SPSO decision report

Case: **202206729, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (A) about the care and treatment that A received from the board in relation to a planned gynaecology (relating to the female reproductive system) surgical procedure. Following a discussion with the operating consultant on the day of the surgery, A said that the planned procedure was changed from a keyhole subtotal hysterectomy (removing the main body of the womb and leaving the cervix in place) to a keyhole total hysterectomy (removing the womb and the cervix). A said that they felt they had been put under pressure to accept the operation, and did not understand the consequences of losing their ovaries.

A's surgery was carried out at a private sector hospital by the board's surgical team due to the board experiencing issues with theatre capacity at that time. During the operation, a complication occurred which caused A to bleed and the procedure was converted to an open procedure to manage the bleeding. Having complained about the matter, the board explained to A that an issue with equipment during the surgery meant that the correct equipment had not been available during the procedure. A complained to the board on two further occasions in order to gain more understanding about the complication and the issue with the equipment which had occurred during the operation. A felt that the board's responses were contradictory and asked C to complain to this office on their behalf.

We took independent advice from a consultant gynaecologist. We found that there were failings in relation to the process of consent at both the pre-operative clinic and on the day of surgery. We also found failings in relation to the documentation of the operation, including the complication and the way this had been managed during the procedure, and in the equipment log of the surgical instruments used during the procedure. To manage the bleeding, we found that the choice of equipment used had been unreasonable, noting it was likely this would have caused further tearing and bleeding, as appeared to have happened in this case. We found that the post-operative communication with A had been unreasonable in relation to the explanation given regarding the complication, and in relation to the change of procedure and the implications of this on A's future health. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failings identified. 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:

- Operations should be carried out to a reasonable standard. Operation notes should provide a clear record of the procedure carried out and include relevant information about technique, and of significant findings and incidents and on the management of same.

- 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.
- Post-operative communication with patients should be informative and transparent. The discussion should be documented in the medical record.
- When significant failings become apparent via the complaint process, the board should commence an internal risk management review process, appropriate to the circumstances of the case.

In relation to complaints handling, we recommended:

- Complaint responses should be clear and fully respond to the issues raised. This should include a full explanation of what occurred and a description of what happened and/or what should have happened at the time.

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.