SPSO decision report

Case: **201507605, Highland NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Outcome: some upheld, recommendations

Summary

Mr C complained about the care and treatment provided to his wife (Mrs A) at Raigmore Hospital. Mrs A needed surgery to dilate and place a stent (a tiny tube inserted into a blocked passageway to keep it open) in the artery in her chest supplying her left arm, to assist with her kidney dialysis. The board were unable to place the stent in a satisfactory position and carried out surgery to remove the stent. This caused internal bleeding and Mrs A was taken to theatre for emergency surgery. The surgery proved too much for Mrs A's vital organs and she died. Mr C raised several concerns about his wife's care and treatment by the board. These included that the board failed to give Mrs A appropriate explanations about the risk of the stent procedure and failed to obtain Mrs A's informed consent for the procedure.

We obtained independent medical advice from a consultant vascular and endovascular surgeon and a consultant interventional radiologist. The board said they did not advise Mrs A of the risk of death, as they consider it to be below the threshold required to be specifically mentioned as a complication. The radiologist adviser said that as Mrs A was unwell and suffered from heart failure and other conditions, the risk that any complication of the procedure would result in very serious consequences for Mrs A was increased. It would, therefore, have been reasonable for the board to have discussed the risk of death with Mrs A. We upheld this part of the complaint.

Both advisers said that the evidence suggested that the board failed to follow their consent procedure, as they only appear to have discussed the stent procedure with Mrs A on the day of the operation. Therefore, Mrs A would not have had adequate time to reflect on the surgical options. We therefore considered that the board failed to obtain Mrs A's informed consent for the procedure. We upheld this part of the complaint.

Recommendations

We recommended that the board:

- feed back our findings on explanation of the stent procedure and informed consent to the staff involved;
- provide us with evidence that a revised consent form has now been implemented;
- ensure that in future, they appropriately advise patients of the risk of death;
- ensure that in future, when they discuss surgical procedures with patients, they give them adequate time to reflect on the information provided before surgery is carried out; and
- provide Mr C with a written apology for the failings identified.