SPSO decision report

Case: **201603239, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained to us that the board had failed to provide reasonable care and treatment to his late sister (Ms A) when she was admitted to Wishaw General Hospital. Ms A had injured her hip in a fall. Scans were carried out in the hospital to explore concerns that she may have fractured her pelvis. These scans did not show any obvious fractures and Ms A was discharged from hospital two days after her admission.

Ms A died several days later. A post-mortem was carried out and the cause of death was found to be deep vein thrombosis (DVT) resulting in pulmonary embolism (where a blood clot in the leg travels up and blocks one of the blood vessels in the lungs). Mr C complained that Ms A had not been given any medication to prevent this when she was discharged from hospital.

We took independent advice from a consultant trauma and orthopaedic surgeon. We found that a risk assessment for DVT should have been carried out when Ms A was admitted to the hospital ward, but that there was no evidence this had been done. Ms A's risk of DVT should also have been reviewed during her period of admission and this would have indicated that she was at increased risk of DVT.

We found that Ms A should have been prescribed medication to prevent DVT on the night she was admitted. There should also have been a documented discussion about whether she should receive this medication when she was discharged, although the records suggested that she had regained her full mobility at that time. A formal risk assessment for DVT when Ms A was admitted to hospital would have provided enough concern for her to be prescribed TED stockings (stockings that help to prevent blood clots) whilst she was a patient and also on discharge. Given these failings, we upheld Mr C's complaint, although we were unable to say whether or not adequate treatment would have prevented Ms A's death.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for failing to provide appropriate care and treatment to Ms A. 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:

- Patients admitted to hospital should be assessed for DVT risk in line with national guidance, appropriate treatment should be instigated and the patient's DVT risk should be routinely reviewed during their stay in hospital.
- Patients, particularly those admitted to an orthopaedic department, should be adequately assessed for their safety before discharge and the assessment should be clearly documented.

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.