SPSO decision report

Case: **201508320, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C attended Glasgow Royal Infirmary with a swollen right leg and foot for investigation of a possible blood clot. Whilst at the hospital, staff took several blood samples from Ms C. Ms C complained that the laboratory at the hospital unreasonably lost one of her blood samples. She said her complaint was not about the length of time she waited for the results, but the fact that the blood sample went missing and that she was told by staff at the hospital that this was a regular occurrence.

We obtained independent medical advice from a nursing adviser. The evidence showed that on the day in question, the board's electronic healthcare information system was not operating properly and staff had to resort to manual recording of blood sample requests. Ms C's blood sample was taken at 14:00 and was received by the laboratory at 17:50. The accounts of staff involved indicated that there was some confusion over the method of transportation which was used to deliver the sample to the laboratory. Staff initially believed that the sample had been delivered by the pneumatic tube system (a network of tubes using compressed air to transport the samples to the laboratory). They then discovered that the sample was on a table in the A&E department waiting to be collected by a porter, and there had been a collection problem. The adviser said that the board's investigation and records indicated that the sample was lost, albeit temporarily, and then found by a member of staff and sent to the laboratory. We were critical of the board in this regard and we upheld Ms C's complaint.

On the matter of Ms C's concern that staff told her that blood samples being lost was a daily occurrence, the board indicated that there had been no previous complaints and their external accreditation review found that the laboratory met the quality standards. The adviser said that the board's response was reasonable.

Recommendations

We recommended that the board:

- review their written procedures for transporting samples to the laboratory to minimise the risk of this situation recurring; and
- provide Ms C with a written apology for the failings identified.