SPSO decision report

Case: **201703864, Grampian NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: some upheld, recommendations

Summary

Mr C made a number of complaints about an inginual hernia repair (an operation to repair a weakness in the abdominal wall) he underwent at Dr Gray's Hospital. Mr C required to have further surgery a week later to remove a testicle due to a rare but recognised complication of the surgery. Mr C complained that he had not been reasonably informed of all the recognised complications when consenting to his surgery. Mr C was also concerned that his surgery was not carried out properly, that he was discharged too soon from hospital after the inginual hernia repair, and that there was an unreasonable delay in receiving a review appointment following the operation to remove his testicle. The board apologised that they were unable to offer him a review appointment within the original planned timescale due to a high volume of patients and took action to address this problem. The board identified no other issues with Mr C's treatment. He was unhappy with this response and brought his complaint to us.

We took independent advice from a consultant general surgeon. We considered that the board's handling of the consent process was below a reasonable standard. It was not clear to what extent the term testicular atrophy (shrinkage/wasting) was explained to Mr C at the time of his clinic appointment or whether he understood this, nor was any additional patient information on the procedure provided to Mr C for reflection at this time. In addition, the consent form Mr C signed was completed on the day of surgery instead of at the out- patient clinical consultation and it did not list the possible but rare risk of testicular complication. Therefore, we upheld this aspect of Mr C's complaint.

In relation to the procedure, we considered that this was completed to a reasonable and appropriate standard. The adviser noted that the rare complication Mr C suffered was not a result of a failing in the surgery. However, we noted that the board incorrectly suggested in their response to Mr C's complaint that a consultant surgeon had performed the surgery when in fact they were supervising it to ensure the quality of the procedure. We did not uphold this aspect of Mr C's complaint but made a recommendation in light of this finding.

In relation to Mr C's discharge, we found no evidence to suggest that he was unreasonably discharged following the inguinal hernia repair. We did not uphold this aspect of Mr C's complaint.

Finally, we found that given the distressing complication Mr C experienced following his surgery, it was unreasonable for him to wait over 26 weeks to be reviewed following removal of his testicle rather than within the planned six to eight weeks. We upheld this aspect of Mr C's complaint but noted that the board had already taken action to address this issue.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the failings in the consent process and the failure to provide accurate information in relation to who had performed the surgery. The apology should meet the standards set out in the SPSO

guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Surgeons should complete the consent process in the pre-operative clinic; ensure the risks are clearly explained to the patient, checking that the patient understands the information and that this is documented; and ensure the patients take a copy of the consent form to enable reflection. Information for patients should be available concerning inguinal hernia repair in a separate booklet that details 'the risks inherent in the procedure, however small the possibility of their occurrence, side effects and complications'.

In relation to complaints handling, we recommended:

- The board should ensure transparent and open communication with patients. In particular, the board should ensure that patients are informed about who undertook their surgery.