

## SPSO decision report

**Case:** 201201859, Orkney NHS Board  
**Sector:** health  
**Subject:** clinical treatment / diagnosis  
**Outcome:** not upheld, recommendations

### Summary

After Mrs C had surgery in a hospital outside the area of her own health board, complications arose that led to irreparable damage to one of her kidneys. She believed that there was unreasonable delay in identifying these and that had they been diagnosed sooner her kidney might have been saved. Mrs C also believed that the care she received (after an attempt to prevent further damage to her kidney) was inadequate. She said that, although her husband was trained to change the type of dressing she was given, no-one in the community nursing service responsible for her care was familiar with it. Mrs C felt that she and her husband were not provided with adequate support following her surgery.

After taking independent advice from one of our medical advisers, we found that the complications arising from the surgery could not have been identified sooner. We also found that the board had offered alternatives to the dressing, but that Mrs C had requested that she be allowed to keep the one provided. The board had supported the couple in this decision and had acted reasonably when Mrs C indicated that she and her husband were experiencing difficulties. We also found that although the board had met with Mrs C informally and had not signposted her towards the formal complaints procedure, their response had addressed the concerns she raised about her treatment.

Although we did not uphold this complaint, we made two recommendations for improvement.

### Recommendations

We recommended that the board:

- consider whether there are any other means of receiving discharge and other types of referral information from hospitals elsewhere; and
- remind relevant staff of the importance of signposting to the complaints procedure.