SPSO decision report

Case: **201204560, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C, who is an advice worker, complained on behalf of her client (Ms A) about the care and treatment she received at two hospitals, the Royal Infirmary of Edinburgh (RIE) and Roodlands Hospital. Ms A had had keyhole surgery (a surgical procedure that allows a surgeon to access the inside of the abdomen and pelvis through a small hole in the skin), but felt that because of her ethnicity and the fact that she had existing scar tissue from a previous operation, she should instead have had open surgery. She was also unhappy about the level of post-operative aftercare she received and said that she was discharged inappropriately from the RIE hospital when she was suffering from low blood pressure. She complained about the level of care she received when she attended Roodlands Hospital's unscheduled care service complaining of pain and discharge from her wound.

To investigate the complaint, we considered all the relevant documentation, including the complaints correspondence and Ms A's medical records. We also obtained independent advice from three of our advisers (two doctors and a nursing adviser). Our investigation found that the decision to perform keyhole rather than open surgery was reasonable and we did not uphold that complaint. We found, however, that the board failed to provide a reasonable level of post-operative aftercare and that the nursing decision to discharge Ms A had been unreasonable. Our advisers said that Ms A's vital signs should have been recorded more frequently and acted upon, her high pain score should have been acted on and that a surgical review should have been requested before deciding to discharge Ms A. They said that actions indicated by the Scottish Early Warning System score (SEWS - a scoring system used as an early warning of deterioration) did not appear to have taken place.

We also found the board failed to provide a reasonable level of care when Ms A attended the unscheduled care service. The advice we received was that there was no evidence that the member of staff who saw her there had taken a separate history of what had happened, or that the examination carried out was of a reasonable standard in terms of assessing post-operative complications.

Recommendations

We recommended that the board:

- apologise to Ms A for the failings identified in these complaints;
- investigate the post-operative care given to Ms A and report back to the Ombudsman with the results of this review;
- provide the Ombudsman with evidence about the education and training currently in place for nursing staff to ensure they are aware of and are following SEWS protocols; and
- ensure that as a learning requirement the nurse involved undertakes a clinical update in the history and examination of a post-operative patient and in particular abdominal examination. This should be discussed with the nurse's line management to confirm these competencies.