SPSO decision report

Case: **201907136, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: not upheld, recommendations

Summary

C complained about the care and treatment that they received after they underwent a minor surgical procedure as a day patient at Forth Valley Royal Hospital. C said that after the procedure they did not recover well from the anaesthetic (drugs administered to cause numbness of pain) and experienced severe chest pain. Despite this, they said that staff had tried to discharge them before they had properly recovered from the anaesthetic and that staff had ignored the symptoms they were experiencing. C said that they had experienced a heart attack and were later admitted to the Intensive Care Unit (ICU). They complained about the conduct of staff while they were there and that they acted inappropriately.

We took independent advice from a consultant anaesthetist (a medical specialist who administers anaesthetics) and a nursing adviser. We found that, while there was a lack of detail in the clinical records, the evidence available demonstrated that the anaesthetic for the procedure had been given in accordance with good practice and guidelines and doses of drugs were appropriate. In particular, there was no evidence of over dosage of general anaesthetic drugs. We noted that there may have been some delay in recognising that the chest pain C was experiencing was not resolving, however, this had no effect on the outcome and when investigations showed that some heart muscle damage had occurred, appropriate treatment was started. We also found that the nursing care given to C had been reasonable and that the nursing notes were completed to a good standard. We noted that the board had apologised that C felt that a member of staff's attitude had been dismissive and also for the behaviour of staff in ICU.

We considered that the care and treatment given to C was reasonable and did not uphold the complaint. However, having reviewed the handling of the complaint, we concluded that the board failed to appropriately investigate and respond to C's complaint. In particular, that there had been a failure to obtain a formal report from the anaesthetist in response to C's original complaint. Therefore, we made a recommendation under section 16G of the SPSO Act 2002, which requires the Ombudsman to monitor and promote best practice in relation to complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to fully investigate and respond to their complaint. 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:

- Relevant staff should be aware of the requirements of the complaints handling procedures, particularly regarding collating and assessing relevant evidence in determining a complaint.

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.