SPSO decision report

Case: **201202584, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care that her husband (Mr C) received in hospital after a catheter (a tube used to drain urine) was inserted into his bladder. Mrs C also complained about poor record-keeping in relation to the catheter's removal and that the board's correspondence to her contained inaccurate information.

Mrs C said that a member of the nursing staff told her that Mr C had pulled the catheter out, but it did not need replacing as he was passing urine normally. After Mr C was discharged from hospital, he suffered recurrent urinary tract infections for approximately six months. He was referred to a specialist and tests showed that a 20 centimetre section of the catheter had been found in Mr C's bladder, which caused Mr C severe pain.

We considered that it was likely Mr C had pulled part of his catheter out due to episodes of confusion and agitation while in hospital. We took independent advice from one of our medical advisers, who said that this was a very unusual case, and that it was good practice for nursing staff to record when a catheter had been removed. We found that there was no evidence to show that nursing staff had ensured that Mr C's catheter had been removed safely or had monitored him in line with the board's guidelines for urinary catheter care. Our investigation also found that whilst the board had apologised to Mrs C verbally for inaccuracies in their correspondence, including referring to her husband by the wrong name and suggesting that he had passed away, we considered that it would have been appropriate for them to have apologised to her in writing, as she had requested.

Recommendations

We recommended that the board:

- review their guidelines on urinary catheter care and care plans, with a view to including a requirement to record the due date and the date when a catheter is removed in order to ensure continuity of care;
- apologise to Mr and Mrs C for the failings identified; and
- draw our findings to the attention of relevant staff, to ensure appropriate written responses and apologies are given where relevant.