SPSO decision report

Case: **201300652, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Miss C, an advice worker, complained to us on behalf of her client (Miss A) about the handling of Miss A's Shetty Gastro-Jejunostomy (SGJ) procedure (the insertion of a feeding tube into part of the intestines). Miss A suffers from gastroparesis (paralysis of the stomach) which does not allow food to empty from her stomach. She was scheduled for the procedure as a day-surgery case and told that a particular radiologist would carry it out. On the day, however, a different radiologist tried to perform the procedure, without success. They were only able to insert a tube into Miss A's stomach, to prepare for a later attempt to insert the SGJ. Miss A suffered pain after the procedure and was kept in overnight for pain relief. Miss C also said that no written information was passed to the ward about the problems encountered during the SGJ. Miss A eventually had a SGJ inserted some seven weeks later.

Our investigation included taking independent advice from one of our advisers, who said that the attempted SGJ was done in a reasonable manner with evidence of good, and even best, practice. The adviser said that this is a difficult procedure and Miss A's condition made it particularly so. There was no evidence that the radiologist who attempted it did not do so in a reasonable way. The adviser also said that the board's decision to allocate Miss A's procedure to the first available suitably qualified radiologist was a reasonable clinical decision, and that the radiologist's decision to insert a tube into the stomach to help a further attempt of the SGJ procedure was good practice. There are two approaches that could have been taken towards a further attempt - either to do so a few days after the first, or to wait for the track made by the stomach tube to mature (a period of four to six weeks) before making a second attempt. Either approach is reasonable and in this case the clinicians chose the latter, which was successful. Overall, we were satisfied that the care and treatment provided to Miss A was reasonable.

The only concerns we had were about a lack of information on the consent form that Miss A signed and a failure to provide written information to the ward about the problems with the procedure. There had been verbal communication but nothing in writing. The board told us that they have amended their procedures to prevent this happening again, and so although we did not uphold the complaint we made a recommendation about this.

Recommendations

We recommended that the board:

- provides evidence that the remedial action taken in respect of the written information provided by the radiology department is sufficiently robust to prevent a recurrence, and that appropriate information is recorded on consent forms.