SPSO decision report

Case: **201203939, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: admission, discharge & transfer procedures
Outcome: some upheld, recommendations

Summary

Mr C had been diagnosed with a retroperitoneal liposarcoma (a malignant soft-tissue tumour) which was removed. Two years later, a CT scan (a special scan using a computer to produce an image of the body) showed that the tumour had grown back, and it was decided that scans should be carried out to monitor its growth. The scans showed that the affected area had grown and so it was decided to surgically remove the tumour. When the operation was carried out, it was not possible to remove the tumour completely. The right ureter (the tube that carries urine from the kidney to the bladder) was also involved in the tumour and it was divided and closed off.

Mr C complained that the surgeon failed to obtain an up to date CT scan of the affected area before he carried out the operation. After taking independent advice from one of our medical advisers, we found that such a scan was not needed as it would not have changed the need for or prevented the surgery on Mr C's ureter. We also found that all the required investigations were performed and documented before Mr C had the operation.

We did, however, uphold his other complaints. Mr C complained that the surgeon had failed to obtain informed consent from him for the operation. He said that he thought that only the tumour would be removed and had never been told that surgery on other tissue or organs might be required. The board's consent policy clearly says that it is essential for health professionals to clearly document both a patient's agreement to treatment and the discussions that led to that agreement. The policy says that this will be done either using a consent form that the patient signs, or by documenting in the patient's case record that they have given verbal consent. We found that the clinical decisions and surgical treatment were correct and in line with the accepted standard of practice for this operation. However, there was no documented evidence that Mr C was given sufficient information before the surgery about possible loss of kidney function. Consequently, we found that that there was no evidence that the board had communicated with Mr C effectively during the consent process.

Several weeks after Mr C was discharged from hospital, he was admitted to another hospital with hydronephrosis in his right kidney (a condition where one or both kidneys become stretched and swollen because of a build-up of urine). Mr C said that he and the staff in the other hospital were initially unaware that his right ureter had been intentionally closed off. Because of this he was initially diagnosed with a possible kidney stone, before it was identified that the problem was related to the surgery on his ureter.

We found that it was not possible to say whether Mr C was given sufficient information after the operation, as there was no written documentation of the discussions on ward rounds. The board said that he was told what had been done. However, it was clear that after the operation Mr C was not fully aware of the extent of the surgery he had. We could not say whether this was because he was told, but did not retain the information, or because this information was not given to him. However, important information shared with the patient on ward rounds should be clearly documented in writing in the clinical notes and there was no evidence in Mr C's notes that staff had effectively communicated details of the operation to him.

Recommendations

We recommended that the board:

- consider if their consent form should be reviewed in order that there is a section to record possible risks and complications; and
- remind the relevant staff involved in Mr C's care and treatment that important information shared with the patient on ward rounds should be clearly documented in writing in the clinical notes.