SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **201910513, Borders NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their client (A) who underwent a cystoscopy (bladder examination using a narrow tube-like telescopic camera). C said that the procedure had life-altering consequences for A, causing bleeding for nine days and leaving them permanently incontinent and susceptible to ongoing urinary infections.

C complained that the board had no urology (a specialty in medicine that deals with problems of the urinary system and the reproductive system) specialists available over the period of A's procedure and that this caused a delay in recognising the symptoms A was experiencing and their significance.

C submitted a complaint to the board regarding A's experiences. C said that, whilst the board apologised to A, they provided little explanation as to what happened or any potential treatment options that may have been available to A.

We found that A's medical history meant that they were at an increased risk of complications such as bleeding and incontinence following surgery. We were critical of the board for a lack of evidence of A being made aware of these risks when consenting to the surgery. We also found that, whilst the board were aware that there would be no specialist urological support available within the hospital following A's surgery, this was not communicated to A. Support was available from a neighbouring health board, however, we found that the board's staff did not seek their input as early as they could have when A began to show signs of postoperative complications. We upheld this aspect of C's complaint.

We also found that there was a lack of accurate record-keeping with regard to A's care at Borders General Hospital and upheld this aspect of the complaint.

We were satisfied that the board handled C's complaint reasonably and did not uphold this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the issues highlighted in our decision. 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:

- That the board conduct a review of the information provided to patients prior to surgery and take steps to ensure patients are fully informed before providing their consent.
- That the board remind urology staff of the importance of maintaining clear and detailed patient records at all times.

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.