# SPSO decision report

**Case:** **201102003, Lothian NHS Board - University Hospitals Division**
**Sector:** health
**Subject:** clinical treatment; diagnosis
**Outcome:** upheld, action taken by body to remedy, recommendations

## Summary

Ms C, an advice worker, complained about the care and treatment provided to Ms A. Ms A had a very complex medical and surgical history. This included a pancreatic and renal (pancreas and kidney) transplant in 2002, during which surgeons also removed Ms A's appendix. The operation note contained details of the procedures relating to the transplants, but did not refer to the removal of the appendix.

In July 2010, Ms A was admitted to hospital with abdominal pain. Following clinical examination, blood tests and a scan, clinicians provisionally diagnosed appendicitis. They operated on Ms A to remove her appendix, but surgeons could not find it. They were not aware that the appendix had been removed in 2002, and Ms A said that she had not been told about it at that time. Ms C complained that the board's failure to tell Ms A about this or to properly record it in her medical records led to an unnecessary operation.

In August 2010, Ms A was transferred to another hospital and underwent further procedures. Shortly after one procedure, Ms A requested help from two nurses to go to the toilet. Only one nurse helped. Ms A was unable to manoeuvre and fell to the floor. She suffered a haematoma (an accumulation of blood) in her leg, which burst causing loss of blood. Ms A said this would not have happened if two nurses helped her as she requested. As a result of her fall, Ms A said that she had to undergo further surgery and suffered significant physical and mental distress.

We found that the board's failure to record the removal of Ms A's appendix in 2002 was unreasonable. This was compounded by the failure to tell Ms A or her GP that her appendix had been removed. Had the surgeons in 2010 known that Ms A's appendix had been removed and thus ruled out acute appendicitis as a diagnosis, the intended appendix operation would have been prevented.

We also found that the board failed to explain the record-keeping omission when responding to Ms C's complaint.

On the issue of Ms A's request for help from two nurses, we found that the board's failure to listen to Ms A and provide more assistance was not reasonable and that her resulting fall had significant consequences for her. As, however, the board had already acknowledged that the nurse should have listened to Ms A, and apologised for this, we made no recommendation in respect of this complaint.

## Recommendations

We recommended that the board:

- amend the transplant protocol to ensure it meets guidelines relating to communication with the patient and the patient's GP; and
- ensure they investigate complaints fully and provide a comprehensive response to complainants.