SPSO decision report

Case: **201703099, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: not upheld, recommendations

Summary

Miss C underwent cataract surgery at Falkirk Community Hospital and, during this operation, she suffered a leak of the fluid in her eye and her eye was stitched following surgery. A few years later, Miss C suffered a detached retina and underwent surgery for this. Following the surgery, Miss C's vision deteriorated significantly, and she subsequently had to have further surgery. Miss C was concerned that the stitching of her eye following her first surgery may have contributed to the detached retina, and she said that staff had commented at the time that they did not have the correct equipment on hand (but went ahead anyway). Miss C was also concerned that she had high pressure in her eye following the second surgery, and required to be readmitted a couple of days later. She felt that she should have been kept in hospital for longer for observation and queried whether this had impacted on the poor outcome of the surgery.

In response to Miss C's complaint, the board explained that the first surgery was complicated by zonule dehiscence (the breaking of the structures that hold the lens in place, which can cause fluid within the eye to come forward). The board said that this may have contributed to Miss C's subsequent detached retina, but that it was unlikely since the detached retina occurred a long time after the surgery.

We took independent advice from a consultant ophthalmologist (a doctor who deals with diseases and injuries to the eye). We found that Miss C suffered a recognised complication during her first surgery, which was appropriately managed, and that the decision to stitch her eye was reasonable. We also found no evidence that staff did not have the correct equipment for stitching the eye and, therefore, we did not uphold Miss C's complaint. However, we noted that there was no record of any discussion with Miss C to explain the complication that had occurred. Therefore, we made a recommendation to the board regarding this.

In relation to Miss C's second surgery, we found that the decision to discharge Miss C for follow-up in a few days was reasonable. Although Miss C had high pressure in her eye, this was not so high as to require continued admission and observation. We found that Miss C's poor vision was affected by the known risks of surgery rather than an outcome of her aftercare. Therefore, we did not uphold this complaint. However, we noted that when Miss C returned to hospital a few days later, staff did not measure her eye pressure and did not record why this was not done. We made a recommendation to the board regarding this.

Recommendations

What we said should change to put things right in future:

- Where a complication has occurred in surgery, staff should inform the patient of this and clearly record this discussion.
- Where staff do not follow the standard practice, the reasons for this should be recorded.

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.