SPSO decision report

Case: **201901805, Lothian NHS Board - Acute Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their partner (A) about surgery they had on their hip. A, who had previously had their hip replaced, was admitted to hospital with an infection which was found to have originated in their hip and required surgery (the first surgery). The following year, A developed pain in their hip again. Scans confirmed that this would again require surgery, which was carried out later that year (the second surgery). A was discharged shortly after, but required to be readmitted twice due to pain. On the second readmission a fracture was identified above their knee, requiring additional surgery. C complained about the first surgery, the second surgery, the aftercare A received and how the board responded to their complaint.

We took independent advice from a consultant orthopaedic surgeon (a surgeon who specialises in the musculoskeletal system). We found that the first surgery was carried out appropriately. C had been concerned that the surgeon had used an incorrectly sized piece of orthopaedic equipment (a stem), however, we noted that the surgeon either used an identical, or slightly smaller stem as they decided not to remove the original cement. We found that this was reasonable.

We found that the second surgery was also carried out appropriately. The surgeon cut a small ‘window’ in the bone to facilitate removal of the cement which was established practice. We considered that this was probably the source of the fracture which A was later found to have, however, there was no indication of a fracture at the time of the surgery.

We were satisfied that the care and treatment A received after their second surgery was reasonable.

As the evidence indicated that the clinical care provided was reasonable, we did not uphold these complaints.

In relation to complaint handling, we found that there was miscommunication regarding delays and a failure to clarify all the issues of complaint. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for miscommunication regarding delays and a failure to clarify the confusion surrounding point two in the complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

- For the findings of this investigation to be shared with staff.

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.