SPSO decision report

Case: **201300596, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the post-operative medical care she received after Tension Free Vaginal Tape Obturator (TVTO) surgery for urinary incontinence at the New Victoria Infirmary in May 2011. After the operation, Ms C suffered constant pain until further tests revealed a year and a half later that she had suffered bladder erosion (where the tape has eroded into the bladder). Ms C was concerned that a cystoscopy (where a camera is used to check for abnormalities) was not used when the tape was implanted, and was unhappy about the time taken to identify this injury. Ms C had a further operation at the Southern General Hospital in November 2012 to have the tape removed. She complained about the nursing treatment for her wound, which became infected a week later, and that the board's response to her complaint did not address her concerns that her wound was not checked during the first week after surgery.

There are no national guidelines recommending that a cystoscopy be performed on all patients undergoing TVTO surgery, and the manufacturer's product information says that it is at the discretion of the surgeon whether to perform a cystoscopy. After taking independent advice from one of our medical advisers, we did not consider it unreasonable that a cystoscopy was not performed. TVTO had been introduced to reduce the likelihood of bladder injury, and it was not the board's policy in 2011 to perform a cystoscopy on all patients undergoing TVTO. After numerous cases of injury with the TVTO procedure were reported over the years, however, this eventually led to the board's change of policy in 2012. Nevertheless, we were critical that when Ms C complained five months later of pain and recurrent bladder infections, a cystoscopy was not arranged as supported by guidance issued by the National Institute of Clinical Excellence.

Although we found that Ms C's wound was checked and redressed twice in the week after her surgery at the Southern General Hospital, there was evidence to suggest that there were three consecutive days when it was not checked, before she told nursing staff that it was painful and leaking. Healthcare Improvement Scotland makes clear that wound charts should be started for all patients with a wound, and we noted that in Ms C's case this chart was not started until after her wound became infected. We concluded that the nursing care fell below the reasonable standard that would be expected in this surgical ward. In addition, the board did not respond to Ms C's complaint about her wound not being checked during the week after surgery and instead concentrated on the redressing that took place after the infection was identified. We upheld Ms C's complaints.

Recommendations

We recommended that the board:

- ensure that complaint responses fully address the concerns raised, in line with the Scottish Government's complaints handling guidance;
- ensure that appropriate staff take into account the relevant guidelines on performing a cystoscopy in patients with pain and recurrent bladder infections following pelvic surgery;
- draw to the attention of relevant nursing staff on the surgical ward at the Southern General Hospital the importance of having in place wound charts in line with Healthcare Improvement Scotland guidance and

ensure daily dressing and/or wound inspections are conducted; and

- apologise to Ms C for the failings identified.