SPSO decision report

Case: **201600121, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained that there was a failure to carry out a proper range of diagnostic tests into the possible cause of blood in his late wife (Mrs A's) urine when she was admitted to Southern General Hospital. Mrs A underwent a change of catheter and a urinary tract ultrasound. A cystoscopy (a medical procedure used to examine the inside of the bladder) was also planned, but was not carried out.

We took independent advice from a urological surgeon. We found that the treatment Mrs A received was reasonable. We also found that an ultrasound and a cystoscopy would normally be the first wave of investigations to investigate blood in urine, and in doing so investigate the possibility of cancer. While an ultrasound was carried out when Mrs A was admitted to hospital, we found that the decision not to carry out the cystoscopy at that time was reasonable. However, we found that the subsequent delay in carrying out a cystoscopy was unreasonable. While the advice we received was that an earlier cystoscopy and diagnosis of bladder cancer may not have changed Mrs A's outcome, we were concerned that the uncertainty caused Mrs A, Mr C and their family considerable distress during a very difficult time. Given the delay in carrying out the cystoscopy we upheld this aspect of the complaint.

Mr C also raised a concern that Mrs A was unreasonably discharged from the Victoria Infirmary following an emergency admission due to side effects from opiate pain relief that had been prescribed to her. Following this discharge Mrs A had to return to the hospital and was admitted a few hours later. We took independent medical advice from a consultant physician. We found that it was unreasonable that Mrs A was discharged and that, while relevant examinations were carried out, the relevant investigations were not. In particular, we found that the medical staff caring for Mrs A should have predicted the potential requirement for further naloxone (a medication used to block and reverse the effects of opiates) after the naloxone given by ambulance crew had worn off. Our adviser said that, according to the medical records, Mrs A was discharged after approximately two hours, which they considered to be too short a period in the circumstances. The adviser also considered that inadequate investigations into Mrs A's home circumstances were carried out before discharge. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- The board should issue a written apology to Mr C for the unreasonable delay in carrying out the cystoscopy.
- The board should issue a written apology to Mr C for unreasonably discharging Mrs A from the Victoria Infirmary.

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

- The board should ensure that patients with visible blood in their urine are investigated in a timely manner.

- The board should ensure that, where a patient with renal impairment or multiple medical problems has overdosed on long acting opiates, relevant investigations are carried out.
- The board should ensure that relevant guidelines are prepared on the use of naloxone in adult patients with renal impairment who have overdosed on long acting opiates.
- The board should ensure that a patient's home circumstances are adequately investigated when notification is received from a family member that they are struggling to cope at home.

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.