SPSO decision report

Case: **202303465, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the post-operative care and treatment that they received from the board after they suffered a leg and ankle fracture. C said that unreasonable post-operative care led to a poor recovery and the requirement for an additional operation.

We took independent advice from a consultant orthopaedic surgeon (specialists in the treatment of diseases and injuries of the musculoskeletal system). We found that the board failed to report some x-rays and to reasonably explain why further x-rays were taken and who had reviewed them. We also found that there had been an unreasonable delay in carrying out a CT scan and in discussing C's case at a Morbidity and Mortality meeting. Therefore, we upheld this part of C's complaint.

C also complained about the board's handling of their complaint. We found that the board handled C's complaint reasonably and did not uphold this part of C's complaint.

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.

What we said should change to put things right in future:

- A patient's medical records should document the reasons why a scan(s) has been taken and who has reviewed them. The results should be recorded on the hospital's clinical portal system.
- There should be processes and guidance in place to ensure when it is appropriate to carry out a CT scan.
- Where a patient's case is appropriate for discussion at a Morbidity and Mortality meeting, this should take place as soon as possible.

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.