SPSO decision report

Case: **201801339, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained that the board unreasonably failed to discover an object left in her nasal tissue after surgery at St. John's Hospital. Ms C said that on removal of stents (splints placed temporarily inside a duct, canal, or blood vessel to aid healing or relieve an obstruction), one stent came away in two pieces. Ms C was alerted at the time that a piece of silicone stent may have been retained. Ms C continued to attend the hospital for treatment of chronic rhinosinusitis (a condition where the cavities around nasal passages (sinuses) become inflamed and swollen for a prolonged period). Sixteen months after the surgery, a scan was carried out which identified that a titanium clip had been retained in the nasal tissue. The silicone stent and titanium clip were removed at the same time Ms C was undergoing another surgery, approximately 12 months after the retained titanium clip was discovered.

We took independent medical advice from a consultant rhinologist (a specialist in conditions affecting the nose). We found that the board unreasonably failed to discover and report on all elements retained in Ms C's nasal tissue after surgery. No investigations were carried out until the scan 16 months after the stents were removed, where it was found that the titanium clip was still in place. After it was discovered, it was over a year before it was removed. We found that there was an unreasonable delay in identifying the retained titanium clip. Therefore, we upheld this part of Ms C's complaint.

Ms C also complained that the board failed to provide a reasonable explanation as to how an object was left in her nasal tissue after surgery. The board accepted that they had not provided a reasonable explanation. The communication regarding this issue was poor. When it was found that a titanium clip had been retained as well as the silicone stent, it was over four months before Ms C was informed of this. No explanation was provided as to why the clip was retained or why Ms C was not informed that this was a possibility. We considered that the board could have been more open and detailed about what happened and why. Therefore, we upheld this part of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings identified by this investigation. 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:

- A review of practice to consider best practice to secure silicone tubes for dacryocystorhinostomy (DCR) surgeries.
- A review of the process for selecting patients for DCR surgery.
- Clinicians should review their diagnosis when patients do not respond to treatment.
- Learning from this investigation is fed back to relevant staff in a supportive way.

- The process of discussing options and consent to treatment should be clear in its documentation.