SPSO decision report

Case: **202300806, Western Isles NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the standard of surgery and post-operative care that they received when they had an elective operation for a long standing hernia (when part of an organ protrudes through your muscle wall). During the procedure the bowel was punctured resulting in an injury and transfer to another hospital.

C said that the small hernia was manageable without an operation, and complained that they had not been told about all the risks and about inadequate care post-surgery.

We took independent advice from a consultant general and colorectal surgeon. We found that it was reasonable to offer C an elective repair of the hernia and for this operation be to done by the consultant surgeon. However, more regard should have been given to whether C was at an increased risk due to their BMI. We found that the board failed to provide informed consent at an appropriate time which meant that the risks of surgery were not effectively communicated to C. We also found that the consent process for C did not meet published guidelines. Therefore we upheld this complaint.

We found that post surgery, recognition and escalation to start Patient Controlled Analgesia was appropriate, and that C responded well to this pain relief. The timing of the CT scan was reasonable. Following escalation to clinical care specialists and treatment, C was transferred for further care which was also reasonable. We therefore did not uphold this complaint.

We provided feedback that consideration should be given to the preoperative risk assessment being carried out at consultant level and that referral to specialist weight management is available for patients who require incisional hernia repairs electively.

Recommendations

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

- Relevant staff should be aware of the required consent procedure and to ensure that the consent discussions are appropriately timed in advance of surgery and documented.
- When a relevant adverse event occurs, the board should promptly carry out an SAER to investigate the cause and identify any potential learning.

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.