SPSO decision report

Case: **201900537, Lothian NHS Board - Acute Division**
Sector: Health
Subject: communication / staff attitude / dignity / confidentiality
Decision: upheld, recommendations

Summary

C underwent specialist reconstructive surgery. After the surgery, C experienced urinary incontinence. C said that they had believed the surgery would be of a routine nature and complained that they had not been not provided with adequate information about it; in particular, that a possible side effect was incontinence.

We took independent advice from a urology adviser (a doctor who specialises in the male and female urinary tract, and the male reproductive organs). We found that the board failed to provide adequate information to C about the planned procedure prior to obtaining their consent and, therefore, we upheld this complaint.

C also complained about the delay in the surgery being carried out. The board accepted that there was a delay in C accessing treatment and explained that the delay reflected the waiting list issues the department had at the time. We found that there was an unreasonable delay in C's planned procedure being carried out. We upheld this complaint.

C complained that the board failed to provide them with reasonable care and treatment. C had concerns about how the board managed their place on the waiting list for the planned procedure and about the aftercare provided. The board acknowledged that there was a breakdown in communication which resulted in C having to arrange aftercare themselves. However, they said that their waiting list was managed appropriately. We found that there was nothing to suggest that C's place on the board's waiting list was managed inappropriately. However, we upheld the complaint on the basis of the breakdown in communication which resulted in C arranging aftercare treatment themselves.

Finally, C complained that the board failed to handle their complaint reasonably. The board acknowledged that there had been a delay in responding to C's complaint and that they had not communicated about the delay with C. We found that the board did not respond to C's complaint within expected timescales or communicate with C about that delay. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the identified failures. 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 consent process should follow national guidelines. Consent should be taken, where possible, prior to the day of surgery. As part of the consent process, there should be a clear discussion of the risks and benefits (of having the surgery and not having the surgery) and of any alternative treatment options; and those discussions should be clearly documented.

- Patients should get appropriate follow-up appointments.

In relation to complaints handling, we recommended:

- Staff should handle complaints in line with the Model Complaints Handling Procedure, which includes responding to complaints within timescales and where this is not possible, advising complainants of this and providing revised timescales.

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.