SPSO decision report

Case: **202303330, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that they received from the board. C underwent a left total hip replacement but returned to the consultant orthopaedic surgeon for follow-up three months later as they were continuing to experience pain and mobility problems. C complained that they were told there was nothing the surgeon could do for them. C sought a second opinion and learned that they had impingement (pinching or rubbing together inside a joint) which would require further surgery. C said that they had been significantly impacted by the initial surgery, both mentally and physically.

In their original complaint response, the board acknowledged the poor outcome of the surgery. Following our formal enquiry the board acknowledged that a different choice of acetabular (socket) implant would have been appropriate. The surgeon acknowledged that this case was one where they would have benefited from advice from a more experienced surgeon. They accepted that they had failed to discuss with C that a poor outcome from surgery was a risk, and failed to document decision making and consent discussions in C's clinical records. They apologised for failings in communication with C during their post-operative consultation. They also apologised for record-keeping failings. The board said they should have discussed this case at a departmental Morbidity and Mortality meeting once it became clear that there were ongoing problems requiring further surgery. They considered that not doing so represented a failure of process, prompting them to review their relevant structures and processes. The board confirmed comprehensive measures to address what had gone wrong in C's case.

We took independent advice from a consultant orthopaedic surgeon (specialists in the musculoskeletal system). We concluded that the board had now appropriately acknowledged the multiple failings in this case, apologising and confirming extensive learning and improvement. Taking all of this into account, we upheld C's complaint and asked the board to apologise but did not make further recommendations for learning and improvement.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C 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.

In relation to complaints handling, we recommended:

- Complaints are investigated with sufficient rigour to identify failings where appropriate. Complaints handling procedure timescales are met.

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.