SPSO decision report

Case: **201805015, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Ms C complained that the board failed to diagnose a ruptured Achilles tendon when she attended Western General Hospital. We took independent advice from a consultant physician in acute internal medicine. We found that given the specific test for excluding a ruptured Achilles tendon was carried out, which resulted in a negative finding, it was reasonable that the ruptured Achilles tendon was not diagnosed. We did not uphold this aspect of Ms C's complaint.

Ms C also complained about the care and treatment she received at the Edinburgh Royal Infirmary after the ruptured Achilles tendon had been diagnosed. We took independent advice from a consultant orthopaedic surgeon (a specialist in the treatment of diseases and injuries of the musculoskeletal system). We found that the care and treatment provided to Ms C was reasonable and did not uphold this aspect of her complaint.

Ms C complained that the board failed to communicate reasonably with her. We found that there was no record of any detailed discussion with Ms C prior to her surgeries about the risks or benefits of the proposed operations, the alternatives to surgery or the varying degrees of success and the possibility that her condition could be made worse. The board had a document for recording fasting and insulin instructions for diabetic patients but this was not completed in Ms C's case. Therefore, we upheld Ms C's complaint that the board's communication with her was unreasonable.

Ms C complained about the way that that the board handled her complaint. We found that Ms C's complaint was not acknowledged within three working days. There was also a delay in responding to Ms C's complaint and the board did not proactively keep her updated about the reason for the delay in responding to her complaint and provide a revised timescale for when she could expect to receive a response. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to record a detailed discussion with her prior to her surgeries about the risk or benefits of the proposed operations, failing to acknowledge Ms C's complaint within three working days and for failing to keep her updated about the reason for the delay in responding to the complaint or providing a revised timescale for the response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients should be given full information about the risks and benefits of proposed operations, including the alternatives to surgery, and these discussions should be documented in line with relevant guidance.
- Diabetic patients should be given fasting and/or insulin instructions prior to surgery and these instructions

should be recorded.

In relation to complaints handling, we recommended:

- Complaints should be handled in line with the model complaints handling procedure. The model complaints handling procedure and guidance can be found here: www.valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs

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.