SPSO decision report

Case: **201705123, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about the care and treatment he received at Monklands Hospital. Following an accident, Mr C presented to the emergency department on three occasions over a two day period. He raised concern that doctors did not listen to his concerns about his injury and that an x-ray was not performed until his third presentation. At the first presentation, Mr C was examined for a head injury and was discharged without an x-ray being performed. Mr C returned to the department the next day and was assessed by a different doctor who also discharged Mr C. A short time later, the doctor revised their decision to discharge Mr C and he returned to the department a short time later. An x-ray identified that he had suffered a spinal fracture.

In response to Mr C's complaint, the board acknowledged that a scan should have been performed at the first presentation and an apology was offered to Mr C. The board detailed a number of steps that would be taken to learn from the issues identified. We took independent advice from an emergency medicine consultant. We found that the board had appropriately identified all the failings in relation to this matter. We upheld this aspect of Mr C's complaint and asked the board to provide evidence of actions taken to prevent these failings reoccurring.

Following the diagnosis of a spinal fracture, Mr C experienced an episode of urinary retention (inability to empty the bladder completely) during the admission. A number of attempts at urethral catheterisation (insertion of a thin tube into the urethra to drain and collect urine from the bladder) were made, yet these were unsuccessful. Urology doctors (a doctor who specialises in the male and female urinary tract, and the male reproductive organs) offered to perform suprapubic catheterisation (surgical insertion of a thin tube through the skin to drain and collect urine from the bladder), yet Mr C did not consent to this procedure. Mr C felt that doctors did not listen to him when attempting catheterisation and was unhappy that a camera was not used to assist catheterisation. We took independent advice from a consultant urologist. We found that the attempts at catheterisation were not sufficiently documented and that the documentation regarding consent was inadequate. Therefore, we upheld this aspect of Mr C's complaint.

Finally, Mr C was unhappy that, during a previous admission to hospital a number of years before, he was not informed that he had experienced complications related to urological treatment. We did not find evidence that Mr C had experienced complications related to earlier treatment and so we were unable to conclude that there had been a failure to inform Mr C. Therefore, we did not uphold this aspect of his complaint. However, we gave feedback to the board regarding communication as it seemed that a communication breakdown had contributed to Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C for the inadequate documentation of the urethral catheterisation attempts and the inadequate documentation of the consenting process for catheterisation. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Where catheterisation has been attempted, this should be documented along with any complications (such as bleeding). Where the attempt fails, the size of the catheter used, the level of obstruction within the urethra and number of attempts should be clearly documented.
- The risks and benefits of catheterisation should be explained to the patient and this should be documented. If a patient has objections or queries about catheterisation, these should be listened to, documented and resolved before proceeding with catheterisation.