SPSO decision report

Case: **202206050, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, an advocate, complained on behalf of A about treatment that they received after sustaining a knee injury. A ruptured the anterior cruciate ligament (ligament connecting the thigh bone to the shin bone) and underwent an arthroscopy of the knee (a type of keyhole surgery). This was followed up with a second surgery at a later date to complete the reconstruction of the ligament.

During the surgery, the surgeon's scalpel snapped and to remove the tip of the blade, the surgeon had to create a larger incision. C raised concerns about the actions taken following the incident. The board acknowledged the incident and explained that damage to instruments is a rare but known complication of surgery.

We took independent advice from a consultant orthopaedic surgeon. We found that when the blade snapped, appropriate care was provided to A. It was appropriate to create a larger incision and the incident was appropriately communicated to A. However, we found that whilst a datix incident report was completed, a more in-depth investigation could have been carried out. There was no evidence that the board considered either the possibility of improper use of the instrument or that there was a defect in the instrument. We also considered that the board should have discussed the incident at a departmental level. In conclusion, we upheld C's complaint about care and treatment in relation to the initial surgery. We did not uphold the complaint about the post operative care provided to A as we were satisfied it was reasonable.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for failing to thoroughly investigate the adverse event where by the scalpel broke during A's surgery. 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:

- Operation notes should be sufficiently detailed, particularly when an adverse event has occurred.
- The board should ensure that adverse events are thoroughly investigated and that appropriate reflection and learning is identified.

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.