SPSO decision report

Case: **202000373, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that they received following their hip replacement surgery. Immediately following the surgery, C began experiencing severe and continual pain. The cause of C's pain was eventually confirmed to be loose cement from the surgery causing irritation. C complained that, although the surgeon who had carried out their hip replacement was aware of the loose cement, this was not conveyed to C. Instead, C had consultations with a total of five consultants before the source of their pain was identified two and a half years after their surgery and remedial treatment successfully provided.

C raised a number of concerns regarding the attitude shown towards their symptoms by the board's consultants and the delays to diagnosing and resolving their pain.

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 C's surgery was carried out reasonably and that there was no immediate indication of the complications that they would subsequently experience. We noted that it is not uncommon for patients to experience pain for up to 12 months following a hip replacement. We were generally satisfied that the board's staff took C's pain seriously and carried out reasonable investigations to establish its cause. We also noted that leaked cement is not uncommon and would not initially be viewed as a likely source of a patient's pain.

We considered that the complications C experienced were extremely rare and required specialist intervention. We found that it was not until an x-ray taken a year after surgery that it became apparent that a large amount of cement had leaked from the surgical site and a later MRI scan identified that C had a degree of psoas tendinopathy (an inflammation of the tendon or area surrounding the tendon).

Whilst we were satisfied that the clinical team followed a reasonable path to establishing and treating the cause of C's pain, we were critical of the time taken to conduct a CT scan following the MRI scan and of the time taken to provide surgery to resolve the issue. Therefore, we upheld C's complaint on that basis.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the unreasonable delays during the diagnosis of and in arranging the treatment of C's postoperative complications. 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:

- The board should arrange for this case to be presented at a local clinical governance meeting (with radiologists present) where the case and imaging should be reviewed.

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.