SPSO decision report

Case: **201200392, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her son (Master A) after a circumcision operation. She said that hospital staff inappropriately discharged her son after the operation; failed to provide the family with information leaflets or advice about what aftercare was required and failed to provide appropriate follow-up treatment when it was evident that the wound was not healing.

After we took independent advice on this case from one of our medical advisers, a paediatric surgeon, we upheld all of Ms C's complaints. The adviser said that, given Master A's level of discomfort and his difficulty in passing urine, he should not have been discharged from hospital when he was. The adviser also said that the board should have provided Ms C with a discharge summary, including plans for follow-up, when Master A was discharged. We found that the board failed to carry out an investigation into their discharge arrangements, information and documentation, as they had said they would, and to promptly convey the results to Ms C.

The adviser also said that a routine follow-up appointment should have been made for Master A, and that the board should have brought forward that appointment after his emergency reassessment, without any intervention from Ms C. Master A was later prepared for theatre without any explanation to his family, but a surgical registrar then decided not to operate and discharged him home. We found that the junior surgeon who initially saw Master A should have made Ms C aware that the final decision about surgery would be made by the surgical registrar.

Recommendations

We recommended that the board:

- ensure that this complaint is used as a learning tool for all staff responsible for the discharge arrangements for patients undergoing this type of procedure;
- ensure that patients undergoing this procedure are appropriately followed up, including ensuring any necessary follow-up appointments are made prior to discharge;
- ensure that a full review of their discharge policy is carried out for patients undergoing this type of procedure and provide the Ombudsman with evidence of the review; and
- provide both Ms C and Master A with a full apology for the failings identified.