# SPSO decision report

**Case:** **201606979, Greater Glasgow and Clyde NHS Board - Acute Services Division**
**Sector:** health
**Subject:** admission / discharge / transfer procedures
**Decision:** some upheld, recommendations


## Summary

Mrs C complained to us about the care and treatment provided to her late husband (Mr A) at the Victoria Infirmary. Mr A had been referred to the board for investigation of macroscopic (visible) haematuria (blood in urine). Mr A had subsequently died from cancer of the bladder.

Mrs C complained that a discharge letter inappropriately referred to Mr A as having been treated for microscopic (non-visible) haematuria. We found that the letter did incorrectly say that Mr A had undergone a cystoscopy (a procedure to look inside the bladder using a thin camera) for microscopic haematuria instead of macroscopic haematuria. The board said that this had been due to a typing error. We upheld the complaint and recommended that the board apologise to Mrs C for this. However, we noted that the investigations that had been carried out where appropriate for a man presenting with macroscopic haematuria and that this typing error had not impacted on Mr A's care.

Mrs C also complained that the board failed to carry out a CT scan (a scan that uses x-rays and a computer to create detailed images of the inside of the body) at the time that Mr A underwent the cystoscopy. We took independent advice from a consultant urologist and we found that there had been no requirement at that time for the board to carry out a CT scan. We did not uphold this aspect of Mrs C's complaint.

Mrs C also complained that the board's response to her complaint had incorrectly stated that there had been no subsequent contact between Mr A's GP practice and the hospital after Mr A's cystoscopy. Mrs C provided evidence which showed that the GP practice had phoned the hospital after Mr A's cystoscopy to report that there was still blood in Mr A's urine. We found that, in line with the relevant guidance, this should have prompted the board to request a CT scan at that time. However, we found that even if a CT scan had been carried out, it was unlikely that Mr A's outcome would have been significantly different. Due to the evidence we saw that there had been contact between the GP and the hospital, we upheld this aspect of Mrs C's complaint.


## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the incorrect information on the discharge letter which inappropriately referred to microscopic haematuria. Also apologise for incorrectly stating in the complaints response that there was no subsequent contact from Mr A's GP practice after the cystoscopy. These apologies should be in line with SPSO guidelines on apology, available at www.spso.org.uk/leaflets-and-guidance.

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

- When a GP surgery contacts a hospital with additional information, it should be recorded and acted on.

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.