SPSO decision report

Case: **201005162, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr A was referred by his GP to a hospital urology department for review of his mixed urological symptoms at that time. He subsequently had a CT scan of his urinary tract which showed appearances of retro peritoneal fibrosis (RPF). Following a consultation with a consultant urologist, he was admitted to hospital for further investigation which showed that his right kidney was providing 90 percent of his renal function and his left kidney only accounted for 10 percent of this function.

After this investigation, a senior registrar in urology wrote to Mr A informing him of the possibility that his left kidney may have to be removed. This was the first time that Mr A had been made aware this was a possibility and that his left kidney was non functioning. Mr A was also referred to a vascular surgeon as he was diagnosed with aortitis. Mr A considered there was an unacceptable delay with this referral.

Mr A requested to be reviewed by another urology consultant for a second opinion. At this appointment it was discovered that the consultant did not have his case notes and had been given the case notes for another patient.

Mr A complaiend to us. He said that he felt that he had not been dealt with in an 'appropriate, timely or professional manner'. He said that there was both delay and failure to treat his condition and also a failure to communicate with him about his condition.

We obtained Mr A's medical records and took professional advice from our independent medical adviser. The adviser explained that RPF is a rare kidney condition which in the case of Mr A presented in an unusual manner. The adviser found that the initial investigation and management of Mr A's condition was conducted in a timely manner and there was no delay in diagnosis of the condition.

However, the adviser stated that following a failure to pass a ureteric stent there was no evidence in Mr A's medical notes that there were discussions about possible other treatment for Mr A's condition. For this reason we concluded that there was a failure to treat Mr A's condition and we, therefore, upheld this element of the complaint.

In relation to the diagnosis and treatment of Mr A's vascular condition, the advice received was that there was a delay in Mr A's treatment and for this reason we also upheld this element of Mr A's complaint. However, the adviser also stated that this did not impact on the treatment that Mr A received and that the treatment in this regard was appropriate for his condition.

We found that there was a failure to communicate with Mr A about his condition and we, therefore, upheld this part of his complaint.

We did not uphold Mr A's complaint that there was a failure to transfer his medical notes to his consultant for an appointment. This was because while it was accepted by the board that the consultant did not physically have in his possession Mr A's medical notes when he saw him, we accepted that the consultant was able to appropriately access all information pertinent to his case through the clinical portal.

Recommendations

We recommended that the board:

- review their procedures so that a robust system is put in place to ensure that the results of investigations are communicated quickly to clinical teams, particularly if they are abnormal;
- review their procedures so that all clinical letters to patients are typed promptly after dictation and any outcomes from these are actioned quickly;
- review their procedures so that discussions by multi-disciplinary teams are recorded and communicated to patients particularly if there is a delay before the patient can be seen in an outpatient clinic;
- apologise to Mr A for their failure to communicate with him effectively about his condition and outcomes; and
- review their systems so as to ensure a patient's medical records, as appropriate, are available when they attend an appointment with a clinician.