Scottish Parliament Region: South of Scotland

Case 200500940: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; Endoscopy

Overview

The complainant, Ms C, raised a number of concerns about what happened to her when she was admitted to Crosshouse Hospital (the Hospital) for diagnostic endoscopy.

Specific complaint and conclusion

The complaint which has been investigated is that the Hospital failed to explain Ms C's inappropriate admission adequately (*upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make; however, she asks that this office be provided with a copy of the guidelines when they are ratified.

Main Investigation Report

Introduction

1. On 28 October 2004 Ms C's GP referred her to Crosshouse Hospital (the Hospital) for diagnostic endoscopy. Among other things, her GP referred to the fact that Ms C suffers from diabetes and was also taking Warfarin to reduce the clotting ability of her blood. Ms C was given an appointment to attend the nurse led endoscopy clinic, for the procedure to be carried out on 14 April 2005. During the pre-operative procedure when Ms C was asked about her health, she informed staff that she had had a more recent Warfarin test done, which showed the level of Warfarin in her blood to be at a higher level than the previous test had shown. (Warfarin testing is done by the Anticoagulant Service with results recorded in the patient held record, Anticoagulant Clinic notes and on the Anticoagulant Service computer system. This test result, however, had not been recorded in Ms C's casenotes and the Anticoagulant Service computer system does not interface with the laboratory results system. The result, therefore, was not available to the staff at the endoscopy clinic.) The staff contacted the Consultant, who considered it unsafe to proceed. The Consultant arranged for Ms C to be given another appointment when he would be available to carry out the procedure himself (see paragraph 8).

2. Ms C was told to come to the Hospital at 10:00 on 21 May 2005 and report to the admissions desk in the foyer. When she arrived there was no-one at the desk and the admissions area was deserted. Ms C said that she saw no instructions telling her how to proceed so she made her way to the ward, after speaking to a cleaner. Her husband was then inconvenienced by having to return to the main foyer to ensure that the appropriate paperwork was completed to admit her. Ms C said that she had to wait a long time before she saw the junior doctor who was on duty. When he failed in his attempt to obtain a blood sample, she had to wait until the following day for a phlebotomist (specialist laboratory technician) to be available to repeat the procedure. A dietician had not been available to advise on diet. On 22 May 2005 she had been permitted to go home for the night, provided she returned in time for the Consultant's ward round the following morning. Although she arrived in time, the Consultant had not seen her. On the morning of the procedure (24 May 2005) she had been given a biscuit instead of a light breakfast and there was some confusion about where her bed was following the procedure. On 25 May 2005 Ms C wrote a letter of complaint detailing all of these matters.

3. The Hospital's Nurse Director replied to Ms C on 29 July 2005. She explained that the difficulties which Ms C had encountered were due to the fact that Ms C had been admitted to the Hospital on a Saturday when the admissions desk was not manned, the junior doctor required to prioritise his work, specialist staff such as phlebotomists worked limited hours and dieticians did not provide a service. Ms C should have been given tea and toast rather than a biscuit for breakfast; the Consultant thought that Ms C was still out when he did his rounds and there had been a misunderstanding regarding her bed following the procedure. The Nurse Director said that she was sorry Ms C had been left with a poor impression of the service. The Consultant had intended Ms C to be admitted on the morning of the procedure to check her blood and for the procedure to be carried out the same afternoon. She concluded that there must have been a breakdown in communication which caused Ms C to spend time in Hospital unnecessarily. Ms C remained dissatisfied and complained to the Ombudsman.

4. In considering the correspondence, I was satisfied that the issues raised by Ms C in her letter of complaint had been specifically and appropriately dealt with in the Hospital's response and I noted that the Nurse Director had apologised to Ms C.

5. The Hospital's response, however, did not explain how the error had been made which had caused Ms C to be admitted to Hospital three days earlier than required. The complaint from Ms C which I have investigated is that the Hospital failed to explain Ms C's inappropriate admission adequately.

Investigation

6. In order to investigate this complaint, I have had access to Ms C's clinical records and the correspondence relating to the complaint. I have corresponded with both Ms C and the Hospital. I have also obtained clinical advice from an adviser who is a hospital consultant (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and Ayrshire and Arran NHS Board (the Board) were given an opportunity to comment on a draft of this report.

Complaint: The Hospital failed to explain Ms C's inappropriate admission adequately

7. The Nurse Director said that it is normal practice for a patient who is on Warfarin, and requires to be formally converted to an alternative medication

prior to a procedure, to be admitted to Hospital a few days in advance. The endoscopy secretaries had, therefore, arranged for Ms C to be admitted on 21 May 2005, for the procedure on 24 May 2005. In Ms C's case, however, that was not what the Consultant had intended. She concluded that there must have been a breakdown in communication.

8. In response to the complaint, the Consultant said that he had reviewed Ms C's extensive and detailed background history which included her diabetes and Warfarinisation. He had not deemed it appropriate to arrange for conversion of her Warfarinisation or interference with her diabetic control, as the risks would significantly outweigh the benefits of such action. When Ms C told the nurse endoscopist the result of the most recent test for the Warfarin levels in her blood, he had agreed with the nurse that it would be unsafe to proceed and had arranged for Ms C to come to the clinic when he could perform the procedure himself. The next available time was 24 May 2005. He intended that Ms C should be admitted that morning to be assessed and, if the results were acceptable, he would proceed with endoscopy that afternoon. He had no idea why Ms C had been admitted a number of days earlier, unless it had been anticipated that Ms C would have conversion of her Warfarin prior to the procedure but that had never been his intention.

9. In response to my further enquiries, the Director of Hospital Services (the Director) said that the Consultant would normally give specific instructions to his medical secretary regarding when to admit a patient. On this occasion, however, he had not told his medical secretary that he did not intend to convert Ms C's medication. Based on what she mistakenly believed to be the correct information, the medical secretary had telephoned the endoscopy secretaries and arranged for Ms C's admission three days prior to the procedure. The Director sincerely apologised for this miscommunication.

10. The Director said that draft guidelines for the admission of higher risk patients who require endoscopic examination are currently being finalised by the Endoscopy Users Group before being ratified by the Drugs and Therapeutics Committee. Once the guidelines were finalised and in use, it was anticipated that this sort of issue (where there was uncertainty about expected admission procedures) would not recur. The Director apologised for the unnecessary distress caused to Ms C.

11. The Adviser said that he had no concerns about the standard of care which Ms C received, from a clinical perspective.

Conclusion

12. Ms C was clearly inconvenienced by having to spend unnecessary time in the Hospital. It is important if something goes wrong that the cause is properly investigated and a clear explanation given to the patient. That did not happen in this case and I, therefore, uphold this complaint.

Recommendation

13. I note that new guidelines are currently being finalised and will shortly be considered by the relevant clinical and management groups for ratification which should prevent a recurrence of this situation in the future. The Ombudsman, therefore, has no recommendations; however, she asks that this office be provided with a copy of the guidelines when they are completed.

21 November 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Hospital	Crosshouse Hospital
The Consultant	The Consultant General Surgeon who carried out the procedure
The Adviser	Clinical adviser to the Ombudsman
The Board	Ayrshire and Arran NHS Board
The Director	Director of Hospital Services

Annex 2

Glossary of terms

Diabetes	A general term relating to disorders characterised by excessive urine excretion
Endoscopy	Inspection by flexible viewing instrument
Phlebotomist	Medical laboratory technician who specialises in taking blood
Warfarin	An inhibiter of blood clotting