SPSO decision report

Case: **202204429, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C was diagnosed with a kidney stone by a neighbouring board. Shortly after, they attended Greater Glasgow and Clyde's Urology Department and received an X-ray. C complained that the board failed to identify the kidney stone, resulting in surgery several weeks later and a kidney injury.

We took independent advice from a consultant urologist. We found that while it was not possible to determine whether the board failed to identify a kidney stone on the X-ray, the board did have doubt about whether the stone had passed. At this point the board should have checked this by means of a CT scan. We found that it was not possible to determine whether failing to confirm a kidney stone, and delayed treatment, would result in a kidney injury. We upheld this part of the complaint because it was unreasonable for the board to have doubt about whether there was a stone present, but not to confirm this.

C complained that the board had failed to arrange a follow-up appointment within an appropriate time period. We found that when passage of the stone was not confirmed, a follow up CT scan should have been arranged within 2 weeks, and that the plan to wait a further 6 weeks in these circumstances was unreasonable. Therefore, we upheld this part of C's complaint.

C also complained that the board did not clearly communicate their diagnosis, and their subsequent request for clarification on how they came to have surgery after being told there was no kidney stone present. We found that there were shortcomings in the board's communication with C, both in relation to the kidney stone and in providing an explanation as to how they came to have surgery. Both of these might have been relatively easily avoided or resolved. We therefore upheld this part of C's complaint.

We asked the board to reflect on the imprecision of using plain X-rays and consider the possibility of updating practice by using low dose non-contrast CT scans as standard.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific communication and process failings identified in respect of their complaints. 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:

- Patients should have a full understanding of what is happening in relation to their diagnosis and ongoing treatment plan. The board should ensure that patients are sign posted to the relevant complaints procedure when they raise concerns.
- Relevant staff should be aware of the requirements of ensuring that patients are stone free, either by

spontaneous passage or clinical removal after 4 to 6 weeks of initial presentation, in accordance with the relevant guidance.

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.