SPSO decision report

Case: **201507813, A Medical Practice in the Fife NHS Board area**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mrs C complained about the practice's handling of her cervical screening (commonly known as a smear test), and also about their response to her complaint.

Mrs C received a positive result from her smear test, and over the following year underwent investigations for suspected cancer. No cancer was detected and in looking into the matter, the board decided to look again at the original smear test result.

The board convened a Problem Assessment Group (PAG) with input from a public health specialist and investigated the circumstances. As part of the investigation they tested the DNA on the original smear test and identified two sets of DNA, Mrs C's and another, unidentified sample. The PAG was unable to say definitively how or when the test was contaminated with another DNA sample. The laboratory that tested the sample was confident contamination could not have occurred there.

The PAG concluded that the correct procedure in handling and processing smear tests had not been followed. All tests should be sent to the laboratory on the day taken or the next working day if done in the afternoon. The practice instead was sending batches of tests over a number of days or weeks. Women who had had smears around the same time as Mrs C were re-tested and none were found to have cancer.

We were not able to establish for certain how the DNA and that of another person ended up in the same sample. Clearly, an error had occurred, and the independent advice we took from a nursing adviser confirmed that the nurse who took the smear test had not followed best practice guidance. The adviser also noted that Mrs C's appointment was not recorded in her medical records; only the date the test was sent was noted, which had led to confusion about the date of Mrs C's test. We made a recommendation to address this.

We confirmed with the board that the nurse in question had discussed the incident at the time with senior staff at the practice and was now processing smear tests in the correct manner. We also noted that the practice had updated its cervical screening protocol in light of the incident. We therefore had no further recommendations to make.

While we noted that Mrs C had found the practice's approach to her complaint to be lacking in empathy, we did not find evidence to support this and so did not uphold this aspect of her complaint.

Recommendations

We recommended that the practice:

- provide reassurance that action has been taken to ensure that both the date of the appointment for the smear test and the date the test is sent to the laboratory are noted.