SPSO decision report

Case: **202004335, A Medical Practice in the Grampian NHS Board area**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) by the practice. A died due to invasive bladder cancer and urinary sepsis (blood infection). C complained that the practice unreasonably delayed referring A to secondary care for investigation despite presenting with recurrent urinary tract infections (UTIs) that did not respond to antibiotic treatment. C considered that A's bladder cancer may have been identified earlier, and that their death avoided, had the practice referred them for investigation much sooner.

The practice's position was that A had a long history of intermittent UTIs, which were usually treated with antibiotics. At one point, all of A's urine samples showed pus cells but a normal range of red cells, which was suggestive of simple UTIs. The early signs of bladder cancer such as blood in the urine were not apparent in A's case until a relatively late stage. The practice considered that abnormalities in A's blood results (increased platelet and white cell count) were caused by A's unrelated medical conditions.

We took independent advice from a general practitioner adviser. We noted that patients over a certain age with recurrent or persistent UTIs (i.e. three episodes in 12 months) associated with haematuria (blood in the urine) should be referred for urgent investigation in accordance with national guidelines. In A's case, they had attended the practice three times in four months with recurrent UTIs and haematuria found on dipstick testing. At this point, we found that A should have been referred on an urgent basis in line with the guidance but that the practice did not do so for a further ten months. We found that the practice had failed to identify that A's blood results showed signs of recognised malignancy and that they had repeatedly failed to record A's clinical history and review the results of investigations performed. As such, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- In view of our findings, carry out a reflective Serious Adverse Event Review (SAER) of this case which includes: a review of the failure to refer A for further investigations, including the lack of detail of their presenting symptoms and the lack of relevant clinical history in A's records; a review of the practice's result handling processes and, where issues are identified, how these are monitored and actioned by a responsible clinician; a review of the guidelines for early referral of suspected urological cancers; and a review of the failure to exclude a urine infection in relation to the care and treatment A received for a kidney infection. Information regarding a patient's care and treatment and diagnosis should be accurately recorded in their clinical records.

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.