SPSO decision report

Case: **202103830, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received from the board. C was diagnosed with an ovarian cyst and admitted to hospital for a laparoscopy (a surgical procedure that allows a surgeon to access the inside of the abdomen and pelvis through a small hole in the skin) to remove the cyst. During the procedure, no cyst was found. However, an unusual mass was identified but not removed. An MRI scan was arranged to further investigate the findings of the laparoscopy.

C was discharged from hospital but became unwell. C attended the A&E with severe vomiting and diarrhoea and was admitted to hospital that same day.

An MRI scan was carried out and the results indicated that the previously identified mass was a haematoma (a collection of blood) and C was discharged home with antibiotics.

C became unwell again and attended a hospital in England where they were diagnosed with Clostridium Difficile Infection (CDI, a bacterial infection of the large intestine, a common healthcare associated infection). A CT scan also identified a cyst.

C commented that clinicians were surprised that C had not been screened for CDI when they previously attended hospital, having presented with diarrhoea several days after a laparoscopy. The clinicians also reportedly questioned why C's haematoma was not removed when it was diagnosed given the likelihood of infection.

C complained that the board misdiagnosed their haematoma and failed to screen them for CDI, resulting in unnecessary complications and illness.

The board, in their response to C's complaint, explained that there was no clinical indication that C was experiencing ongoing diarrhoea, and were satisfied that they did not therefore screen for CDI. The board said that having reviewed the care provided to C during their admission, they were satisfied that, whilst C suffered complications, the care provided was appropriate and reasonable

We took independent advice from a general surgeon adviser. We found that C presented with a history of diarrhoea prior to admission and that this was not identified or flagged to relevant clinicians on their admission to hospital. Given C's history prior to admission, C should have been screened for CDI and therefore, we upheld this aspect of the complaint.

With respect to the C's diagnosis and treatment, we found that the conservative management plan which was adopted was reasonable in the circumstances. Whilst we identified some aspects of the clinical review undertaken of C's condition which could have been better, they did not negatively impact on C's outcome and we did not uphold this aspect of the 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-leaflets.

What we said should change to put things right in future:

- That the board ensure that they implement, or have implemented, all of the recommendations of the Guidance on Prevention and Control of Clostridium difficile Infection (CDI) in health and social care settings in Scotland.
- That the board review their practices and ensure that all staff are operating in line with the Guidance on Prevention and Control of Clostridium difficile Infection (CDI) in health and social care settings in Scotland.

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.