SPSO decision report

Case: **201902477, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the board's management of a retinal detachment (when the thin layer at the back of the eye becomes loose) and other issues affecting their eye. C attended hospital with a small hole in the centre of the retina and subsequently attended a number of appointments with the board's ophthalmology department (specialists in the study and treatment of disorders and diseases of the eye). Due to the condition of C's eye, a "watch and wait" approach was taken.

C later experienced a deterioration in their eye and attended an emergency clinic. A scan was carried out and C was discharged home on the basis that the eye remained stable. C was concerned that the examining consultant did not carry out additional tests or provide any treatment in light of the deterioration in their vision. C travelled abroad on holiday the following month and their eye deteriorated further. They attended a local ophthalmologist who identified a full retinal detachment. C underwent retinal reattachment surgery.

C complained that the retinal detachment should have been diagnosed at the emergency appointment and that, had it been diagnosed, they would have undergone surgery, avoiding the expense of private treatment abroad.

We took independent advice from a consultant ophthalmologist. We found that changes to the eye were visible on the scan taken at the emergency appointment. We considered that this should have led to a more detailed examination of the eye and that a retinal detachment would likely have been identified at that point. We upheld C's complaint. However, even if a retinal detachment had been identified at that point, it would have been a matter for the professional judgement of the surgeon as to whether surgery was advisable. It would not have been unreasonable for the surgeon to have advised against surgery, given the condition of C's eye and the risks association with surgery.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to identify and act upon the changes visible when they attended the emergency clinic. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Share this decision with the staff involved in C's treatment with a view to identifying ways of avoiding similar problems for future patients.

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.