Scottish Parliament Region: North East Scotland

Case 200501624: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant raised a number of concerns that, following his stroke, a hospital did not assess his vision properly, did not carry out a carotid artery scan properly, did not communicate adequately with him and did not arrange his further care at a more local location.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) assessment of vision (*upheld*);
(b) carotid artery scan (*not upheld*);
(c) communication (*not upheld*); and
(d) rehabilitation location *(not upheld).*

Redress and recommendations

The Ombudsman recommends to the Board that patients with neurological conditions, when initially assessed, should receive a full neurological examination, including the bedside assessment of visual fields. If investigations point to a specific area of brain damage, the medical team should ensure that the appropriate clinical examination has been performed. She also recommends that the Board apologise in respect of complaint (a).

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mr C, Tayside NHS Board as the Board and Ninewells Hospital as the Hospital. Annex 1 is a reminder of all abbreviations. On 14 September 2005 the Ombudsman received Mr C's complaint about his care and treatment at the Hospital in January 2005, following a stroke.

2. The complaints from Mr C which I have investigated concern:

(a) assessment of vision;
(b) carotid artery scan;
(c) communication; and
(d) rehabilitation location.

Investigation

3. I was assisted in the investigation by one of the Ombudsman's clinical advisers, a consultant physician (the Adviser). His role was to explain, and give an opinion on, the events. We examined the papers provided by Mr C and the Board and the notes of my meeting with Mr C. To identify any gaps and discrepancies in the evidence, the content of relevant papers on file was checked against information elsewhere on file and also considered against my own and the adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. Finally, in line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

4. Mr C was admitted to the Hospital on 3 January 2005, having suffered a stroke. Mr C had a past history of a condition in which the heart beats fast and very irregularly. This condition reappeared shortly after admission, and drug therapy was arranged. Mr C was admitted to a medical assessment unit and later transferred to the Hospital's stroke unit under the care of Consultant 1, a consultant physician. He was also assessed by the physiotherapy, occupational therapy and

language therapy services. Progress was made, and discharge home, with continued rehabilitation, was arranged for later in January.

(a) Assessment of vision

5. Mr C felt that the visual loss he had had since the stroke was never properly addressed while he was an in-patient in the Hospital, leading to potential dangers after discharge, such as being run over by moving vehicles which he could not see properly. When I met him in September 2005, he said the Board had told him they would have arranged for an ophthalmologist (eye specialist)'s evaluation in due course but that he considered this as too late because he could have had an accident by then. (Such an evaluation was done on 7 March 2005.)

6. I summarise in this paragraph the Board's initial account, which includes information from the Board in answer to my enquiries. Mr C's vision on admission was appropriately tested. This was done on the ward by the team of admitting doctors, as is usual. This was an initial assessment only as such doctors do not have the specialist equipment of the ophthalmology staff. On 11 January 2005, occupational therapy staff found that Mr C had a hemianopia (blindness over half the field of vision) and suggested a referral to the ophthalmologists. However, it was not the Board's practice to refer patients with a right-sided difficulty (like Mr C) as the ophthalmologists consider that they can do little for patients where the difficulty is on the right side. Additionally, the notes of a research worker for 11 January 2005 state, 'When testing [he] would not cover [his] eye properly'. It would not, therefore, be correct to say that the medical team did not attempt to consider the visual problem.

7. I summarise in this paragraph the Adviser's initial views on complaint (a). When Mr C was admitted, he had an eye examination but this did not include his visual fields. It is acknowledged that no formal ophthalmological review was mandatory. But, as a minimum, the medical staff should have carried out an assessment of the visual fields at that time. Visual fields can be assessed at the bedside, and this is a technique routinely taught to medical students. Special equipment or access to an ophthalmologist is not necessary for such a bedside assessment. That assessment was not done – either on admission or when the result of Mr C's scan was known, even though the scan showed that Mr C's stroke had affected the area of the brain which is responsible for vision. Had any doctor

in the medical team done a simple bedside assessment of the visual fields, the visual defects would have been found. Mr C could then have been given stronger warnings and advice about what he might face after discharge. This point has nothing to do with the need, or otherwise, for an ophthalmological opinion: it is a matter of good medical practice in relation to examining a patient with a stroke which is likely to have affected the vision. Examination by a research worker would not normally be regarded as a substitute for a ward-team examination because such workers do not tend to be involved with the day-to-day clinical management of a patient and there is no guarantee that research workers' findings or notes will be made known to the rest of the medical team. Finally, it is acknowledged that Mr C might not have co-operated with visual field testing, but an attempt to perform that part of the examination should have been made.

8. In commenting on a draft of this report, the Board made further comments, which I summarise in this paragraph. The research worker was a competent clinical doctor, specifically trained in visual field assessment, and, as she was an integral member of the medical team, it would not be correct to suggest that her findings or notes would not be shared with the rest of the team. On 11 January 2005, when the research worker tried to assess Mr C's visual fields, Mr C was unwilling to co-operate, although the reason for the examination was given to him. Following a stroke, communication can be difficult, which was the case here. In respect of the draft investigation report's recommendation about neurological assessments, full neurological assessment is – and was at the time in question – the Board's usual practice. However, in the initial stages after Mr C's stroke, he was unable to speak to establish what he could or could not see, which meant his vision could not be fully assessed at that time. An occupational therapist's assessment, also on 11 January 2005, outlined Mr C's vision difficulties. At the time in question, the Hospital's stroke service was not fully developed. However, there is now a specific stroke ward, which has benefited stroke patients. In terms of visual assessments, the orthoptic staff are now involved where appropriate, for example, in assessing any visual difficulties in patients who are ready for discharge, and this service is continually being reviewed and, where necessary, improved.

9. In this paragraph I summarise the Adviser's views about the Board's comments on the draft report. His original comment (see paragraph 7) that,

normally, examination by a research worker would not be regarded as a substitute for a ward-team examination still applies, for the reasons given in that paragraph. However, it is accepted that, in this case, the research worker was an integral member of the medical team. This does not alter the original view that Mr C's initial assessment should have included a bedside visual fields assessment. The hospital admission notes (3 January 2005) contain a reasonably full history and also statements that Mr C's speech was unco-ordinated, that he was unable to obey complex commands and that his eye movements were normal. The records for the following day (4 January) repeat the statement about a lack of co-ordinated speech and also state that Mr C could obey simple commands and that he explained to a doctor his lack of abdominal pain, his recent eating and drinking pattern and the history of his appendix. The records for 4 January also show that, despite expressing reservations that day about starting a particular drug, Mr C later that day, following discussion with a doctor, accepted the doctor's logic for the drug. Thus, the early clinical records indicate an ability by Mr C to communicate to a certain extent and to obey simple commands. The occupational therapist's assessment of 11 January refers to Mr C's visual difficulties but describes him as alert and 'mildly' confused.

10. From the points at paragraph 9, the Adviser has concluded that the evidence in the clinical records does not support a view other than his original one. Therefore, his original comments (see paragraph 7) and the Ombudsman's original recommendations still apply.

(a) Conclusion

11. Mr C was concerned that his poor vision put him at danger, for example from moving road traffic, and the Adviser has said that a simple bedside assessment by any member of the medical team of Mr C's visual fields could, and should, have been done. It is a matter of concern that something as quick and simple as this was not done, particularly as the consequences to Mr C of not doing it could have been serious. It is also of concern that no appropriate assessment was done even when the scan showed damage in the relevant area of the brain. In all the circumstances, I uphold complaint (a).

(a) Recommendation

12. The Ombudsman recommends that patients with neurological conditions, when initially assessed, should receive a full neurological examination, including the bedside assessment of visual fields. If investigations point to a specific area of brain damage, the medical team should ensure that the appropriate clinical examination has been performed. She also recommends that the Board apologise in respect of complaint (a).

(b) Carotid artery scan

13. Mr C was concerned that both sides of his neck were pressed at the same time during the carotid artery scan, rather than one side at a time; he felt this was dangerous. In their reply to his complaint, the Board said that such scans were not dangerous. The Adviser said that such a scan is a routine (but important) investigation following a stroke and that, whilst there is a theoretical possibility of dislodging material from the carotid artery while the test is in progress, this is extremely rare, and the advantages of having the test far outweigh any potential disadvantages. He does not consider the complaint to be justified. I should add that the Adviser does not consider that both sides of Mr C's neck would have been pressed at the same time. This is because the recording machine takes ultrasound images from the neck, one side at a time. I note that Mr C told me that the person who did the scan did not seem to be clear about what she was doing and had to ask a colleague a few times. In theory, therefore, it seems possible that at one point she did press both sides of Mr C's neck. However, this cannot be proved, so I make no further comment about this but accept the Adviser's advice about the relative lack of danger.

(b) Conclusion

14. I accept the Adviser's advice and, therefore, do not uphold complaint (b).

(c) Communication

15. Mr C complained that Consultant 1's ward rounds were infrequent and extremely brief and that he was given little information about his condition. I note several examples in the clinical records of doctors' discussions with Mr C, such as on 4 January (two doctors) and on 7 and 10 January and on various dates by therapists. The Adviser considers that, from the evidence available, there is no sign of inadequate information being given to Mr C. Consultant 1's ward rounds

are noted as taking place on 6, 10, 13 and 17 January, which the Adviser considers to be an adequate frequency. The Board's reply to the complaint also said that Consultant 1 and his team had confidential discussions about each patient before and after the ward rounds, rather than at the bedside. Clearly, this would greatly reduce the time at each bedside. It is not possible to prove whether discussions were held away from the bedside, but the Adviser has said that this is recognised and acceptable practice.

(c) Conclusion

16. Based on the Adviser's advice, I do not uphold complaint (c).

(d) Rehabilitation location

17. Mr C was impressed by the speech and occupational therapists at the Hospital. But he felt they should have enquired about such provision at his local community hospital because he could, therefore, have been discharged from the Hospital earlier (which he would have preferred) and received such therapy on an out-patient basis closer to home.

18. I summarise in this paragraph the Adviser's views on this aspect of the complaint. Stroke management has become a discipline in its own right and quite correctly involves a multi-disciplinary team headed by a neurologist. That is what existed at the Hospital. Admission to a stroke unit involves investigations, assessment and therapy. Mr C's investigations were carried out efficiently by experts who were used to dealing with such work. Unavoidably, these took up several of the days at the start of Mr C's admission. The therapists remained concerned about Mr C's physical abilities throughout his stay and quite rightly wanted to keep him under supervision. It was also considered that Mr C was making progress during his stay. For all these reasons it was better, and in Mr C’s interests, that he remained under the Hospital's care.

(d) Conclusion

19. Based on the Adviser's advice, I do not uphold complaint (d).

27 February 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Tayside NHS Board
The Hospital	Ninewells Hospital
Consultant 1	Mr C's consultant physician at the Hospital
The Adviser	Clinical adviser to the Ombudsman, a consultant physician