SPSO decision report

Case: **201608164, Lothian NHS Board - Acute Division**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Decision: some upheld, recommendations

Summary

Mr C complained that he was unreasonably discharged from the Royal Infirmary of Edinburgh following hip replacement surgery, as he was unable to pass urine and was constipated at the time of discharge. Mr C eventually had a catheter fitted and was advised by a consultant at the Western General Hospital that he would be put on a waiting list for transurethral resection of the prostate (a surgical procedure that involves cutting away a section of the prostate - a small gland in a man's pelvis located between the penis and bladder). Mr C complained that the board misled him about the date for his surgery and that they failed to carry out his operation within a reasonable time.

We took independent advice from a nurse. They said that it was appropriate for Mr C to be discharged from hospital, as his notes indicated that he was not experiencing any issues with passing urine or that his bowels were not working. Therefore, we did not uphold this part of the complaint. However, we noted that the board recognised they should have provided Mr C with oral laxatives on discharge and will take action to address this issue in future.

Based on the information available we did not consider that the board misled Mr C about the date for his surgery and we did not uphold this part of the complaint. However, we noted that the board had indicated that they had taken steps to try to ensure that in future, the medical team and their secretaries were kept notified of waiting times for procedures and we asked the board to provide evidence of this.

The adviser said that Mr C's surgery was completed outwith the 12 week treatment time guarantee and as the procedure was classified as 'urgent', this appeared unreasonable. The board explained the steps that they had taken to try to reduce the waiting times for patients and identify alternative providers and we asked for further evidence of this. We also found that there was poor communication between the board and Mr C regarding the delay in his surgery, advice and support available to him and in their handling of Mr C's complaint. Therefore, we upheld this part of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the unreasonable delay in providing surgery, not discussing the advice and support available to him and for the communication error in complaints handling. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- The board should inform patients as soon as possible of any inability to meet treatment targets and provide them with all the required information. This should include options available to them in the

circumstances and how to provide comments/feedback or make a complaint about the delay.

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.