Scottish Parliament Region: Glasgow

Case 200502428: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital; Gastro-intestinal/Genito-urinary (Urology); Clinical treatment; Diagnosis

Overview

The complainant (Mr C) considered that his partner (Ms A) did not receive professional care and treatment from hospital staff, and that former Argyll and Clyde NHS Board Area (the Board) failed to deal with his complaint appropriately.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) inadequate treatment by staff at Inverclyde Royal Hospital (the Hospital) prior to and after Ms A's day surgery on 25 May 2005 (*upheld*); and

(b) the Board's failure to adequately address Mr C's complaint in their response to him (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) with reference to the SPSO Guidance Note on Apology, apologise to Ms A and Mr C for the distress and pain caused by the poor preparation for the procedure carried out on 25 May 2005, as well as the uncertainty over the

[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde Health Board.

stent before that time which led to Ms A having to be x-rayed unnecessarily; and

(ii) ask staff at the Hosptial's Day Surgery Unit to review their practice for Endoscopy procedure preparation, and benchmark that practice against other similar units within the Board area. This would form part of the work already in progress to review pre-assessment practice for day surgery throughout the Board area.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 1 December 2005 the Ombudsman received a complaint from a person who is referred to as Mr C. Mr C is the partner of Ms A, an 84-year-old woman who was a patient at Inverclyde Royal Hospital (the Hospital) in the former Argyll and Clyde NHS Board (the Board) Area. At the time of the key events relating to the complaint Ms A was 81.

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

(a) inadequate treatment by staff at the Hospital prior to and after Ms A's day surgery on 25 May 2005; and

(b) the Board's failure to adequately address Mr C's complaint in their response to him.

Investigation

3. In writing this report I have had access to Ms A's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional clinical advisers (the Adviser), a Consultant Physician and Nephrologist, regarding the clinical aspects of the complaint. We examined the information provided by Mr C and the Board. The Board disagreed with some of the findings in the proposed version of the report and so I sought further advice from 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 the report can be found in Annex 1. A glossary of the medical terms used can be found at Annex 2. Mr C and the Board were given an opportunity to comment on a draft of this report.

Medical history

5. Ms A suffered from a wide range of medical conditions including heart disease for which she was taking Warfarin. In October 2004 she was admitted to the Hospital with bowel problems and abdominal pain. Medical investigation showed that the right kidney was blocked by a stone. The blockage was by-passed by the insertion of a stent in the ureter to allow urine to flow. In January 2005 consideration was given to removing the blocked kidney. This plan was abandoned, however, taking into account Ms A's state of health. Instead the stent was changed for a shorter one and in addition a bladder

catheter was inserted. In April 2005 Ms A saw her GP and was unsure whether or not she had a stent in place. The GP referred the matter to Ms A's Consultant Urologist and an x-ray was performed to confirm that a stent was indeed in place. In May 2005, following day surgery at the Hospital for removal of the stent and changing of the bladder catheter, Ms A developed haematuria and difficultly in passing urine and was readmitted to the Hospital as an in-patient for nine days.

(a) Inadequate treatment by staff at Inverclyde Royal Hospital prior to and after Ms A's day surgery on 25 May 2005

6. Mr C complained about Ms A's treatment shortly after her discharge from the Hospital on 3 June 2005. He was unhappy that on arrival at the Day Surgery Unit at the Hospital on 25 May 2005 he and Ms A were asked if she was taking Warfarin and if she knew what her International Normalised Ratio (INR) was, which he expected that the hospital staff would already know. After she was discharged from the Day Surgery Unit, Ms A experienced problems with her catheter and was in pain. Mr C called the Day Surgery Unit for advice and was told to contact Ms A's GP. As a result of contacting the GP, a District Nurse visited Ms A. The District Nurse called the in-patient ward for advice and she was told to remove the catheter, at which time she noticed that Ms A was bleeding and that blood had clotted. Mr C was also unhappy that there was confusion over whether or not Ms A had a stent in place, and that he was, apparently, told that a stent should be changed every four to six weeks. At a meeting between Mr C and complaints staff from the Board on 16 June 2005, it was recorded that the main issues and questions identified by Mr C were:

- Why were staff not aware that Ms A was on and/or the level of Warfarin prior to her admission on 25 May 2005, especially if there was a possibility that she could bleed following the procedure?
- Why did staff not check to see if the catheter was free flowing prior to discharge?
- Why did the nurse ask if Mr C was aware what Ms A's INR was during the removal of the stent? Why not before the procedure?
- Why did the ward/Day Surgery Unit decline to offer any assistance when Mr C called on 25 May 2005 and instead refer him to Ms A's GP, especially when she had just been discharged and was in severe pain and bleeding profusely?
- Why was there some uncertainty regarding whether or not Ms A had a stent inserted? Why was an x-ray requested to confirm this? Should the hospital records not have clearly recorded this?

The record of the meeting was agreed, following some amendments, by Mr C and the Board.

7. In his complaint to the Ombudsman, Mr C said that Ms A never fully recovered from the trauma of the operation and is now in a nursing home. He said that it had also affected his health as he had to provide care for Ms A. In response to my enquiries Mr C also said that the fact that Ms A was 81 and on Warfarin medication should have been known to hospital staff and this should have influenced the decision on whether Ms A should have been admitted as an in-patient rather than having the stent removed as a day surgery procedure. In addition, Mr C said that communication between staff and him and/or Ms A during all treatments and procedures was extremely poor and, in many situations, non-existent.

8. I made enquiries to the Board and in the next eight paragraphs I will deal with the Board's response to specific issues I raised.

9. The Board informed me that the decision not to remove or operate on Ms A's kidney was taken because 'it would be potentially life-threatening and would not address the main problem'. The removal of a stent is normally done as a day surgery procedure which requires the use of a flexible telescope without general anaesthesia. They described is as a 'minor procedure and usually well tolerated'.

10. In relation to asking Ms A and Mr C about her medication the Board said that this information is usually given by the GP in their letter of consultation, or in a data field for drug history for electronic referrals. In Ms A's case the Board said that there was a discussion with her before the procedure on 25 May 2005 to 'establish various matters including drug history'. The Board went on to say that Ms A:

> 'was scheduled for a procedure which would not normally require knowledge of the INR … and when patients identify that they are on Warfarin it is routine to ask them if they have their INR results as many patients carry a record card with this information on it. In this case the GP was contacted and the most recent INR result and date were obtained … It is considered appropriate to ask patients if they know their INR.'

Day Surgery Unit staff have reviewed their procedure and feel they should continue to ask patients on admission if they have a record card of the most recent blood result.

11. The Consultant Urologist said that a catheter should be checked before a patient is discharged, but the amount of urine passed is not particularly significant, rather it is important that there appears to be free drainage and that the urine is clear. The Day Surgery Charge Nurse advised that as a large amount of urine had been passed and Ms A was re-catheterised, evidence of drainage indicated that the catheter was patent at the time. The Board also advised that bleeding and clotting is a known complication of insertion of a catheter, and that the fact that a patient is taking Warfarin does not make it more likely that they will bleed, but if they do bleed it is likely to be more prolonged.

12. The Board informed me that telephone calls made to the ward were not routinely logged due to the number of calls and, given that calls often concerned patients who had left the ward, staff did not have access to patient details and medical records. However, the Board said that this complaint had given them an opportunity to review practice and look at implementing a system of recording calls.

13. There was no evidence that Ms A was given a Ureteric Stent Information Leaflet which would have informed her that she had a stent and that it would need to be removed in due course. However, the Board said that it is standard practice to issue a leaflet to every patient discharged with a ureteric stent in place. The leaflet states:

> 'In theatre today you have had a stent, a plastic tube into your ureter (the tube from your kidney to your bladder). This tube needs to be removed or replaced within 3 months. If you have not received an appointment for this please contact the number below.'

The Board said that experience has shown that stents may be left in place for longer than three months and that the leaflet needs to be modified in line with current practice.

14. In relation to the record of stents, the Board informed me that a register is kept in the Urology Theatre recording every ureteric stent. The date, patient's name and side of the body the stent was placed, along with the stent batch and

code number and expiry date are recorded. The Board said that the register had been checked and there is a clear record that Ms A had a stent inserted on 10 October 2004, that it was changed on 11 January 2005, and that the stent inserted on 11 January 2005 was removed in the Day Surgery Unit on 25 May 2005. The Board also said that in order to reassure Ms A and Mr C, and eliminate any uncertainty, an x-ray was arranged and that the Consultant Urologist:

> 'acknowledges that he is responsible for the confusion because the relevant note was not available at the earlier clinic appointment on 16 February 2005. This coincided with a period when there had been a delay in typing and filing due to secretarial shortages. He had relied on his memory of the operation performed on 11 January 2005 and recalled, incorrectly, that the stent had been removed.'

The Board have accepted that the confusion regarding the stent caused Ms A and Mr C distress and inconvenience.

15. An unaddressed letter of 4 February 2005 from the Consultant Urologist outlined Ms A's history since November 2004 and said 'now a shorter stent has been inserted'. The letter does not include dates at each stage of Ms A's history. A letter of 27 April 2005 from the Consultant Urologist to Ms A's GP stated that:

> 'there has been a little bit of confusion about whether or not she has a stent. My notes suggest that we did replace the stent but I am going to bring her up to the Inverclyde Clinic to have a plain x-ray to clarify this once and for all.'

16. The notes made by staff in Ms A's medical records demonstrate concern for her health conditions and a desire to alleviate her distress. The notes describe Ms A as frail and being exhausted.

17. The Adviser was clear that, in his view, the management of Ms A in relation to the urological procedures planned while she was taking Warfarin was inadequate. He said that whilst such procedures usually will not produce bleeding it is a recognised complication. He noted that the Consultant Urologist commented in his letter of 4 February 2005 that Ms A's bladder 'was reasonably normal but did show some tendency to bleeding following inflation'. The Adviser's opinion was:

> 'To embark on a procedure in a patient on Warfarin which can be associated with bleeding and where previous bleeding has been noted, without knowing the INR is poor preparation. We have no information as to what the INR reading obtained from the GP was, nor when the blood sample for that result was taken.'

The Adviser noted from the records that Ms A's INR was 5.2 when she was re-admitted later on 25 May 2005. This showed that she was over anti-coagulated and that:

> 'The urological manipulations combined with the raised INR caused significant bleeding with a drop in haemoglobin of 3.8gms over four days, in addition, the passage of urine containing blood clots is often distressing and painful for the patient and this was the case with [Ms A].'

18. In relation to the uncertainty over the stent, the Adviser's view is that such uncertainty should not have been necessary as the Consultant Urologist's letter of 4 February 2005 clearly stated that the stent had been replaced with a shorter variety. However, the Adviser also said that, in the absence of clear records, the decision to x-ray Ms A was a reasonable one.

19. The Adviser noted that statements from nurses involved in Ms A's care indicated that there was good urine flow before the catheter change but only a small volume was passed after the change. He appreciated that a Day Surgery Unit would be busy and have a rapid turnaround of patients, and, therefore, there would be little time to observe a patient after what appeared to be an uncomplicated procedure. The Adviser said:

> 'The fact that some urine was observed to have passed and without record of bleeding, suggests that the catheter was patent and no active bleeding was occurring at the time. This is not to say, however that the bleeding was not related to the urological procedures. I am fully convinced that the combination of the urological procedures and the raised INR found later in the day led to significant bleeding and distress to the patient.'

20. The Adviser accepted that a Day Surgery Unit is not the appropriate place to deal with new problems that arise after a day procedure. He also found that the advice given by Day Surgery Unit staff on the telephone to Mr C was reasonable.

(a) Conclusion

21. In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable, in the circumstances at the time in question. By reasonable, I mean whether the decisions and actions taken were within the boundaries of what would be considered acceptable by the medical profession in terms of knowledge and practice at the time.

22. In terms of Mr C's complaint that there was poor or non-existent communication during all treatments and procedures, and whether or not Mr C was informed that a stent should be changed every four to six weeks, there is no evidence to prove or disprove this and, therefore, I am unable to reach a finding on this aspect of the complaint. However, it should be noted that the records indicate (see paragraph 16) that there was concern amongst staff to help Ms A. The Board have also indicated that they will review practice and look at implementing a system of recording of telephone calls, which is to be welcomed.

23. The uncertainty over whether or not Ms A had a stent should not have happened. The Consultant Urologist had made a record of a shorter stent being in place in his letter of 4 February 2005, but there was no date against this record. If this had led to uncertainty, that uncertainty should have been removed by checking the stent register which the Board have stated clearly records what stents Ms A had in place and when they were inserted. There was a failure to check this definitive record which led to Ms A unnecessarily having to be x-rayed to confirm that a stent was in place. In addition, the Board acknowledges that the current Ureteric Stent Information Leaflet does not reflect current practice.

24. It is clear from the medical records and the Board's response that staff at the Day Surgery Unit did not know about Ms A's medication or INR result in advance of her procedure. The Adviser has indicated that, given Ms A's history, this was unacceptably poor preparation, and I concur with his view. There was also a failure to record the INR result received from the GP and the date of that result. Ms A, who had a history of bleeding as a result of urological procedures, was later found to be over anti-coagulated. However, it appears that checking of the catheter was adequate given the circumstances in the Day Surgery Unit.

25. In relation to whether or not Ms A should have been admitted as an in-patient rather than the procedure being carried out at the Day Surgery Unit, the Board have said that the stent removal is normally carried out as a day surgery procedure. The Adviser's view is that the key issue was poor preparation by staff at the Day Surgery Unit, rather than whether or not Ms A should have been admitted. Had the preparation been better, it is likely that the day surgery procedure would have been less distressing for Ms A.

26. I concur with the Adviser's assessment that telephone advice given by staff in the Day Surgery Unit was reasonable, and that they could not have been expected to re-admit Ms A to that unit.

27. Ms A and Mr C have clearly been very distressed by the events of 25 May 2005 and the immediate aftermath. It is clear from the evidence that while an in-patient procedure would have been less distressing for Ms A, it was reasonable for the stent removal to be carried out at the Day Surgery Unit, and, therefore, I do not uphold this specific aspect of the complaint. In addition, I am satisfied that the post-operative care was of a reasonable standard. However, on balance, taking into account the uncertainty regarding basic information on whether or not a stent was in place and the poor preparation for the day surgery procedure which led to significant distress and pain for Ms A, I originally decided to uphold the complaint.

28. In commenting on the proposed report, the Board disagreed with my finding that preparation was poor, and as evidence they provided a completed Nursing Assessment for Ms A's cystoscopy procedure, as well as that day's Endoscopy list which included a note of Ms A's INR number obtained from her GP (see paragraphs 17 and 24). The Board's view was that these documents were proof that there had been adequate preparation. However, the Board did accept that:

> '… the increasing use of Warfarin is adding to the complexity of pre-operative assessment for minor procedures and are undertaking to increase the information recorded for Endoscopic procedures at [the Hospital].'

29. To ensure that due consideration was given to the Board's concerns, I referred the matter back to the Adviser. He reviewed the proposed report in the light of the Board's comments and the new evidence provided by them. In responding to me, he said that his original criticism about preparations for

Ms A's cystoscopy referred specifically to the question of Warfarin treatment and Ms A's INR level. The Endoscopy list showed a handwritten note against the entry for Ms A that read 'INR 1.6' and then was followed by a date that could be interpreted as either '11/3/05' or '11/5/05'. The Adviser's view on this new evidence was:

> '… even if we accept that the date was 11/5/05 it is clear that in the subsequent two weeks over anti-coagulation occurred. We do not know what the reason for this was. Nevertheless, it is the case that the INR rose from 1.6, which is a low and inadequate level of anti-coagulation, to 5.2 which indicates over anti-coagulation. The latter figure was recorded when [Ms A] was readmitted later in the day of 25/5/05. Thus, the facts speak for themselves: the practice of accepting a verbally reported INR from a GP surgery on a blood sample taken at least two weeks earlier resulted in a urological procedure being carried out on a patient who was over anti-coagulated. This resulted in severe bleeding, retention of urine and associated pain and distress due to blood clots blocking the bladder catheter. In my view this was poor practice and poor preparation and as such I see no reason to withdraw the criticism made.'

30. I have reviewed the comments and new information provided by the Board and the further comments from the Adviser, and I concur with his view. On this basis my finding remains that the preparation for Ms A's procedure was poor. Coupled with the uncertainty over the stent, which the Board have accepted, I therefore uphold this complaint.

(a) Recommendation

31. The Ombudsman recommends that the Board:

(i) with reference to the SPSO Guidance Note on Apology, apologise to Ms A and Mr C for the distress and pain caused by the poor preparation for the procedure carried out on 25 May 2005, as well as the uncertainty over the stent before that time which led to Ms A having to be x-rayed unnecessarily; and

(ii) ask staff at the Hospital's Day Surgery Unit to review their practice for Endoscopy procedure preparation, and benchmark that practice against other similar units within the Board area. This would form part of the work already in progress to review pre-assessment practice for day surgery throughout the Board area.

32. The proposed report also had two further recommendations. The first was that the Board inform the Ombudsman of the outcome of the review of practice for recording telephone calls to the ward and what system was implemented as a result. In commenting on the proposed report the Board advised me that ward nursing staff should only give advice by telephone about patients who have recently been discharged from the ward and about whom they have direct knowledge. If these conditions are not met, callers will be advised who best to approach for advice. The second further recommendation asked the Board to confirm that the Ureteric Stent Information Leaflet has been updated to reflect current practice. The Board confirmed this and sent me a copy. This revised leaflet states that stents may remain in place for long periods of time, if necessary up to six months. I would like to thank the Board for already taking steps to comply with these two recommendations.

(b) The Board's failure to adequately address Mr C's complaint in their response to him

33. The Board's substantive response was sent to Mr C by the Community Healthcare Partnership Director on 9 November 2005. As already mentioned (see paragraph 6), Mr C identified five main issues/questions that he was seeking answers to. The Board responded to each of the five issues in the 9 November 2005 letter. The records provided to me by the Board show that their internal investigation concluded that Mr C's complaint was 'partly upheld'. On that basis, the Board's response apologised if being asked about the INR alarmed Mr C or Ms A. The Board also offered sincere apologies for any inconvenience caused to Mr C and Ms A because of the uncertainty over the stent. The response also acknowledged that it had been a particularly difficult and stressful time for Mr C and Ms A.

34. In their response to my enquiries the Board acknowledged that, in addition to the apologies offered to Mr C in the letter of 9 November 2005, a further apology could have been offered because he had cause to raise his concerns in the first place.

35. The Adviser's view on the response was that it was inadequate in relation to the INR issue (see paragraph 10). He said:

> 'Whilst the policy of the Day Unit was and apparently remains that matters such as drug treatment including Warfarin are dealt with on admission, the events in this case should prompt the Board to review this policy. To rely on results from a GP may mean that an out of date result is obtained. In

my view whenever a procedure which could cause bleeding is planned, if the patient is on Warfarin this should be known in advance and an up to date (within a few days) INR result obtained. Because this was not the procedure in place, [Ms A] underwent a procedure at a time when she was over anti-coagulated.'

In relation to other aspects of the complaint, the Adviser's view was that the Board's response was adequate.

(b) Conclusion

36. The Board were responding to the complaint brought by Mr C after Ms A was discharged from the Hospital in June 2005. Five main issues/questions were identified by Mr C at a meeting with Board staff on 16 June 2005 (see paragraph 6). These issues were recorded by the Board and the record of this meeting was agreed by Mr C following amendments suggested by him. The Board's written response on 9 November 2005 dealt with each of the issues raised and generally provided a reasonable response. However, as identified by the Adviser, the practice of asking patients about drug and INR information on admission caused Ms A and Mr C confusion and distress. In addition, while it is to be welcomed that the Board apologised in their letter, I do not believe that the apology was strong enough. This is because the apology was for 'distress this may have caused', yet the circumstances related in this report clearly demonstrate the pain and distress Ms A suffered. As acknowledged by the Board, they could also have apologised for this situation arising in the first place which led to Mr C and Ms A having to complain. On this basis I partially uphold this complaint.

(b) Recommendation

37. The Ombudsman has already made a relevant recommendation relating to apology under section (a) of this report.

38. The Board have accepted the re commendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Ms A	The aggrieved
The Hospital	Inverclyde Royal Hospital, Greenock
The Board	Greater Glasgow and Clyde NHS Board (at the time of the complaint this was dealt with by the former Argyll and Clyde NHS Board)
The Adviser	The Ombudsman's professional adviser – a Consultant Physician and Nephrologist
GP	General Practitioner
INR	International Normalised Ratio

Annex 2

Glossary of terms

(Ureteric) Stent	A tube made of metal or plastic that is inserted into a vessel or passage to keep it open. A ureteric stent is placed in the ureter
Anti-coagulant	A drug used to reduce the ability of the blood to clot
Catheter	A tubular, flexible, surgical instrument for withdrawing fluids from (or introducing fluids into) a cavity of the body, especially one for introduction into the bladder through the urethra for the withdrawal of urine
Haematuria	The appearance of blood in the urine
International Normalised Ratio	A standard test used to monitor the dose of anti-coagulant drug and the level of anti-coagulation in the blood
Nephrologist	A specialist who is expert in the treatment of kidney insufficiency and kidney disease
Ureter	The tube which runs between the kidney and the bladder
Warfarin	An anti-coagulant drug