Scottish Parliament Region: Glasgow

Case 200501786: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; General Surgical

Overview

The complainant (Ms C) raised a number of issues concerning the treatment her father (Mr A) received prior to and following an operation.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) that staff failed to fully establish Mr A's current medical condition prior to surgery *(partially upheld)*; and

(b) inappropriate discharge *(not upheld)*.

Redress and recommendation

The Ombudsman recommends that the Board remind staff of the importance of recording appropriate information.

The Board have accepted the recommendation made in this report.

Main Investigation Report

Introduction

1. On 4 October 2005 the Ombudsman received a complaint from Ms C about the care and treatment provided to her father (Mr A) at the Western Infirmary, Glasgow (the Hospital) relating to a hernia operation on 9 June 2004.

2. The complaints from Ms C which I have investigated are:

(a) that staff failed to fully establish Mr A's current medical condition prior to surgery; and

(b) inappropriate discharge.

Investigation

3. In writing this report I have had access to papers provided by Ms C, Mr A's clinical records for the appropriate period and the complaints correspondence from Greater Glasgow and Clyde NHS Board (the Board). I have also obtained advice from one of the Ombudsman's professional clinical advisers (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report can be found in Annex 1. A glossary of medical terms used can be found at Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

Medical Background

5. Mr A was 82 years of age and had a history of cerebral embolism and atrial fibrillation in 1994 and was commenced on warfarin therapy. On 28 February 2003, Mr A's GP wrote a referral letter to the consultant surgeons at the Hospital for an opinion on Mr A's hernia. Mr A attended the outpatient clinic on 24 March 2003 and agreed to take part in an Asymptomatic Hernia Study. Mr A attended the outpatient clinic again on 16 March 2004, where examination revealed that the hernia had substantially increased and was causing Mr A discomfort. Mr A was placed on the waiting list for surgery. Mr A was admitted to the Hospital on 7 June 2004, the operation took place on 8 June 2004 and he was discharged home on 9 June 2004. On 10 June 2004, Mr A was admitted to the Acute Stroke Unit at the Hospital with facial weakness and dragging of the left foot.

He was found to have sustained a stroke, due to infarction in the middle cerebral artery territory of the brain. Mr A was discharged from the Acute Stroke Unit on 17 June 2004 to another hospital for rehabilitation. He was reviewed at the outpatient clinic on 26 July 2004, where it was noted he was continuing to make a recovery from his hemiparesis.

(a) Staff failed to fully establish Mr A's current medical condition prior to surgery

6. Ms C complained to the Board that there had been serious lapses in the standard of treatment which her father received. He was admitted to the Hospital on the Monday, the operation was carried out on the Tuesday and he was then discharged on the Wednesday. Mr A suffered a stroke and was readmitted to the Hospital on the Thursday. The family felt the stroke was as a direct result of the hernia procedure. Prior to the stroke, Mr A was alert and highly independent and led a full lifestyle including driving his car. The stroke caused brain damage and he is now blind in one eye and prone to confusion, depression and mood swings. He has left-sided weakness and cannot mobilise without supervision. Ms C said that the family and Mr A felt the outcome could have been avoided if several staff involved in Mr A's care had acted differently. Ms C said Mr A told her that he had not been informed of the risks of surgery. Ms C felt that Mr A's medical history of transient ischaemic attacks (TIAs) and receiving warfarin for approximately eight years would have been evident to staff that he was at heightened risk. Mr A had told her that he would never have undergone the operation if he had been made aware of the risks. In addition, on the day of the operation, Mr A had been told it might not go ahead as there was a concern about his blood results and Ms C wondered whether this had been fully taken into account.

7. The Acting General Manager responded to Ms C's complaint. She said that Mr A had taken part in a hernia study and that the hernia had increased significantly in size and was causing pain. It was explained that information from the Unit's study of inguinal hernia had shown that, when they start to cause discomfort, patients may present as an emergency with an obstruction which has a potential for compromise to the viability of the small bowel and associated increased risks to the patient's health. In these situations it is a balance of risks but, from experience, high risk operations are always best carried out in a planned elective manner under optimum conditions, as was the case with Mr A's procedure.

The Surgical Registrar (SR) had agreed that Mr A was a high risk patient because of his history of cerebral vascular disease. However, the risk was thoroughly assessed in the outpatient clinic and, during a consultation, it was found the hernia was becoming increasingly symptomatic. The SR confirmed that the risks of the procedure were discussed in full with Mr A although none of the family members were present. The risk of such problems recurring was highlighted to Mr A, including the possibility of bleeding as Mr A was on warfarin. The SR said preoperatively Mr A had reported a CVA and TIA in 1994, at which time he had also been diagnosed with atrial fibrillation. However, Mr A did not mention to medical staff at that stage that he had been having frequent and regular TIAs.

8. The Acting General Manager said that there was some concern about whether surgery should proceed because of Mr A's ongoing warfarin therapy, but the result of a blood test was within normal levels which meant the surgery could proceed. A tissue sealant was used in theatre to minimise the risk of post-operative bleeding. The General Manager wrote a letter to Ms C and explained that if staff had been aware of Mr A's recent TIAs then they may have been investigated and, based on the findings of the investigation, the operation may have been deferred.

9. The Adviser said that Mr A suffered a stroke two days after surgery. While it was not possible to exclude entirely that the events were related, the Adviser thought it was unlikely. Firstly, Mr A's warfarin therapy remained in the therapeutic range throughout his treatment and, secondly, the Adviser would have expected the stroke to have occurred after a shorter interval had it been caused by the operation. If Mr A's warfarin had been stopped and had the INR fallen below the therapeutic range then that would have been strong evidence to support a cause and effect but this was not the case. Since Mr A was having TIAs prior to surgery then he was at very high risk of having a stroke at any time. Therefore, for this to happen two days after the operation was probably coincidental. The Adviser felt that the decision not to stop warfarin prior to the operation was reasonable. He also thought the fact that the staff were unaware of the recent TIAs prior to the operation was of great importance. It would depend on when the TIAs occurred. The GP referral letter made no mention of TIAs and neither was there evidence it had been discussed at the outpatient clinic appointments or communicated on

admission to hospital. The Adviser felt that staff had completed appropriate checks of Mr A's INR levels during the period of admission.

10. The Adviser, however, had concerns about the standard of record keeping concerning the clinical assessment prior to the operation. At the initial assessment at the outpatient clinic in March 2003, and when the decision was made to operate in March 2004, there is no documentation of Mr A's co-morbid conditions. The Adviser would have expected the notes to contain the information that Mr A was taking warfarin and had suffered a stroke in the past. In addition, the documentation failed to provide confirmation that there were discussions about the suitability of Mr A for surgery.

(a) Conclusion

11. In view of the advice which I have received and accept, I have decided to partially uphold this aspect of the complaint. It is important that staff take fully into account the ability of patients to provide medical information and document it accordingly. More weight would be behind the staff decisions had they taken the appropriate medical history, prior to considering Mr A's suitability for surgery. However, there are no concerns about the actual treatment provided to Mr A and I am persuaded that the decision to operate was reasonable and that it was not the cause of the stroke.

(a) Recommendation

12. The Ombudsman recommends that the Board take notice of the Adviser's comments regarding failings in documentation and remind staff of the need and importance of recording appropriate information and its implications for clinical treatment.

(b) Inappropriate discharge

13. Ms C complained that her father had been discharged from the Hospital 14 hours after undergoing surgery. Due to his past medical history, she felt it may have been wise to keep him in for monitoring. This was important because he did not have a follow-up appointment at the anti-coagulation clinic and could not obtain one for another six days. This had been pointed out to staff on the day of discharge and reinforced her belief that he had been discharged too early.

14. The Acting General Manager said that the ward sister confirmed that Mr A's INR level was checked on the day of discharge to confirm his warfarin levels were stable. It was also confirmed from medical staff that Mr A could attend his normal warfarin clinic the next week. Mr A was discharged, with arrangements for follow-up and to continue with his normal dose of warfarin. The SR explained that, in his view, further hospitalisation would not have prevented the CVA.

15. The Adviser said that staff had monitored Mr A appropriately while he was in hospital and that it was reasonable to discharge Mr A on 9 June 2004, in full knowledge that the next warfarin review was in six days.

(b) Conclusion

16. The advice which I have received and accept is that it was reasonable for staff to discharge Mr A on 9 June 2004, with a review at the anti-coagulation clinic the following week. Accordingly, I do not uphold the complaint.

(b) Recommendation

17. The Ombudsman has no recommendations to make in this regard.

28 November 2006

Annex 1

Explanation of abbreviations used

Ms C	The complainant
Mr A	Ms C's father
The Hospital	The Western Infirmary Glasgow
The Board	Greater Glasgow and Clyde NHS Board
SR	Surgical Registrar
Acting General Manager	Divisional Acting General Manager
General Manager	Divisional General Manager
The Adviser	The medical adviser to the Ombudsman

Annex 2

Glossary of terms

Asymptomatic Hernia Study	A study of hernias which do not display any symptoms.
Atrial fibrillation	Heart rhythm disorder.
Cerebral embolism	A blood clot which formed in another part of the body and travelled through the bloodstream to the brain.
Hemiparesis	Muscle weakness on one side of the body.
INR	International Normalised Ratio - blood test used to monitor the effects of warfarin therapy.
Stroke (CVA)	Acute injury where the blood supply to the brain is disrupted.
Transient Ischaemic Attacks (TIAs)	Mini stroke caused by temporary disruption of the blood supply to the brain.
Warfarin	A blood thinning drug which prevents clotting.