SPSO decision report

Case: **202001221, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C underwent surgery for removal of a complex cyst on their right ovary. C complained that during the surgical procedure the board unreasonably removed their left ovary despite their express wishes it should be retained. They said that in the absence of a fully informed pre-surgical consultation, the board had not understood their surgical choices and had unreasonably prepared them for surgery. They said that following surgery, the board had failed to provide them with adequate pain relief and had withheld their medication. C also complained that the board's handling of their complaint was inadequate and that there were delays and inaccuracies in their response.

We took independent advice from an appropriately qualified adviser with experience in obstetrics and gynaecology (pregnancy, childbirth and the female reproductive system). We found that the surgical procedure performed was in line with the recommendations of a multidisciplinary team (MDT) and that the board had acted on what they believed were C's express instructions and for which written consent had been obtained. As such, we did not uphold this part of the complaint.

We found that despite reasonable attempts to include C in the pre-surgical decision-making and consent process, the board had failed to clarify with C their understanding of the proposed surgical plan and the circumstances in which C's left ovary was to be removed. We also found that the board had not telephoned C following the MDT team meeting as had been agreed, and some of the pre-surgical discussions that had taken place between the parties were brief or had not been documented in the clinical records. Therefore, on balance, we upheld this part of the complaint.

Following C's surgical procedure we found that there were two occasions where analgesia (pain medication) had been delayed after being requested, and on one of those occasions where it appeared to have been an inadequate dose. However, we found that C's usual pain regime medications had been administered regularly and their acute pain medications administered when requested. As such, we found that C had been provided with appropriate pain relief and did not uphold this part of the complaint.

We found that the board's complaint handling in this case was poor. There was a failure by the board to update C on the progress of the investigation and there were delays in a number of their responses. The board's final response contained a number of factual inaccuracies and it had not adequately addressed all of C's concerns. As such, we upheld this part of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to clarify their understanding of the proposed surgical plan, the circumstances in which their left ovary was to be removed and for failing to handle their complaint reasonably. Also apologise for not sufficiently documenting the discussions that took place between the parties at the initial consultation, for failing to contact C by telephone following the MDT meeting, and for failing to document

the pre-operative discussions which took place between the parties on the morning of C's surgery. 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:

- Ensure all discussions between patients and clinicians are clearly documented as part of the consent process.
- All relevant clinical staff should be reminded of the need to ensure all reasonably practical steps are taken to clarify a patient's understanding of a proposed surgical plan prior to consent being obtained and that patients are fully counselled on the nature of borderline ovarian cancer results.

In relation to complaints handling, we recommended:

- The board should ensure all complaints are handled in line with the NHS Model Complaints Handling Procedure, particularly in terms of the requirement to respond in writing and in a timely manner. Where a response to a complaint cannot be provided within an agreed timescale, complainants should be provided within an updated timescale as to when they can expect to receive a response. The board should ensure all responses are accurate, reflect the available evidence and information, and address all points raised. Where there has been a delay in providing a response beyond the normal timescale, the board's stage 2 response should include an apology.

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.