SPSO decision report

Case: **201700604, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment that staff at Forth Valley Royal Hospital provided to her over a number of years.

Mrs C was seen by the board's consultant orthopaedic surgeon and elected to have knee replacement surgery. She experienced some pain and discomfort following the surgery, and was seen during this time by an orthopaedic nurse. Approximately three years later, Mrs C continued to experience pain and discomfort and was then seen by two additional consultant orthopaedic surgeons.

Mrs C raised concerns that the knee replacement surgery was carried out inadequately as she felt that the board had provided her with a knee prosthesis that was too small. She also raised concerns about the monitoring that the board provided following her surgery. She also complained about the level of care and treatment that the board provided when she was seen by consultant orthopaedic surgeons over the following years.

We took independent advice from a consultant orthopaedic surgeon. We found that there was no evidence from the records and x-rays that the prosthesis was the wrong size, or that there was any other error in the initial surgery. We noted that there is an inherent risk that surgery will result in a patient experiencing ongoing pain and difficulties, without this being caused by any failure in the surgery. We did not uphold this aspect of Mrs C's complaint.

We upheld Mrs C's complaint about monitoring. We found that there was evidence of Mrs C expressing pain and discomfort during her reviews with an orthopaedic nurse that should have led to her being reviewed by a consultant orthopaedic surgeon, or should have led to some communication from a consultant.

We did not uphold Mrs C's complaint about the subsequent care and treatment she received when she reported problems with her knee in the following years. We found that the documented views of the board's consultant orthopaedic surgeons were not unreasonable, and that the treatment provided was appropriate.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in monitoring following her surgery. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.