SPSO decision report

Case: **201508267, Western Isles NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C raised concerns that the there was a failure to reasonably inform her of her treatment options prior to having a laparotomy (a surgical procedure that involves an incision being made into the abdominal wall) at Western Isles Hospital. Two ultrasound scans of Ms C's pelvis, carried out six weeks apart, showed she had a cyst on her right ovary. Ms C said she initially understood that she was to have a laparoscopy (a surgical procedure to access the abdomen and pelvis) to treat the cyst and only learned at a pre-operative appointment that she was to have a laparotomy. The board accepted that more explanatory detail could have been provided to Ms C.

We took independent advice from a medical adviser who said that the entries in Ms C's medical records indicated that she was always to have a laparotomy, and as she thought she was having a laparoscopy, she evidently had not been given enough information to make an informed choice about her treatment options. Also, it was unclear if the risks of surgery had been explained to Ms C. Therefore, we upheld this part of the complaint.

Ms C also complained she had not been provided with reasonable care and treatment. When Ms C had the laparotomy, no cyst was found on her right ovary and she questioned this. The adviser agreed with the board that the most likely explanation was the cyst had ruptured before surgery. The adviser also said that overall, the care and treatment Ms C received was reasonable. We agreed with this and did not uphold this part of the complaint.

Ms C further complained that she was not provided with reasonable post-operative care. She said that following the laparotomy she suffered continuing abdominal pain and tenderness. The advice we received was that the symptoms Ms C was experiencing post-operatively were not unusual and would be expected. There was also no evidence she had a post-operative infection. While we did not identify any failings in Ms C's clinical care we considered there were failings in communication with Ms C and for this reason we upheld this part of the complaint.

Recommendations

We recommended that the board:

- apologise to Ms C for the failure to ensure that she understood the surgical procedure she was to undergo;
- provide evidence that clinicians have been advised to confirm with patients that they understand the procedure they are to undergo and that this information and any comments made by the patient will be recorded in the patient's case records;
- ensure that where the risks of surgery are explained to a patient, this information is clearly recorded in the patient's medical records;
- provide an update on the review and development of their obstetric and gynaecological protocols;
- consider investing in appropriate training to improve the communication skills of their medical staff; and
- feed back the outcome of this investigation to the relevant clinicians.