SPSO decision report

Case:	**201707366, Fife NHS Board**
Sector:	health
Subject:	clinical treatment / diagnosis
Decision:	some upheld, recommendations

Summary

Mrs C attended the emergency medicine department at Victoria Hospital with abdominal pain. She was reviewed by medical staff and it was considered that she probably had pain related to possible endometriosis (a condition where the tissue that lines the womb is found outside the womb, such as in the ovaries and fallopian tubes). She was discharged home and advised to see her GP. On the following day, Mrs C was admitted to the surgical admissions ward at the hospital under the care of a general surgery consultant. Blood tests were carried out and she was started on intravenous antibiotics. She was found to be improving and was discharged. Mrs C was readmitted to the hospital just over one month later. An ultrasound scan was carried out and an ovarian cyst was detected. Mrs C subsequently had surgery to remove the cyst.

Mrs C complained that she had not received a reasonable standard of care and treatment when she attended the emergency department. We took independent advice from an emergency medicine consultant. We found that the standard of assessment and treatment she received there had been reasonable. We did not uphold this aspect of Mrs C's complaint.

Mrs C also complained about the surgical care and treatment she received when she was admitted to the hospital. We took independent advice from a general surgery consultant. We found that Mrs C should have had a magnetic resonance imaging (MRI) scan or computerised tomography (CT) scan during or shortly after her initial admission. The delay in carrying this out delayed her subsequent surgery. Therefore, we upheld this aspect of Mrs C's complaint.

Mrs C also complained about the medical care and treatment she had received during her admissions. We found that she should have had early medical investigation to establish an underlying cause for her symptoms during or shortly after the initial admission. In addition, although antibiotics were prescribed and given, there was no evidence that the sepsis pathway plan was implemented. Although it had been reasonable to discharge Mrs C from hospital after her first admission, additional investigations should had been carried out whilst she was an in-patient or shortly after her discharge. In particular, she should have had a repeat test to ensure her blood tests were returning to normal. We also upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the delay in carrying out a scan and in diagnosing that she had an ovarian cyst and for the failure to carry out repeat blood tests during or shortly after her first admission to hospital. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- The board should ensure that patients receive the appropriate tests.