SPSO decision report

Case: **201904442, Grampian NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C, an advocacy worker, complained to us on behalf of their client (A) about the care and treatment they received at Aberdeen Royal Infirmary. A had an autologous fascia sling procedure (where a strip of tissue from the abdomen is used to create a sling under the urethra) to treat stress urinary incontinence (where urine leaks out of the bladder when it is under pressure). A suffered two complications from the surgery; including a bladder injury and overactive bladder (needing to get to the toilet in a hurry or leaking urine before reaching the toilet). C complained that A was not properly informed about the risks during the consent process.

We took independent gynaecology (specialists in the female reproductive system) advice. We found that at A's clinic appointments, they were given appropriate information about the risks involved in the surgical options available. However, a significant period of time passed until A had the surgery. Moreover, surgery had not been A's first choice of treatment, and there was a change to the planned procedure. In the circumstances, we found that it was particularly important to have reiterated all the significant risks of surgery when A signed the consent form. However, we found no evidence that A was advised about the risk of overactive bladder, even though it is a common complication. We upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for failing to appropriately inform them of the risk of overactive bladder. 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. As part of the consent process, information about the common and serious complications of surgery should be reiterated to the patient as close as possible to their surgery; and that information should then be clearly documented.

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.