SPSO decision report

Case: **201507830, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C raised concerns about the care and treatment she received at Aberdeen Royal Infirmary. She complained that she was provided with inappropriate gynaecological treatment for her reported symptoms, that her operation was cancelled on the day of the proposed surgery, and that she was discharged despite having received pre-medication. She complained that there was poor communication about her medication and about the rescheduled operation. She also complained that the length of time she would have to wait for the rescheduled operation was unreasonable.

We took independent advice from a consultant gynaecologist and a consultant physician. We were advised that both the treatment suggested and the management of Mrs C's medication were reasonable. We were also advised that the date given for the rescheduled operation meant that the board had failed to meet the target guarantee time in line with The Patient Rights (Scotland) Act 2011 and that, as such, the delay was unreasonable. However, the medical records demonstrated that alternative options had been discussed with Mrs C's GP. We were advised that Mrs C's operation would not be classed as medically urgent.

We were concerned that the board was unable to provide copies of Mrs C's medical records from her admission to Aberdeen Royal Infirmary and that therefore the adviser was unable to comment on the care and treatment provided after Mrs C was admitted to hospital, including her discharge and the level of communication.

While the medical records demonstrated there was some communication with Mrs C and her GP following the cancellation of the operation, we were not satisfied that this was adequate.

Recommendations

We recommended that the board:

- provide a plan detailing the changes which have been made to prevent a recurrence in relation to the failure to store medical records securely;
- apologise to Mrs C for the failings identified in this investigation; and
- remind relevant staff involved in this case of the importance of maintaining comprehensive records in line with General Medical Council guidance.