SPSO decision report

Case: **201803568, Highland NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Miss C complained about the care and treatment her late mother (Mrs A) received at Raigmore Hospital after she was admitted with symptoms of bleeding from her stoma (an artificial opening made into a hollow organ, especially one on the surface of the body leading to the gut or trachea). Mrs A died around three weeks later following surgery to revise the stoma (resected ileostomy). Miss C raised concerns that the surgery was unnecessary and Mrs A had not properly consented to it; that the nursing care was poor (in terms of wound management, personal care, repositioning Mrs A and cables that had tied down her hands); and that the board did not handle Miss C's concerns through the NHS Model Complaints Handling Procedure (MCHP) appropriately.

We took independent advice from a consultant general and colorectal surgeon (a surgeon who specialises in conditions in the colon, rectum or anus). We considered that the decision to operate was reasonable on the basis that Mrs A had multiple admissions in the period immediately prior to this admission and required blood transfusion. In addition, Mrs A had undergone appropriate investigation to identify the source of gastrointestinal blood loss and that the pathology report of the resected ileostomy had confirmed that it was the source of bleeding. In addition, we were of the view that although Mrs A had experienced a rare complication of the surgery, there was no evidence that it had fallen below a reasonable standard. However, we found that there was insufficient evidence to show that any of the recognised risks of the surgery had been discussed with Mrs A. We considered this unreasonable and not in accordance with guidance. Therefore, we upheld this aspect of Miss C's complaint. We noted that the board's investigation had accepted that the documentation regarding communication was of an unreasonable standard and that the staff involved had reflected on their practice for learning and improvement. The board also took steps to amend the surgery consent form to ensure that the recognised risks of surgery are clearly captured.

In terms of nursing care, we found this to be reasonable and appropriate. We did not uphold this aspect of Miss C's complaint.

In relation to complaint handling, we found that the board should have summarised the issues for investigation and checked whether Miss C wanted to provide any further information before they issued their response to the complaint. Therefore, we upheld this aspect of Miss C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for the failings identified in terms of the documentation of communication; the surgery consent process; and the handling of her complaint. 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:

- Ensure surgical staff understand their responsibilities in ensuring important events and communications with the patient or supporter is recorded; and involving patient supporters in decisions about treatment in accordance with the Good Surgical Practice guidance.
- Ensure the current standards of consent are followed as outlined by the Royal College of Surgeons.

In relation to complaints handling, we recommended:

- Ensure complaints are handled in line with the NHS MCHP: www.spso.org.uk/the-model-complaints-handling-procedures

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.