

SPSO decision report



Case: 202204222, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained they had received substandard care across a series of surgeries to their nose. They said that the board inaccurately stated that C was suffering from a recognised complication and that the board failed to provide C with sufficient information about the possible complications of surgery. The surgery had left C with a deformed nose, significant impairment to their breathing, constant pain and affected their ability to work. C was seen for a second opinion by another Health Board in Scotland and had received surgery in England from a surgeon with expertise in this area. C believed their medical records had been deliberately falsified or altered to conceal mistakes in their care.

The board had responded to a series of complaints from C, but their position was that C was suffering from recognised complications, which treatment had been unable to resolve. They did not accept C had been misled about their treatment, or that C's records had been altered or falsified.

We took advice from a consultant surgeon, with expertise in the type of surgery C underwent. We found that C's complications were ones associated with the type of surgery that they had undergone. Therefore, we did not uphold this aspect of the complaint. Parts of C's records were not well maintained, although there was no evidence of falsification or alteration. Consequently, it could not be demonstrated that C had given informed consent to some of the procedures, and board staff failed to have full and frank discussions with C about their surgeries and the condition of their nose. We upheld this aspect of the complaint around providing sufficient information on the complications of surgery.

We found that C was suffering from a recognised complication of surgery, but that the consent process had fallen below a reasonable standard. There were errors in C's medical records, particularly around the first surgery C underwent, but overall, we found that C's care and treatment was reasonably documented. Therefore, we did not uphold this aspect of C's complaint.

There was not, however, a clear enough treatment plan for C, and some aspects of the complications C was experiencing were not being addressed. We also found that the board's own complaint investigations should have identified the errors in C's records. Therefore, we upheld this aspect of the complaint around ongoing treatment plans.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsos.org.uk/information-leaflets.
- The board should confirm that they have considered whether there are additional referrals required to manage the issues caused to C by their surgeries and that staff have reflected on whether these should have been made earlier as part of C's treatment plan.

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

- Patients should be given complete and accurate information during the consent process for surgery to enable them to make informed decisions about the planned procedure. Discussions with patients should be fully documented in the medical record and include key areas of discussion in relation to the pros/cons of the procedure, the risks associated with the procedure generally, and with reference to any specific risks for the individual patient.

In relation to complaints handling, we recommended:

- The board's complaint handling monitoring, and governance system should ensure that concerns raised are appropriately investigated, failings, and good practice, are identified and that learning from complaints is used to drive service development and improvement. There should be a review of complaints by senior staff during the board's investigative process.