DVT must have been present at their initial presentation to hospital and that action should have been taken at that time to address their symptoms and therefore there was a missed diagnosis.

We took independent advice from two clinical advisers: a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans) and a consultant physician. We found that although there was no evidence of a DVT on the original ultrasound scan, staff failed to act in accordance with guidance and arrange a D-dimer test (a blood test that can be used to help rule out the presence of a serious blood clot) and a further ultrasound scan within seven days. Staff gave C advice to seek further medical opinion should their clinical condition deteriorate which C did. There was no delay to the actual diagnosis of DVT and C's treatment regime would not have altered in the period until the second scan was performed. However, we upheld the complaint on the basis that there was a failure to act in accordance with the guidance.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to follow the guidance when a negative scan result was obtained. 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:

- Staff should ensure that they are aware of and follow the guidance concerning negative ultrasound findings for DVT.

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.