SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201103232, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained that she received poor care in hospital after undergoing a procedure to remove a gallstone from her bile duct, which resulted in her bowel being perforated. Mrs C also raised specific concerns that the risk of perforation was not explained to her; there was a lack of information given to her about what happened during the procedure, and she had not been aware of a tube having being inserted during the procedure.

The board said that the procedure was appropriate as not removing the gallstone could have led to recurrent inflammation of the pancreas (pancreatitis), inflammation of the bile ducts and jaundice (yellowing of the skin or eyes). In addition, the procedure carried a lower risk than open surgery. We considered this response reasonable as earlier investigations had showed a small stone blocking the bile duct.

However, we upheld Mrs C's complaint. Our medical adviser said that, while junior medical staff did consider at an early stage the possibility that there had been a perforation, aspects of Mrs C's after-care fell below a reasonable standard. This was because there was no senior doctor accountable for Mrs C's care after the procedure, and no clear supervision of the junior medical staff who were reviewing her. Our adviser considered that there should have been a clear and consistent action plan from the time the perforation was identified to the time Mrs C was transferred to another hospital (five days later) for surgical review. In addition, there did not appear to be any clear instructions by medical staff about feeding or fluids. Therefore, five days were lost in getting the perforation effectively healed, due to poor nutrition and the likelihood that Mrs C's immune system was weakened.

The board said that Mrs C had been sent a leaflet on the procedure which included information on the risk of perforation. Our investigation, however, identified that Mrs C was given a different leaflet that did not explain any of the specific risks. General Medical Council (GMC) guidance says that doctors must tell patients if an investigation or procedure might result in a serious adverse outcome, even if the likelihood of it happening is very small.

In addition, although the consent form Mrs C signed included information on the risks of bleeding, infection and pancreatitis, it did not include information on perforation. GMC guidance on the recording of informed consent says that the patient's medical records or consent form must record the key elements of the discussion that has taken place.

While the board explained to Mrs C the reasoning behind the medical staff's initial diagnosis of pancreatitis before the perforation was identified, there was no clear record made of any discussions the medical staff had with Mrs C either before or after the complication was identified. We noted that the board were correct in informing Mrs C that a tube had not been inserted at the time of the procedure.

Recommendations

We recommended that the board:

- apologise to Mrs C for the failings identified in our investigation;
- ensure there is clear guidance to consultants regarding the clinical oversight and management of a person's care and supervision of junior colleagues, including care arrangements to cover out of hours, weekend care and periods of leave;
- consider reviewing patient information leaflets on the procedure (ERCP) to ensure all possible risks and complications are clearly explained; and
- consider reviewing their consent policy to ensure that all common and serious risks are fully explained to patients when obtaining consent and that these are clearly recorded on the consent form.
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