SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201500696, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Ms C complained about the care and treatment she received from University Hospital Crosshouse for what she believed was suspected appendicitis. She said she made frequent visits to the A&E department at the hospital and was also admitted to the hospital, but her condition was not reasonably assessed and treated. She said her condition then deteriorated and spread to her bowel and she had to have part of her large and small bowel removed. Ms C also complained that her complaint about her treatment was not reasonably responded to by the board.

We took independent advice from two advisers, one a consultant in emergency medicine and the other a consultant colorectal surgeon (who specialises in conditions relating to or affecting the colon and rectum). The emergency medicine adviser said that the treatment Ms C received in the A&E department at the hospital was reasonable.

The colorectal surgical adviser said they did not think that there was an unreasonable failure by the board to diagnose Ms C's appendicitis sooner, as the initial clinical signs would not have been very obvious for acute appendicitis. They also said there was a delayed diagnosis of acute appendicitis, but explained that the diagnosis of this is sometimes challenging even to an experienced surgeon and it would have been difficult to know and impossible to determine at what precise moment Ms C actually had acute appendicitis. We therefore did not uphold Ms C's complaint that her condition was not reasonably assessed and treated, but we did make a recommendation based on the advice we received about how the board should have shared the learning points from Ms C's complaints.

In terms of the complaints handling, Ms C indicated in her complaint to the board that she was concerned about the care and treatment she received from the board and her GP. The board did not appear to take any action to assist in progressing Ms C's complaint about her GP, either by contacting Ms C's GP practice or by advising Ms C to do so herself. We, therefore, considered that her complaint was not reasonably responded to by the board and we upheld this part of Ms C's complaint. We also found that at the time of Ms C's complaint, the board did not have a full written complaints procedure in place. They said that they were in the process of compiling a toolkit that would address this, so we made a recommendation about this too.

Recommendations

We recommended that the board:

- take steps to ensure that in future they keep documentary evidence of the remedial action taken as a result of patients' complaints;
- feed back our decision on their handling of Ms C's complaint to the staff involved;
- provide us with a copy of their comprehensive complaints tool kit and evidence that this has now been launched; and
- provide Ms C with a written apology for failing to respond reasonably to her complaint about her GP.