SPSO decision report

Case: **202008323, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Communication / staff attitude / dignity / confidentiality
Decision: some upheld, recommendations

Summary

C complained about the care and treatment they received from the board in relation to knee replacement surgery. C said that a surgeon failed to adequately advise them of the potential risks of a total knee replacement and therefore failed to obtain their informed consent for the operation. C also complained that the surgeon failed to adequately examine their leg either pre or post operatively. C said that they had experienced a mal-alignment of their leg as a result of the operation leading to significant pain and loss of mobility.

The board was unable to identify the cause of the mal-alignment of C's leg, but did not identify any failings in their care and treatment.

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, despite some failings, the consent process in C's case was reasonable. We also found no evidence that the board's surgeon failed to adequately examine C's leg either pre or post operatively. Therefore, we did not uphold these parts of C's complaint.

C also complained that the board failed to adequately investigate or respond to their complaint. We found that the board's complaint response was unreasonable and upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflet.

In relation to complaints handling, we recommended:

- Complaint investigations should be carried out in line with the NHS Model Complaints Handling Procedure. The investigation should be thorough, and the complaint response should be accurate in their findings and conclusions and supported by relevant evidence such as medical records. Where there have been failings in surgery, the case should be presented and discussed within a departmental surgical morbidity and mortality meeting.

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.