SPSO decision report

Case: **201703851, Borders NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment she received at Borders General Hospital. Ms C suffered from lower abdominal pain and appeared to have diverticular disease (disease of the colon). Ms C attended the emergency department at hospital on six occasions over a number of months. She complained that over this period of time the board did not treat her reasonably and failed to carry out suitable investigations. As a consequence, she said her diagnosis was delayed and her treatment options were reduced. Ms C also complained about the actions of nursing staff and about the way the board dealt with her complaint.

We took independent advice from a consultant general and colorectal surgeon (a specialist in the medical and surgical treatment of conditions that affect the lower digestive tract) and from a registered nurse. We found that Ms C's initial investigations had been satisfactory. However, she continued to present with similar symptoms and persistent pain which, therefore, should have indicated that her diverticular disease had progressed and she should have received a scan earlier. Had this been the case, her distress and symptoms could have been managed earlier, although her surgery options were unlikely to have been different. We upheld this aspect of Ms C's complaint.

In relation to the actions of the nursing staff, we found that there was a great deal of confusion about where Ms C's future treatment was to take place; an appointment had been cancelled at extremely short notice and she was incorrectly advised that treatment would be given in England. Therefore, we upheld this aspect of Ms C's complaint.

Finally, we also found that this incorrect information about Ms C's future care was included in the board's complaint response. We considered this to be unreasonable and upheld this aspect of Ms C's complaint. However, we noted that the board has already taken remedial action in relation to the issuing of the incorrect information and we made no further recommendations in light of this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to consider further investigations despite the persistance of pain. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- In circumstances similar to Ms C, consideration should be given to making further investigations.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.