SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201304484, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C had an operation at Perth Royal Infirmary, after which she experienced complications and was transferred to Ninewells Hospital for more surgery. Her husband (Mr C) complained on her behalf about how clinical and nursing staff responded to her pain levels and other concerns. He also complained that, after Mrs C was transferred, there was a delay before she was taken to an operating theatre. Finally, he said that the risk of the complications (perforation of the uterus and damage to the bowel) were not included in the information leaflet sent to her before the surgery.

During our investigation, we took independent medical advice from a consultant obstetrician and gynaecologist, and nursing advice from a nursing adviser. Our medical adviser said that Mrs C had an appropriate operation in Perth Royal Infirmary, and experienced a recognised complication of the procedure, for which she received appropriate treatment.

We did, however, uphold Mr C's complaints. There was no written record by doctors at Perth Royal Infirmary, so our medical adviser could not say whether there was a delay in diagnosing the perforation or whether a consultant should have been contacted earlier. Because of this lack of records, we also could not confirm whether there was a delay in transferring Mrs C. We were concerned that her consent for the procedure had not been properly obtained. The board explained that their consent process for hysteroscopy (a procedure that lets the doctor look inside the womb) was being reviewed to ensure that it follows guidance from the Royal College of Obstetricians and Gynaecologists.

Our nursing adviser said that, given Mrs C's level of pain, nursing staff at Perth Royal Infirmary should have increased the frequency of their observations, and should have told the nurse in charge. They did not follow guidance on the Scottish Early Warning Scoring System (a set of patient observations to assist in the early detection and treatment of serious cases and to support staff making clinical assessments). The board told us that staff had been reminded of the need to increase the frequency of observations in such cases, but did not explain how this would be monitored. The board had also accepted that more proactive observation of Mrs C's vital signs should have been undertaken, and had taken action on this.

In relation to Mr C's concern about delay, the board accepted that a senior doctor should have been alerted immediately after Mrs C arrived, and that better communication might have helped her reach theatre earlier. Our adviser said that there was no evidence that this had a detrimental effect on the eventual outcome, but we were concerned about a possible delay in carrying out surgery. We were also concerned that, when Mrs C was so unwell, her family were asked to leave as visiting times had ended. Finally, patients have the right to information about the treatment that is proposed and we noted that the board now include in their leaflet information about the risk of perforation.

Recommendations

We recommended that the board:

- apologise for the failings identified in this case;
- report back to us on the outcome of the review of the consent process for hysteroscopy;
- report back to us on how they will monitor the action taken to remind nursing staff of the need to increase the frequency of observations when there is unresolving pain;
- remind all staff in the gynaecology unit of the need to record their findings when reviewing patients;
- report back to us on the action taken to share this case with all medical staff in gynaecology, to ensure patients who require senior review are seen as a matter of urgency; and
- report back to us on action taken to discuss the issue of relatives and visiting times with nursing staff in the relevant ward.