Scottish Parliament Region: South of Scotland

Case 200603770: A Medical Practice, Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Family Health Services – GP & GP Practice; Clinical treatment/ diagnosis

Overview

Mrs C complained that there had been a significant delay in diagnosing her late husband (Mr C)'s kidney condition and, further, that he had not been told he was suffering from kidney problems for some months. Mr C had been treated as an emergency by Crosshouse Hospital in February 2005. He attended his GP Practice (the Practice) over the following months before being admitted as an in-patient to Ayr Hospital on 19 January 2006 where, sadly, he died on 30 January 2006. Mrs C said that Mr C had been diagnosed with a serious kidney condition while being treated as an out-patient in June 2005 but that this had never been communicated to him.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was a delay in diagnosing Mr C's kidney condition and his treatment for this was inadequate (*not upheld*); and

(b) information about Mr C's kidney condition was not appropriately communicated to him (*not upheld*).

Redress and recommendations

The Ombudsman has made no recommendations.

Main Investigation Report

Introduction

1. Mr C was admitted to Crosshouse Hospital (Hospital 1) as an emergency admission in February 2005. He was found to have traces of blood in his urine at a level that would not be detectable to the eye. Mr C's GP referred him for further tests to Ayr Hospital (Hospital 2) and he attended there in May 2005. In June 2005, Mr C had an ultrasound examination at Hospital 2. Mr C attended at his GP Practice (the Practice) in July 2005 and October 2005. Mr C had further investigations at East Ayrshire Community Hospital (Hospital 3) in December 2005 and again attended the Practice in December. He was admitted to Hospital 2 on 19 January 2006 and sadly died there on 30 January 2006.

2. In September 2006, Mrs C complained in detail about her late husband (Mr C)'s care and treatment. In summary, she said there had been a ten-month delay in informing her husband that he was suffering from a kidney condition, following his initial presentation in February 2005. She said she was also aware Mr C had been diagnosed with kidney failure in June 2005 but he had not been informed of this.

3. The Practice responded to Mrs C's concerns and said that kidney abnormalities were only discovered late in 2005 and that it appeared the cause of his renal failure was not a chronic condition. The tests Mr C had in June 2005 were marginally outside normal but this was not uncommon in a man of Mr C's age. The Practice added that the letter in June 2005 from the specialist who arranged the tests did not show anything of undue concern.

4. Mrs C complained to the Ombudsman's office on 11 January 2007 about both Ayrshire and Arran NHS Board (the Board) and the Practice. The complaints about the Board have been dealt with in a separate report number 200601141.

5. The complaints which have been investigated are that:

(a) there was a delay in diagnosing Mr C's kidney condition and his treatment for this was inadequate; and

(b) information about Mr C's kidney condition was not appropriately communicated to him.

Investigation

6. In investigating this complaint, I have obtained the background documentation relating to the complaint and Mr C's medical records from the Practice. Advice was also obtained from a clinical adviser to the Ombudsman, (the Adviser).[1]

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Practice were given an opportunity to comment on a draft of this report.

Background

8. Mr C died aged 76 years on 30 January 2006 in the Urological unit of Hospital 3. His death certificate recorded Myocardial Infarction and Coronary Artery Disease as the primary causes of death. Chronic Renal failure was listed as a secondary cause.

9. Mr C had been admitted as an emergency admission to Hospital 1 on 28 February 2005 following a telephone call to NHS24. There was some concern that blood and protein were present in his urine. Mr C had been noted to have had similar results in 2003. The results were forwarded to his GP, who repeated the test and March 2005 and referred Mr C to a urology clinic (the Clinic). Mr C attended the Clinic on 24 May 2005, where he was seen by a staff grade surgeon (the Surgeon). A letter to Mr C's GP from the Surgeon was received by the Practice on 30 June 2005. This said that Mr C would have further tests and that he would be reviewed at the Clinic in six months, provided the other investigations were normal.

10. On 14 July 2006 a note was made in Mr C's GP records of his blood pressure and that his urological symptoms were improving. He attended the Practice again on 22 July 2005, reporting abdominal pain and one episode of blood in his urine. These were both said to have then settled. In October 2005 he was noted in the GP records to have improving blood pressure.

[1] The standard used in this report for assessing the actions of medical staff is whether the actions were reasonable. By reasonable, I mean the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time.

11. On 2 December 2005, Mr C again attended the Clinic as an out-patient and reported a further episode of blood in the urine but that the flow had improved. The Consultant he saw (the Consultant) decided to do further x-rays of the kidney (an intravenous pyelogram – IVP). Kidney functions tests were taken on 9 December by the Practice. A GP record of the same day referred to pain in the joints, which were thought to relate to gout which Mr C had suffered from some time before. When the Practice received the results, they noted a repeat test was required. An appointment was made for 21 December but cancelled by Mr C. On 5 January 2006, Mr C was sent a letter asking him to make a repeat appointment.

(a) There was a delay in diagnosing Mr C's condition and his treatment for this was inadequate; and (b) Information about Mr C's kidney condition was not appropriately communicated to him

12. The Adviser reviewed Mr C's medical records. He said that, following Mr C's emergency admission, the Practice received the result of tests taken on 28 February 2005 which showed blood in the urine. A repeat test was made on 15 March 2005 and Mr C referred to the Clinic when this again showed blood in the urine. The Adviser said in his view this was appropriate action.

13. The GP noted receipt of a letter from the Surgeon on 4 June 2005. This appeared to be a short summary discharge letter, as a fuller letter with the results of Mr C's blood tests was noted as received on 30 June 2005. The results did indicate a creatinine level of 139 umol/l[2] Creatinine is a waste molecule which is generated as a by-product of energy production in muscles. This is processed by the kidneys and if the kidneys are impaired the level of creatinine in the blood will rise. As a result, the levels of creatinine present in the blood have been found to be a fairly reliable indicator of kidney function.

14. The Adviser said that, on receipt of this letter, the GP would have understood that the Surgeon was concerned that Mr C's prostate was enlarged. There was nothing in this letter to indicate Mr C had been or could be seriously ill. In the related report number 200601141, a specialist urological adviser has said that, in his view, the creatinine level combined with problems seen in an ultrasound also taken in June 2005 should have suggested to the Surgeon that further investigation was required.

[2] A standard measurement referring to micromoles per litre.

15. The Adviser reviewed the Practice's contact with Mr C over the rest of 2005. Mr C attended the Practice on 14 July 2005, 22 July 2005, 13 October 2005 and 9 December 2005. On 22 July 2005 Mr C said that he had reported abdominal pain and one episode of blood in the urine but this had then settled. Following his attendance on 9 December 2005, the GP arranged blood tests. These showed significantly raised creatinine levels of 279 umol/l. The GP noted these as received on 12 December 2005. He noted this test should be repeated and Mr C was asked to re-attend on 21 December but he cancelled this appointment. Mr C attended the Clinic on 2 December and 29 December 2005. The letters relating to these appointments were received by the Practice on 4 January and 20 January 2006 respectively. The letter received on 4 January 2006 said further investigations were being undertaken. A handwritten note on the Practice copy indicated that Mr C should be followed up and a letter asking him to attend for the blood test to be repeated was sent on 5 January 2006. Mr C attended at the Clinic on 10 January 2006 for further tests and was admitted to Hospital on 19 January 2006.

16. In reviewing all the actions taken the Adviser said that, in all the circumstances, and given the letters received from the specialist urologists, the actions taken by the Practice were reasonable.

(a) and (b) Conclusion

17. The advice I have received is that the actions taken by GPs in the Practice throughout 2005 in response to Mr C's symptoms and the advice received from the specialists at the Clinic was reasonable. On this basis, I do not uphold these complaints.

18. In the related report number 200601141, it is clear that the advice the Practice were given in June 2005 was wrong. However, there was nothing in the results seen by the Practice which would have indicated to a non-specialist that they should query the view of the specialists at the Clinic. Given this, there was no reason why they should have felt that the creatinine results were of particular significance or to have communicated this to Mr C. Given the failings identified in the related report, I understand very well why Mrs C wished the GP involvement in her husband's care to be reviewed as well. I hope this report provides her with some reassurance that Mr C's Practice did act reasonably in response to the information they had at the time and did inform Mr C of all matters they believed to be of significance.

Annex 1

Explanation of abbreviations used

Mr C	The aggrieved, Mrs C's late husband
Hospital 1	Crosshouse Hospital
Hospital 2	Ayr Hospital
The Practice	Mr C's GP Practice
Hospital 3	East Ayrshire Community Hospital
Mrs C	The complainant
The Board	Ayrshire and Arran NHS Board
The Adviser	Clinical Adviser to the Ombudsman
The Clinic	The Urology clinic, which was held at a number of separate locations
The Surgeon	Staff grade surgeon who saw Mr C at the Urological clinic
The Consultant	Consultant who saw Mr C at the clinic and in Hospital 2

Annex 2

Glossary of terms

Creatinine	Creatinine is a waste molecule which is generated as a by-product of energy production in muscles. This is processed by the kidneys and if the kidneys are impaired the level of creatinine in the blood will rise
Urology	Urology is the medical specialty which deals in the medical and surgical diseases of the kidneys and urinary tract