# SPSO decision report

**Case:** **201301190, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** clinical treatment / diagnosis
**Outcome:** upheld, recommendations


## Summary

Miss C complained about the care and treatment she received from a consultant urologist. (Urology is the branch of medicine that relates to the urinary system.) She said that the level of aftercare she received was insufficient. Miss C also complained that the consultant did not communicate adequately with her, and did not communicate adequately with her GP after the procedure.

Our investigation found that Miss C was admitted to hospital for a relatively rare urological procedure. The day after the procedure she was discharged, but was not told about any follow-up care, other than an appointment in the urology clinic four months later. After she was discharged, Miss C became unwell, and went to see her GP. She told us that her GP was unable to provide effective care beyond pain management because at that time he did not have any information from the board about her admission. Miss C became more unwell, and was admitted to her local hospital ten days after the operation.

After taking independent advice on this case from a urology adviser and a general medical adviser, we upheld both Miss C's complaints. The urology adviser was critical that Miss C's clinical notes did not mention any discussions with her before the procedure about what was involved and what the risks were. He also said that Miss C had not had a scan a week after her procedure, although this had clearly been intended, and that the scan was not mentioned on the immediate discharge letter for her GP. This meant that neither Miss C nor her GP could follow up with the board appropriately when arrangements for the scan were not made.

In relation to communication with the GP, we found that the board appropriately prepared the immediate discharge letter and a discharge summary letter. We could find no evidence to show when the medical practice received these, but the immediate discharge letter had clearly not been received by the time Miss C consulted her GP. We were also concerned that it did not contain information about the scan, making it impossible for Miss C or her GP to ensure that appropriate aftercare was given.


## Recommendations

We recommended that the board:

- remind urology department staff of the need to ensure that all aftercare appointments are in place prior to discharging patients;
- ensure that discussions about consent, including the risks of a procedure, are documented at the time they take place;
- take steps to ensure patients are informed of any follow-up appointments on discharge and that the GP is advised appropriately; and
- apologise to Miss C for their failure to provide appropriate aftercare and for their failure to communicate appropriately with her and her GP.