SPSO decision report

Case: **201801442, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained that medical staff failed to diagnose her husband (Mr A) with urethral obstruction (a blockage that inhibits the flow of urine through it's normal path). Mr A presented to Royal Alexandria Hospital on a number of occasions with urology (the branch of medicine and physiology concerned with the function and disorders of the urinary system) problems, including difficulty urinating and passing blood. An X-ray was carried out which showed no kidney stones and tests confirmed no infection. He was discharged but attended several days later to the emergency department, unable to pass urine. He was examined, catheterised and discharged home with medication to relax the bladder neck. No follow-up appointment was arranged. Nine days later Mr A was admitted to hospital as he was unable to pass urine. Following further tests, and subsequent attendances at hospital with issues regarding his catheter, including treatment with antibiotics for infection, Mr A underwent a cystoscopy (bladder examination using a narrow tube-like telescopic camera) where a intra-urethral stone was extracted from the penis. Mrs C said that doctors did not take account of the symptoms Mr A had presented with and they failed to carry out basic checks. It was not until they sought private opinion that appropriate tests were carried our and the stone causing the obstruction was discovered.

We took independent medical advice from a consultant urologist. We found that on the initial presentations to hospital, physical examinations of the abdomen and genitals were not carried out, despite repeat presentation and reported symptoms indicating this should have occurred. Appropriate examinations, particularly of the penis when indicated, would likely have identified the presence of the stone. Medical and nursing staff did not adequately document and act on difficulties which were encountered in passing the catheter. We, therefore, upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr A for the failure to carry out appropriate physical examination, escalate difficulties in catheterising, and to arrange for further assessment with flexible cystoscopy. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/leaflets-and-guidance" www.spso.org.uk/leaflets-and-guidance .

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

- Emergency staff, when presented with blood in urine in the absence of infection, should recognise this requires urgent investigation.
- Relevant medical and nursing staff should be aware of the need to take a good history and perform appropriate genital examinations. Nursing staff should be aware of potential causes for difficulties in catheterisation and empowered to ask for support or abandon catheterisation if difficulties are encountered.

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.