Scottish Parliament Region: Lothian

Case 200500768: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Medical

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment she had received for a bowel condition.

Specific complaints and conclusions

The complaints which have been investigated are that there was failure:

(a) by medical staff to manage adequately Mrs C's care, reach a diagnosis quickly and provide appropriate treatment (*not upheld*);

(b) to keep Mrs C in a special unit for a reasonable time following her operation (*not upheld*);

(c) by nursing staff to provide adequate post-operative nursing care (*upheld*);

(d) to provide a clean room (*not upheld*); and

(e) to discharge Mrs C from hospital within a reasonable time (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) stress to clinicians the importance of ensuring, as far as possible, that patients are made aware of the reasons for clinical decisions made in relation to their care, particularly when being transferred between medical teams;

(ii) provide evidence of the use of their Manual Handling Policy on all wards so that staff are aware of patients' handling needs and the recording of these needs and provide further evidence that staff receive the appropriate training in handling techniques;

(iii) put in place procedures to prevent a recurrence of the delay in replacing broken handsets and, in the interim, ensure alternatives are available;

(iv) provide evidence of the strategies in place to implement effective patient discharge planning; and

(v) provide evidence of recent audit of nursing discharge planning on the surgical wards.

The Board have accepted the recommendations and have acted upon them accordingly.

Main Investigation Report

Introduction

1. On 16 June 2005 the Ombudsman received a complaint from Mrs C, that the failures in the treatment and care she received in the Western General Hospital, Edinburgh (the Hospital) in 2005 led to an avoidable delay in the diagnosis of and recovery from a bowel condition.

2. Mrs C complained she was very unwell when she was admitted as an emergency to the Hospital on 16 February 2005, but that medical staff had failed to manage adequately her care, reach a diagnosis quickly of her bowel condition and provide appropriate treatment. Following the operation on her bowel, she complained that she had been transferred out of a special unit prematurely and had received inadequate nursing post-operative care. In particular, she had been handled in a manner that had caused bruising and had been neglected when incontinent which had led to a loss of dignity. She stated that she had also had been placed in a side room which had not been cleaned. Finally, Mrs C complained that there was an unreasonable delay in discharging her from hospital. Mrs C brought her complaint to the attention of Lothian NHS Board (the Board) on 31 March 2005. The Board responded on 25 May 2005, but Mrs C remained dissatisfied and came to the Ombudsman.

3. The complaints from Mrs C which I have investigated are that there was failure:

(a) by medical staff to manage adequately Mrs C's care, reach a diagnosis quickly and provide appropriate treatment;
(b) to keep Mrs C in a special unit for a reasonable time following her operation;
(c) by nursing staff to provide adequate post-operative nursing care;
(d) to provide a clean room; and
(e) to discharge Mrs C from hospital within a reasonable time.

Investigation

4. In writing this report I have had access to documents provided by Mrs C, Mrs C's clinical records covering the period of complaint and correspondence relating to the complaint from the Board. I have obtained advice from the Ombudsman's medical and nursing advisers (Adviser 1 and Adviser 2) on the clinical aspects of this complaint. 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 is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical background

5. According to Mrs C's clinical records, her past medical history included removal of her womb and ovaries, followed by radiotherapy for a cancer of the lining of her womb in 2001. She was known to have a hiatus hernia, severe diverticular disease of her large bowel and an incisional hernia on the left side of her hysterectomy scar. Mrs C was admitted to the Hospital on 16 February 2005. Mrs C was complaining of a sudden onset of lower and central abdominal pain radiating to her back associated with nausea and vomiting on four occasions. She had had her bowels opened that evening on two occasions. On examination, she was noted to have an increased body mass index, normal temperature and pulse and a blood pressure of 155/85. An abdominal examination showed it to be soft with no rebound tenderness but with mild tenderness under the right side of her hysterectomy scar rising out of her pelvis. She was also tender over her central abdomen. Bowel sounds were said to be normal. At the time, the impression was that it might be a recurrence of Mrs C's endometrial tumour and/or gastritis. Routine blood tests were all normal, as was a plain x-ray of the abdomen, and there were no signs of an obstruction. The clinical plan was for her to have pain relief tablets, to stop her vomiting and a gynaecological triage. Following a one-day transfer to the Royal Infirmary of Edinburgh (the second hospital) to exclude a gynaecological cause of her symptoms, she returned to the Hospital and underwent surgery on 3 March 2005 for an incarcerated incisional hernia, with a degree of small bowel obstruction. Mrs C was transferred to a surgical ward from the High Dependency Unit (HDU) on 4 March 2005 and discharged on 11 March 2005.

(a) There was failure by medical staff to manage adequately Mrs C's care, reach a diagnosis quickly and provide appropriate treatment

6. Mrs C complained that on 16 February 2005, she was admitted to the Hospital with severe abdominal pain, high temperature and sickness. She was transferred to the second hospital on 17 February 2005, where it was confirmed that her condition was not gynaecological and she returned to the Hospital later that day (paragraph 5 refers). She complained that she then received no communication or examination from the doctors during their morning rounds despite being very unwell until 25 February 2005 when Consultant 3 arranged

for a scan and x-ray for the stomach and bowel respectively. These were taken on 28 February 2005. The results showed that she had a hiatus hernia, two ruptures on the site of her previous operation for a hysterectomy and a blockage in the small bowel.

7. The Board responded that when Mrs C had been admitted, she had been carefully examined by junior staff and Consultant 1. She had been referred to the second hospital to be reviewed by a gynaecologist. On Mrs C's return to the Hospital, an abdominal x-ray was taken which showed only faecal loading and there was no evidence of any small bowel obstruction. Consultant 1 examined Mrs C again on 18 February 2005 and responsibility for her care was transferred to Consultant 2 on 19 February 2005. On that day, Mrs C had been seen by a specialist registrar and Consultant 2 had reviewed her care on 20, 21 and 22 February 2005 while specialist registrars saw her daily on the ward. The medical impression was that Mrs C had an obstruction of her small bowel which was resolving with conservative care. Medical staff had obtained information required to manage Mrs C's condition from blood tests, abdominal x-ray, ultrasound and the function of the nasogastric tube. The Board apologised if this had not been clearly communicated to Mrs C. On 1 March 2005, a barium follow-through had showed a dilated small bowel and Consultant 3 decided that surgery was appropriate. Consultant 4 carried out the operation on 3 March 2005.

8. Adviser 1 reviewed Mrs C's clinical records and the complaint correspondence. He said the medical notes showed a very high level of input by staff, timely and contemporaneous record-keeping, appropriate investigations and appropriate care planning and care choices. Mrs C had a sub-acute, small bowel obstruction which came and went and then came again. The records and blood results show that at times Mrs C was very well and the teams were doing their best to avoid surgery, whilst maintaining a careful watch. She had been reviewed regularly and appropriately by the medical staff in charge of her care and the appropriate tests had been carried out. However, he was critical of the level of communication with Mrs C. He said that it was important when a patient in an acute surgical ward is transferred from one team to the next, that the system is explained to patients and that each new team should introduce themselves. In spite of making good clinical decisions, the medical staff did not seem to have managed their relationship with Mrs C during the transfer period and she did not appear to be included in the management team's decision making.

(a) Conclusion

9. Mrs C complained that medical staff did not manage her care adequately, reach a diagnosis quickly and provide appropriate treatment. However, the advice which I have received, and accept, is that the care Mrs C had received had been appropriate and that medical staff had applied sound clinical principles in their diagnosis and treatment of Mrs C. In these circumstances, I do not uphold the complaint. However, although the care and treatment provided to Mrs C for her small bowel obstruction had been clinically appropriate, this had not been clearly communicated to Mrs C. This was particularly important given that Mrs C's condition had changed during the period from her admission to her operation. I criticise the Board for this.

(a) Recommendation

10. I recommend the Board stress to clinicians the importance of ensuring, so far as possible, that patients are made aware of the reasons for clinical decisions made in relation to their care, particularly when being transferred between medical teams.

(b) There was failure to keep Mrs C in a special unit for a reasonable time following her operation

11. Mrs C complained that she had been transferred out of the HDU 24 hours following her operation when Consultant 4 had told her she would stay there for two days.

12. The Board responded that on the day after Mrs C's operation, the medical team had indicated that Mrs C could return to a surgical ward that afternoon if the unit needed the bed but that Consultant 4 would review Mrs C. After reviewing Mrs C, Consultant 4 agreed that Mrs C could return to the ward.

13. Adviser 1 said there was no evidence in the clinical records to suggest that Consultant 4's decision to return Mrs C to the surgical ward was inappropriate. He said it was reasonable to move patients once they no longer needed the facilities of the HDU because of the demands on the unit.

(b) Conclusion

14. The advice which I have received, and accept, is that Mrs C's transfer had not been unreasonable. I do not uphold the complaint.

(c) There was failure by nursing staff to provide adequate post-operative nursing care

15. Mrs C complained that, in the HDU on 4 March 2005, while being helped to and from a chair, she had been handled in a manner that had caused bruising by nurses. She had then been placed in a side room on a surgical ward which had no buzzer or bell to attract attention if anything went wrong. On 6 March 2005 she obtained a bell to attract attention but when she rang it to seek help to go to the toilet, no one responded and she suffered incontinence leading to distress and a loss of dignity. Despite being discovered by a nursing auxiliary, it was a further 20 minutes before she received help to return to bed. Finally, there was a delay in providing Mrs C with water and she had not received oral hygiene from nursing staff.

16. The Board responded that Mrs C had required prompting and reassurance to be helped to the chair but once in the chair had said she was comfortable. The Board stated that, after a few moments, Mrs C wanted to return to bed and while being helped to bed she had begun to panic and pull at her lines. Mrs C's grip on Nurse 1's arm tightened to her discomfort. Nurse 1 and another member of staff had to manage Mrs C on to the bed and she had needed their help to keep her lines and drains in situ. Nurse 1 had apologised to Mrs C if she felt she had been poorly handled back to bed. Nurse 1's concern had been not only for Mrs C's safety, but that of the drains, lines, as well as her own and her colleague's safety. The Board also apologised for the lack of a buzzer in her room (which had taken time to repair because of a missing part) and said that staff had tried to offer an alternative. It was unacceptable for Mrs C to be left in the condition she had described due to incontinence and they apologised for Mrs C's distress. The management team had highlighted that basic nursing care, which maintains the dignity of patients, is a priority with the staff involved. Regarding the issue of water and oral hygiene, Nurse 1 had not been able to give Mrs C water in the morning following her operation until the medical staff had said that it was okay to do so but had assisted her with oral hygiene. That afternoon, medical staff had agreed water could be provided, however, Nurse 2 apologised on behalf of her staff that Mrs C had to wait unduly for water while on the surgical ward.

17. Adviser 2 reviewed Mrs C's clinical records and complaints correspondence. She said there is a record in Mrs C's nursing records of attempts by staff to assist Mrs C to sit out of bed on the evening of 4 March 2005. It is documented that Mrs C became 'very tearful' at this point

and that she panicked, after which she was helped back to bed. There was no indication that staff had been aware that Mrs C's arm had been hurt in the process. Adviser 2 said that the risk assessment for manual handling (moving in transferring a patient) should have been carried out for Mrs C after her operation which would have given an insight into her ability to move herself and of any additional equipment required by staff in transferring her in and out of bed. In response to my enquiries, the Board said there was no evidence that a manual handling assessment had been carried out whilst Mrs C had been a patient in the HDU. However, there were entries in her records which suggested that nursing staff had been aware of her manual handling requirements.

18. Adviser 2 was not satisfied that the entries suggested Mrs C's handling needs had been recognised by nursing staff. She advised that the appropriate manoeuvres used to move a patient in bed, and to transfer in and out, plus any equipment required and the supervision needed, must be clearly identified through formal assessment and recorded so all staff are aware of the patient's handling needs. Adviser 2 expressed concern that manual handling assessments had not been carried out in any of the clinical areas during Mrs C's admission, especially as her needs altered significantly after her surgery.

19. On the issue of the lack of call buzzer, which had been non-functioning for nearly six weeks when Mrs C had been admitted, Adviser 2 said this was unacceptable and unfair on both patients and the nurses caring for them. In response to my enquiries, the Board said the manufacturer did not routinely stock this particular model of handset and their policy is to wait until they have enough broken handsets to produce a new batch for the Board and the other hospitals in the UK who still use them. This can cause a long delay in replacing the broken handsets, which can sometimes be as long as eight months.

20. The consequences of the Board's failure to provide an effective call system was that Mrs C was unable to attract attention and suffered an episode of incontinence on the way to the toilet. The Board have apologised for the unacceptable condition Mrs C had been left in and for her distress. The Board have not disputed the episode happened even though it was not documented in Mrs C's clinical records.

21. Adviser 2 has pointed out that there are further problems with the nursing records in that although there are indications that care plans had been

completed for Mrs C, these was missing from her records. These are important in ensuring appropriate care planning took place for Mrs C, although the nursing records generally were detailed, of a reasonable standard and provided evidence of good nursing practice in places.

22. On the issue of oral hygiene, Adviser 2 said there is an entry on 3 March 2005 in Mrs C's nursing records stating 'oral hygiene', but no further detail. Also, the records show that at 20:00 on the evening she had been transferred to the surgical ward from the HDU, it was documented that Mrs C required further prescription of intravenous fluids, but that they were not given until 23:45. This meant Mrs C had not received a substantial amount of fluid for some hours. This may have been due to the time of transfer, 21:00, which meant there were fewer nursing staff on the night shift.

(c) Conclusion

23. Mrs C complained about the inadequate post-operative nursing care she had received. This essentially comprised of three elements: the manner in which Mrs C had been handled; the lack of call buzzer, including an episode of incontinence; and undue delay in the provision of water. I deal with each in turn.

24. The Board and Mrs C have different interpretations on how she was handled, although the Board have apologised if Mrs C had felt poorly handled. Given this, and that the medical records are not conclusive on this point, I cannot conclusively determine how Mrs C had been handled but I am concerned that manual handling assessments had not been carried out in any of the clinical areas during Mrs C's admission and that the Board have not fully acknowledged that this was a failing in their management of the care of Mrs C. On the second element, I was pleased to see the unequivocal apology given to Mrs C for the distress caused by her episode of incontinence, but I am not satisfied with the Board's response regarding the handsets. This is an operational issue and should be addressed at a senior managerial level. The Board had two opportunities to do this; when the complaint had first been raised by Mrs C and when I asked the Board about it in my enquiries. I criticise the Board for their failure to address this, particularly as they have acknowledged the importance of having an effective system in which to attract the attention of nursing staff to the care of patients including maintaining their dignity. On the last element, there is insufficient evidence to determine conclusively whether oral hygiene had been provided and what this amounted to, but it is clear that

Mrs C did not receive sufficient fluid on her transfer to the surgical ward. In conclusion, although the Board have apologised for their failings in this complaint, I am not satisfied they have taken remedial action to address them and so I uphold the complaint. Finally, this complaint highlighted that the nursing records fell short of the standard required in that care plans were missing from the records. I would draw this to the attention of the Board.

(c) Recommendations

25. I recommend that the Board:

(i) provide evidence of the use of their Manual Handling Policy on all wards, so that staff are aware of patients' handling needs and the recording of these needs and further provide evidence that staff receive the appropriate training in handling techniques; and

(ii) put in place procedures to prevent a recurrence of the delay in replacing broken call buzzer handsets and, in the interim, ensure alternatives are available.

(d) There was failure to provide a clean room

26. Mrs C complained that the side room in the ward she had been transferred to from the HDU had smelled of smoke and had not been cleaned following the departure of the previous occupant.

27. The Board responded that the room into which Mrs C had been transferred had been occupied by a patient who continually smoked in the bathroom, despite being repeatedly told that this was not allowed by hospital policy and health and safety regulations. Mrs C's transfer from the unit had been deliberately delayed so that the room could be thoroughly cleaned. Despite continual cleaning and use of air fresheners, the smell of smoke remained evident. The Board apologised for the fact that they could not offer an alternative room.

(d) Conclusion

28. It is clear that the room smelled of smoke when Mrs C was moved into it. When Mrs C complained about this, the Board accepted that the room smelled of smoke despite continual cleaning. They also explained the reason for this (due to the actions of the previous occupant) and apologised to Mrs C that they could not offer an alternative room. I can understand Mrs C's sense of concern over the situation. The Board have accepted that the room smelled of smoke, despite continual cleaning, and explained the reason. They also apologised.

Having considered this carefully, I am satisfied that appropriate remedial action had been taken before the complaint was put to the Ombudsman and for that reason I am not upholding the complaint.

(e) There was failure to discharge Mrs C from hospital within a reasonable time

29. Mrs C complained that on 11 March 2005, she had been discharged but had to wait six hours for her prescription during which time she became very sore as she had to sit on a chair in the TV room.

30. The Board said that when a decision is made to discharge a patient on the morning round, the medical staff must first complete a full ward round before discharge letters and medications are arranged. The doctor would not have begun this process until after midday. The Board apologised if this had not been explained to Mrs C while she had been waiting.

31. Adviser 2 said the records indicate the intention on 10 March 2005 to discharge Mrs C the following day. The discharge medication could have been obtained on 10 March 2005, avoiding the delay experienced by Mrs C the following day. Also, discharge communication could have been raised 24 hours earlier, which also reduces the pressure on medical staff on the day of discharge. Good discharge planning takes all these issues into account. The Board should be addressing effective early discharge planning as a means of improving the patient's journey and minimising delays in the flow of patients through the hospital.

(e) Conclusion

32. The advice which I have received, and accept, is the importance of effective early discharge planning to both the hospital and patients. I welcome the Board's apology to Mrs C but I am not satisfied they have taken action to remedy the situation. I uphold the complaint.

(e) Recommendations

33. I recommend the Board:

(i) provide evidence of the strategies in place to implement effective patient discharge planning; and

(ii) provide evidence of recent audit of nursing discharge planning on the surgical wards.

34. The Board have accepted the recommendations and have acted upon them accordingly.

24 October 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Hospital	Western General Hospital
The Board	Lothian NHS Board
Adviser 1	The Ombudsman's professional medical adviser
Adviser 2	The Ombudsman's professional nursing adviser
The second hospital	The Royal Infirmary of Edinburgh
HDU	High Dependency Unit
Consultant 1	Consultant surgeon who was responsible for Mrs C's treatment on 17 and 18 February 2005
Consultant 2	Consultant surgeon who was responsible for Mrs C's treatment from 19 February 2005
Consultant 3	Consultant surgeon who treated Mrs C from 25 February 2005
Consultant 4	Consultant surgeon who operated on Mrs C on 3 March 2005
Nurse 1	Nurse who treated Mrs C
Nurse 2	Nurse who treated Mrs C

Annex 2

Glossary of terms

body mass index	A measurement of the relative percentages of fat and muscle mass in the human body, in which weight in kilograms is divided by height in metres and the result used as an index of obesity
diverticular disease	A condition of the large intestine whereby small sacs or pouches called diverticula form in the wall of the large intestine. These diverticula can become infected, leading to a condition known as diverticulitis.
dilated small bowel	small bowel obstruction
endometrial tumour	a tumour of the uterus or womb
faecal loading	constipation
gastritis	inflammation of the lining of the stomach
incisional hernia	A condition which occurs when part of the bowel pushes its way through a hole in the abdomen wall at the site of a previous incision