SPSO decision report

Case: **201508416, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of Mrs A regarding the care and treatment she received at Forth Valley Royal Hospital. A scan showed a large abscess on Mrs A's liver. She had undergone surgery to remove her gall bladder three years earlier and it was noted on the scan that one of the surgical clips had become dislodged. It was felt that this was the source of Mrs A's infection and abscess formation. The abscess was initially drained radiologically (a process in which, using radiological imaging, a thin needle is guided into the abscess and a drainage catheter placed). Following two further hospital admissions with recurrence of the abscess, surgical drainage was carried out and the clip was removed. A further admission took place following a small recurrence and the surgical incision was re-opened and the fluid drained again.

Ms C complained that the board failed to appropriately manage the complication arising from Mrs A's earlier surgery. In particular, she considered that a delay in removing the surgical clip resulted in the abscess recurrence and need for multiple admissions . We took independent medical advice from a consultant surgeon who noted that the possibility of surgical clips becoming dislodged was well recognised but rarely caused problems. They considered that it was reasonable for the board to have considered less invasive treatment than surgery in the first instance. They noted that, when this was unsuccessful, it was appropriate to proceed to surgery and remove the clip, which they noted was done within seven weeks of the first admission. They considered this reasonable.

However, the adviser did not consider that the recurrence of the abscess was due to the ongoing presence of the clip, but rather due to inadequate drainage. They noted that the drain was only left in place for four days the first time and five days the second. They considered that the drain should have been left in place for 10 to 14 days initially and that the board could also have considered flushing the abscess cavity to ensure that there was no residual fluid collection.

They advised that this could potentially have avoided the need for surgery. In relation to the further small recurrence, following surgery, the adviser noted that the surgical incision had to be widened to improve drainage and they considered that this was as a result of the incision having been too small in the first instance. They considered that a wider incision was required for an abscess of the nature of Mrs A's. We concluded that the complication Mrs A experienced could have been better managed by a longer drainage period and a larger surgical incision. We therefore upheld this complaint.

Recommendations

We recommended that the board:

- apologise to Mrs A for the failings identified in this investigation; and
- feed back the findings of this investigation to relevant staff, highlighting the adviser's comments regarding the length of the abscess drainage period and the size of the surgical incision.