SPSO decision report

Case: **201708994, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her mother (Mrs A) when she attended Queen Elizabeth University Hospital for a graft repair of a brain aneurysm (a procedure in which a catheter is passed through a small cut in the groin area to an artery and then to the blood vessel in the brain where the aneurysm (a bulge in the blood vessel wall) is located in order to repair it using coils (spirals of wire) which stabilise the aneurysm). Ms C complained that there had been complications and that there was a delay in the vascular team (specialists in the treatment of diseases affecting the vascular system including diseases of the arteries, veins and lymphatic vessels) coming to assist with the repair. Ms C also said that during Mrs A's recovery, the vascular team had not reviewed Mrs A.

We took advice from a consultant in interventional neuroradiology (a specialist in minimally invasive image-based technologies and procedures used in diagnosis and treatment of diseases of the head, neck, and spine) and a vascular surgeon. We found that the graft repair of brain aneurysm procedure was carried out reasonably, and the leakage of blood where the blood vessel had been closed is a well recognised complication of this procedure. We found that the complication had been managed in a timely and appropriate way, and that the care provided to Mrs A after her surgery was reasonable. However, we found that consent for the graft repair of brain aneurysm had only been taken on the day of surgery. We considered that this should have occurred earlier in order to allow Mrs A to fully understand the procedure and risks. We also found that there was no evidence that Mrs A had been provided with an information leaflet prior to the surgery. Finally, we found that the management plan after the procedure was not adequately communicated to the relevant team. Therefore, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs A that the consent process was not initiated at an earlier point than on the day of the procedure, that she was not provided with an information leaflet prior to the procedure, and that the management plan after the procedure was not adequately communicated to the relevant team. 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:

- The consent process for graft repair of a brain aneurysm should be initiated at an earlier point than on the day of the procedure (unless there is an emergency situation) and information leaflets should be provided at the appropriate time.
- The plan regarding which team are responsible for the patient should be clear.