SPSO decision report

Case: **201701411, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C, who works for an advice and support agency, complained on behalf of Miss A about the medical and nursing care and treatment Miss A received at Stracathro Hospital following hip replacement surgery. Ms C raised a number of concerns, including that Miss A suffered a stroke after surgery which was not picked up on by staff, despite her repeatedly reporting visual disturbance and blurred vision.

We took independent advice from a consultant physician and cardiologist (a doctor who specialises in disorders of the heart), a consultant orthopaedic surgeon (a surgeon who diagnoses and treats a wide range of conditions of the musculoskeletal system) and a nursing adviser. We found that there were no case note entries by the junior medical staff at any time in Miss A's post-operative notes (including in relation to the complaint of visual blurring) and that the board failed to assess Miss A's complaint of post-operative visual blurring in an appropriate manner. The failing was not that they did not diagnose a stroke as the cause of her visual blurring, but rather that they did not assess it at all. We also found that the medical staff failed to take Miss A's medical history or carry out a simple bedside assessment of her eyes. We noted that the board appropriately prescribed aspirin to Miss A on discharge. However, prescribing aspirin alone does not follow the board's protocol and there was no reason recorded in Miss A's notes to explain why this decision was taken. There was also no evidence of a 'venous thromboembolism (VTE - condition where a blood clot forms in a vein) risk assessment tool' being completed. We considered that the medical treatment provided to Ms A was unreasonable and upheld this aspect of Ms C's complaint.

In terms of the nursing care and treatment, we found that the nurses acted reasonably by informing the medical staff about Miss A's complaints of visual blurring and ensuring Miss A was seen by a doctor. Therefore, we did not uphold this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss A for failing to respond appropriately to reported visual blurring, the lack of record-keeping and for not giving her appropriate blood thinning medication. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Medical staff should take a patient's medical history and respond to complaints of postoperative visual blurring in a timely and appropriate manner.
- Staff should complete patients' 'VTE risk assessment tool' forms in cases of this type, prescribe blood thinning medication following hip replacement surgery in line with national guidance, and give patients blood thinning medication in accordance with the board's protocol and, if the board consider it appropriate to deviate from the protocol, to record the reason for this in patients' records.