SPSO decision report

Case: **202209356, Fife NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained that the board failed to provide them with reasonable care and treatment when they attended the emergency department with pain and swelling in their leg. C was advised that their symptoms did not indicate a pulmonary embolism (a blood clot that blocks a blood vessel in the lungs) and that they were on appropriate medication. C was also referred to the deep vein thrombosis (DVT, a blood clot in a vein, usually in the leg) clinic for further investigation.

We took independent advice from a consultant in emergency medicine. We found that the medical care and treatment provided to C in the emergency department was reasonable. Therefore, we did not uphold this part of C's complaint.

C also complained about the care and treatment that they received when they attended the DVT clinic several days later. C was advised at the clinic that it was highly unlikely that they had a DVT. However, around two weeks later, C attended the emergency department again due to worsening symptoms. C was diagnosed with a pulmonary embolism.

We took independent advice from a consultant in general medicine. We found that an advanced nurse practitioner did not give sufficient consideration to C's significantly high D-Dimer blood test result (a test used to check for blood clotting problems) and did not seek input from medical staff. In addition, the board's DVT protocol at the time was too simplistic to take into account all of C's risk factors. It did not mandate the recording of those risk factors and deviated from the national guidance at the time, which recommended a repeat scan six to eight days later. Therefore, we upheld this part of C's complaint.

C also complained about the Significant Adverse Event Review (SAER) the board had carried out. We found that the SAER fully recognised the omissions in the board's protocol and changes were subsequently made to this. However, when carrying out the SAER, the review team did not seek input from C in line with national guidance. Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- All relevant staff should be aware of the board's revised DVT protocol.

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.