Scottish Parliament Region: Lothian

Case 200801134: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C) raised concerns regarding the care and treatment received by his late mother (Mrs A) at the Royal Infirmary of Edinburgh (the Hospital). Mrs A underwent surgery on 27 June 2007 for the removal of a pelvic cyst and a hysterectomy and Mr C was unhappy with the level of information provided prior to the surgery; the appropriateness of the decision to operate; the handling of the surgical complications and the timing of Mrs A's discharge. The specific points of complaint are listed below.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the consent process was not properly carried out and there was insufficient communication with regard to operative risks (*partially upheld to the extent that the doctor obtaining consent did not have the appropriate level of seniority and experience*);

(b) the surgical decision-making process was inappropriate (*upheld*);

(c) the surgical complications were not dealt with appropriately (*upheld*); and

(d) Mrs A was discharged prematurely from the Hospital (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) review their procedures to ensure that the process of obtaining patient consent is carried out by a clinician with an appropriate level of seniority and experience, ideally the doctor who will be carrying out the surgery;

(ii) review their procedures to ensure that there is consultant involvement in decisions to proceed to surgery and in decisions regarding the type of surgery to be carried out;

(iii) reflect on the delay in identifying Mrs A's intra-abdominal bleed and implement an action to prevent similar future failures;

(iv) ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective; and

(v) apologise to Mr C for the failings identified in this report.

Main Investigation Report

Investigation

1. In writing this report I have had access to the aggrieved (Mrs A)'s medical records and the complaints correspondence with the Royal Infirmary of Edinburgh (the Hospital). In addition, I obtained advice from two of the Ombudsman's advisers, one an obstetrics and gynaecology adviser (Adviser 1) and one a cardiology adviser (Adviser 2).

2. 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 and a list of the policies considered is at Annex 3. Mr C and the Board were given an opportunity to comment on a draft of this report.

Introduction

3. Mrs A, attended her GP in October 2006 with a history of abdominal swelling for approximately one year. She was subsequently referred to the gynaecology department at the Hospital and was found to have a pelvic cyst which was initially managed conservatively and kept under review. However, Mrs A subsequently experienced increasing abdominal discomfort and the records show that she expressed a wish for the cyst to be removed.

4. Mrs A was subsequently admitted to the Hospital on 27 June 2007 when she underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy, omental biopsy and peritoneal washings. The operation was noted to have been straightforward, however, Mrs A was later found to have intra-abdominal bleeding and she had to be returned to theatre. During the surgery, Mrs A suffered a heart attack and was subsequently admitted to the high dependency unit. She was then transferred to the gynaecology ward on the afternoon of 29 June 2007 and was subsequently discharged on the afternoon of 5 July 2007. However, sadly, Mrs A collapsed and passed away in the early hours of 6 July 2007.

5. The complainant, Mr C, raised his concerns regarding his late mother's care and treatment in a letter to Lothian NHS Board (the Board) dated 14 August 2007. He subsequently met with the Board on 20 September 2007 and then contacted them again on three separate occasions with his remaining

concerns, culminating in the Board's response letter of 25 March 2008. Mr C then brought his concerns to the Ombudsman on 25 July 2008.

6. The complaints from Mr C which I have investigated are that:
(a) the consent process was not properly carried out and there was insufficient communication with regard to operative risks;
(b) the surgical decision-making process was inappropriate;
(c) the surgical complications were not dealt with appropriately; and
(d) Mrs A was discharged prematurely from the Hospital.

(a) The consent process was not properly carried out and there was insufficient communication with regard to operative risks

7. In his letter to the Board dated 14 August 2007, Mr C asked what risks were involved in Mrs A's operation and he questioned whether those risks were explained to her. He subsequently met with the Board on 20 September 2007, however, this meeting was not minuted and Mr C contacted the Board again in November 2007 to request that they respond to his initial questions in writing.

8. In their response letter of 24 January 2008, the Board advised that the possible complications were discussed with Mrs A prior to obtaining her consent. They confirmed that she was made aware of the possible complications of infection, bleeding, perforation and thrombosis and that she signed the consent for her surgery on 22 May 2007.

9. Mr C wrote to the Board on 26 February 2008 and again queried whether the relevant risks had been discussed with Mrs A. The Board responded on 25 March 2008 and stated that it was their normal practice to discuss the risks of surgery with every patient prior to the surgery. They advised that the consent form clearly stated the potential risks associated with major abdominal surgery and they reiterated those risks as being that referred to in their previous response letter. They assured Mr C that the risks had been clearly documented and discussed with Mrs A.

10. In his complaint to the Ombudsman, Mr C expressed his concern that Mrs A was not advised that she could die from the operation and he questioned whether a specific warning should have been given regarding the risk of death.

11. I asked Adviser 1 to comment on this matter and he noted that the senior house officer who went over the consent process with Mrs A had indeed

recorded the risks referred to by the Board in their response to Mr C. Adviser 1 informed me that the Royal College of Obstetricians and Gynaecologists (the College) guidance concerning consent advice for hysterectomies lists serious risks as damage to the bladder and ureter or bowel; haemorrhage and return to theatre; pelvic abscess or infection; and venous thrombosis or pulmonary embolisms. He advised that these relate respectively to the risks of perforation; bleeding; infection; and thrombosis, as recorded on Mrs A's consent form.

12. Adviser 1 noted that the consent form does not explain the risk of death and he stated that this is difficult to individualise but that it is recorded in the College guidelines as being one in every 4,000 cases. He advised that this refers to abdominal hysterectomies for younger women and that it would, therefore, clearly be higher for an older woman such as Mrs A, who was 82-years-old. He stated, however, that the precise risk would be difficult to quantify.

13. Notwithstanding this, Adviser 1 did have concerns regarding the grade of doctor obtaining consent. Although he acknowledged that some senior house officers may have the depth of experience to adequately consent patients, he noted that they would not have the level of experience to carry out the surgery. He advised that the College guidelines state that consent should be undertaken 'by the doctor who intends to supervise or carry out the procedure'.

14. Adviser 1 summarised that the relevant major complications, with the absence of the risk of death, were outlined to Mrs A. However, he stated that it was not clear from the notes as to the level of detail they were explained in and whether any additional information in the form of leaflets was provided. He noted that the style of consent form used in Scotland differs to that used in England and Wales in that it does not include a space for a description of the benefit of surgery, or a specific space for the risks of surgery.

15. I contacted Mr C by telephone on 24 September 2009 to clarify whether any other family members had been present when the risks were explained and consent was obtained from Mrs A. He advised that his sister had accompanied Mrs A to every consultation and that she had not been invited in to the consultation in May 2007 when consent was obtained, despite being asked in to the previous consultation in January 2007.

(a) Conclusion

16. Although there was a risk of death associated with the surgery, Adviser 1 noted that the precise nature of this risk is difficult to quantify and it is clear that all the major risks recorded in the College guidance were explained to Mrs A. I, therefore, do not uphold this element of the complaint.

17. However, the doctor who provided the information, and obtained consent, was not of an adequate grade to carry out the surgery (and consequently may not have been able to answer some questions relating to the surgery). Adviser 1 expressed concern regarding this as it is not in line with the College guidance and I, therefore, accept this advice and uphold this aspect of the complaint. Overall, I partially uphold this complaint.

(a) Recommendation

18. The Ombudsman recommends that the Board review their procedures to ensure that the process of obtaining patient consent is carried out by a clinician with an appropriate level of seniority and experience, ideally the doctor who will be carrying out the surgery.

(b) The surgical decision-making process was inappropriate

19. In his initial letter to the Board, Mr C questioned why it was necessary to perform the surgery on Mrs A. He queried whether any tests were carried out to establish whether her heart was strong enough to withstand such an operation at her age.

20. The Board responded by advising that a hysterectomy was the conventional approach to removing a cyst from a patient in Mrs A's age group, as the nature of the cyst could not be determined prior to the procedure. They noted that there were no specific concerns identified at Mrs A's pre-operative assessment and that no medical referral was indicated. They informed Mr C that a routine Electrocardiography (ECG) had been carried out as a result of Mrs A's history of high blood pressure and her regular medication was noted.

21. In Mr C's subsequent letter to the Board, he queried whether there was any other method of removing the cyst, other than open surgery, and, if so, whether such alternatives were explained to Mrs A.

22. The Board responded by advising that the other method of removing the cyst would have been by laparoscopy procedure. They stated, however, that

this was not recommended for Mrs A as it was thought to be more appropriate to clear the pelvis area due to the possibility of the cyst being malignant. They noted that Mrs A's cyst turned out to be benign, however, they advised that this could not have been determined without removing it and, to do so laparoscopically would have involved draining and collapsing the cyst. They advised that this would have risked spreading the disease had the cyst turned out to be malignant.

23. The Board said that Mrs A had a choice and that she had been very clear in indicating her preference to have the surgery. They noted that she had indicated that she was experiencing discomfort and wanted to have something done about her cyst. They stated that any perception she had that she 'had to have' the operation was not as a result of influence from the medical staff. They also advised that it is routine practice for the operating surgeon to review the medical notes prior to surgery and visit the patient on admission for further discussion of the planned surgery. They assured Mr C that no doubt had been raised by Mrs A regarding her decision to have surgery.

24. In his complaint to the Ombudsman, Mr C asked again why it was necessary to put his mother through the surgical trauma when the test results had seemed to suggest that the cyst was benign. He noted the Board's indication that Mrs A had requested the operation, however, he disputed this and said that Mrs A had indicated that she had been advised to have surgery.

25. In commenting on this matter, Adviser 1 noted that, at the consultation on 22 May 2007, the senior house officer recorded that Mrs A was in increasing abdominal pain and wished for the cyst to be removed.

26. Adviser 1 stated that the College guidance regarding the management of cysts in post-menopausal women recommended a variety of imaging techniques and he noted that the techniques employed in Mrs A's case were in keeping with this guidance. Based on Mrs A's circumstances and the results of the tests carried out, he advised that it would have been reasonable to have assessed her as having a low risk of malignancy (RMI) or, at the very worst, in the lower range of moderate risk. He advised that the management of such cysts with a low RMI should be conservative if they are less than 5 centimetres. He stated, however, that surgical management is recommended for women who do not fit this criteria and, while Mrs A did have a low RMI, Adviser 1 noted that her cyst was around 13 centimetres.

27. Adviser 1 commented that the original plan for conservative management was not unreasonable given Mrs A's age but he stated that, equally, he could not be critical of a surgical approach. He advised that the recommended surgical approach was to proceed with removing both ovaries laparoscopically, however, he noted that not all surgeons may be comfortable with removing cysts as large as 13 centimetres by this method. He stated that the larger the cyst, the greater the risk of it rupturing during such a procedure, leading to spillage of the cyst contents. He advised that, if it was subsequently shown that the cyst was malignant, the spillage of its contents would have resulted in a poorer survival after treatment.

28. With regards to other options, Adviser 1 stated that an alternative to a laparoscopic oophorectomy would have been a laparotomy (open operation) and removal of both ovaries.

29. Adviser 1 stated that Mrs A had been listed for a total abdominal hysterectomy, bilateral salpingo-oophorectomy and omentectomy, which he noted as an operation usually reserved for women with suspected ovarian malignancy (or ovarian cancer itself). He did note that, in point of fact, an omental biopsy was undertaken rather than an omentectomy and there was no suggestion of ovarian malignancy at the time of the operation. He advised that the surgical decision seemed to have been undertaken by a senior house officer with discussion by a registrar. He noted that there did not seem to have been any consultant involvement in the decision for surgery and he considered this regrettable. He informed me that the decision to operate was based on Mrs A's request for the cyst to be removed and her history of increasing abdominal pain, however, he stated that, in such a case, a consultant should have been involved in the decision to operate and on the type of surgery undertaken.

30. I also sought a cardiology opinion from Adviser 2 and he noted that, although Mrs A had extensive coronary artery disease at autopsy, the only abnormality found in her pre-operative assessment was an irregular pulse. He stated that there is extensive data to suggest that, in the absence of cardiac symptoms or a history of cardiovascular disease, there is no overall benefit in investigating the cardiovascular status of patients prior to surgery. Therefore, he advised that, in the absence of any heart symptoms or significant risk factors, he did not believe that any additional tests on Mrs A's heart were indicated.

(b) Conclusion

31. I accept Adviser 2's view that, once the decision was made to proceed to surgery, relevant tests were carried out on Mrs A's heart and no further tests were deemed necessary. However, Adviser 1 has raised concerns regarding the level of doctor who made the decision to proceed to surgery and also concerns regarding the extent of the surgery. The advice I have received clearly indicates that there should have been consultant involvement in the decision-making process and, as this does not appear to have been the case, I uphold this complaint.

(b) Recommendation

32. The Ombudsman recommends that the Board review their procedures to ensure that there is consultant involvement in decisions to proceed to surgery and in decisions regarding the type of surgery to be carried out.

(c) The surgical complications were not dealt with appropriately

33. Mrs A experienced internal bleeding, necessitating a return to theatre, during which she was noted to have suffered a heart attack. In his initial complaint letter to the Board, Mr C queried what had caused the internal bleeding and he also questioned the outcome of the subsequent tests carried out on Mrs A's heart.

34. In their letter of 24 January 2008, the Board noted that Mrs A had experienced post-operative complications and that she had developed a bleed from the left angle of the vaginal vault. They advised that this is the most common site of bleeding post-hysterectomy and that they felt the most likely cause of the bleeding would have been as a result of a suture slipping. They noted that Mrs A had to return to theatre overnight for repair of the bleed, after which she was transferred to high dependency unit for a period of observation.

35. The Board noted that, post-operatively, Mrs A had a short episode of atrial fibrillation. They stated that she had appeared to have recovered well and a 24 hour ECG, carried out on 3 July 2007, had demonstrated two further short-lived episodes of atrial fibrillation which required no medical intervention. They noted that she was seen again by a cardiologist on 4 July 2007 and no further follow-up was advised. They stated that the cardiologist was happy with Mrs A's proposed discharge and they confirmed that no further investigations were requested.

36. In his subsequent letter to the Board, Mr C asked whether any tests were carried out to determine the condition of Mrs A's arteries following her heart attack. He also noted the Board's indication that Mrs A's operation had been comparatively straightforward, however, he felt that they had omitted to state the obvious concerns after the initial operation and both prior to, and after, the second visit to theatre.

37. In the Board's response, they confirmed that the standard pre-operative assessment is that of an ECG, which Mrs A received. They advised that all pre-operative assessment test results are examined by medical staff and, if any abnormalities are noted, the anaesthetic team are notified and appropriate action taken for each individual. They stated that, following Mrs A's heart attack, she was under the care and guidance of the medical and nursing specialists within cardiology and they again advised that a 24 hour ECG was carried out.

38. The Board stated that details of the concerns after Mrs A's first operation, and prior to the second operation, were comprehensively documented within the case notes. They reiterated that Mrs A's surgery was comparatively straightforward and caused no immediate concern. They advised that it became evident later that evening that Mrs A was not maintaining her blood pressure as well as they would have expected, however, they stated that this is not uncommon post-operatively and she was treated appropriately with gelofusin. They noted that this did not have the desired effect and Mrs A's condition did not improve so they felt it likely that she had developed a post-operative bleed. The Board advised that arrangements were, therefore, made to return to theatre to source and repair the bleed.

39. In Mr C's letter to the Ombudsman, he advised that he had received a copy of the incident report which was completed by the consultant who had operated on Mrs A (the Consultant). Mr C noted that the form recorded the harm resulting from the complication as being moderate. He commented that Mrs A 'had a heart attack during the second operation which probably contributed to her death' and he questioned how that can be classed as moderate harm. He also noted that the incident form stated that the Scottish Early Warning System had been utilised to allow early detection and medical staff were alerted to the potential of a post-operative bleed. Mr C disputed this and advised that there had been constant concern about Mrs A's condition and

that, despite the Consultant reviewing her earlier, 'it was only when the wound burst that they took [Mrs A] up to the operating theatre'.

40. Upon reviewing the records, Adviser 1 confirmed that the operation note read as a straightforward procedure, however, in his opinion, there was a delay in making the diagnosis of the subsequent intra-abdominal bleed. He noted that the decision to return to theatre was made at 00:15 on 28 June 2007 but he advised that there was good evidence of a bleed at 20:00 on 27 June 2009 when Mrs A developed a significant tachycardia.

41. Adviser 1 then advised that the nurse looking after Mrs A recorded a retrospective note indicating that she was sufficiently concerned to contact doctors at 21:00. He observed that Mrs A was reviewed by the Consultant at 21:25 and he noted that blood was recorded to have been soaking through the wound onto the dressing. Adviser 1 stated that this fact, along with the recorded pulse and blood pressure, should have alerted the Consultant to the high probability of an intra-abdominal bleed. He also noted that Mrs A's haemoglobin had dropped between the pre-operative and post-operative reviews and, while this could at least in part have been explained by intra-operative blood loss and would not have provided any immediate cause for concern, Adviser 1 noted that the clinical signs should have raised cause for concern.

42. Adviser 1 observed that the Consultant planned for continued observation and for bloods to be taken. He noted that there was a further significant fall in haemoglobin as of 22:55. In his view, there was sufficient evidence from the chart to be concerned that there was an intra-abdominal bleed and he stated that action should have been instituted before the medical team were once more summoned at 23:55 on 27 June 2007. He did note that the team had commenced treatment with gelofusin at 21:00 but he stated that, for an intra-abdominal bleed following surgery, this would have been an immediate resuscitation measure only and not definitive treatment.

43. Finally, Adviser 1 noted that further surgery was undertaken and the bleed was noted and secured. He advised that the anaesthetic notes record that Mrs A was unstable at that time and she was also noted to have atrial fibrillation. He stated that the heart attack subsequently noted was felt to have been secondary to this atrial fibrillation along with the fall in blood pressure and anaemia.

44. I also asked Adviser 2 to review the records and he noted that an ECG was performed at 23:38 on 27 June 2007, just prior to Mrs A's second operation. He advised that the ECG was abnormal but not diagnostic of a heart attack. He observed that during the surgery her condition was described as unstable and she developed atrial fibrillation and was given a drug to stabilise her heart rhythm. He also observed that Mrs A's troponin level was elevated and he noted that a subsequent ECG, recorded at 03:45 on 28 June 2007, showed persistent atrial fibrillation. Adviser 2 also noted that subsequent ECGs carried out on 28 June 2007 showed that Mrs A had reverted back into a normal sinus rhythm but that there were persistent abnormalities. He advised that these findings, combined with the elevated troponin level, confirm that Mrs A had experienced a heart attack.

45. Adviser 2 then noted that Mrs A's case was discussed with the cardiology specialist on 28 June 2007 and it was felt that she had had a heart attack secondary to low blood pressure, acute anaemia due to acute blood loss, and atrial fibrillation. He indicated that a 24 hour ECG was suggested and it was noted that, if this was normal, Mrs A would be considered for beta-blockers to control her blood pressure. It was also noted that she should have secondary prevention measures when stable, including aspirin and a statin, and that she should also have an echocardiogram. Adviser 2 stated that there is no evidence that Mrs A was actually seen by a member of the cardiology team.

46. Adviser 2 observed the outcome of Mrs A's 24 hour ECG, however, he noted that there was no evidence that the result was formally reported or conveyed to the cardiology team. He also observed the result of the echocardiogram and advised that there was a note on the report indicating that it had been 'actioned' on 4 July 2007. Finally, Adviser 2 noted that other relevant investigation results included a very low cholesterol with low triglyceride and low high-density lipoprotein/low-density lipoprotein (see Annex 2).

47. In his summary, Adviser 2 stated his belief that Mrs A had her cardiac event prior to her second visit to theatre. He expressed his agreement with the first cardiology opinion that the cardiac event was related to Mrs A's low blood pressure and acute anaemia caused by blood loss following her first operation. He stated that the second operation was an emergency life-saving procedure and, although her cardiovascular state was described as unstable, he advised

that the actions taken during her second operation enabled her to survive the procedure. He advised that, in his opinion, once Mrs A had her complication of gynaecological surgery, the outcome was inevitable. In his view, the cardiological advice and help provided to the gynaecological team following Mrs A's heart attack was substandard but he stated that this did not contribute to her death.

48. Notwithstanding this, Adviser 2 noted that Mrs A had had a significant cardiac event following surgery and he observed that the only cardiological input appeared to have been two telephone conversations between the junior doctors in the gynaecology team and specialist registrars in cardiology. He stated that, despite suggesting three investigations (24 hour ECG, echocardiogram and lipid levels), there was no evidence that the cardiology team reviewed the results or took any action on them. He also noted that there was no indication in the records as to whether the nurse specialist in cardiac rehabilitation saw Mrs A prior to her discharge.

49. Adviser 2 noted it to be well documented that acute coronary syndromes carry an especially poor prognosis in the elderly. He advised that the elderly are also significantly less likely to be able to tolerate investigations, including diagnostic coronary angiography. He stated that, in Mrs A's case, her recent surgery may have counted against an aggressive approach to her acute coronary syndrome but he believed that discharging her, following her significant cardiac event, with the comment 'no need for cardiology review' was inappropriate. However, Adviser 2 did note that, even if coronary angiography had been performed, on the basis of the autopsy findings, the result would have shown extensive coronary disease which would have been unlikely to have been suitable for coronary angioplasty. With her recent gynaecological surgery, and troponin positive event, Adviser 2 suspected that a cardiac surgeon would have wished to defer surgery for some weeks, in which case there would have been no difference to the ultimate outcome.

(c) Conclusion

50. The advice, which I have received and accept, indicates that there was a delay in identifying Mrs A's intra-abdominal bleed. In Adviser 1's opinion, there were clinical signs from 20:00 on 27 June 2007 which should have given cause for concern, however, the medical team were not summoned again until 23:55 and the decision to return to theatre was not taken until 00:15.

51. With regards to the cardiological complications, the advice which I have received suggests that the actions taken during the second operation were appropriate and enabled Mrs A to survive the procedure. However, concerns have been raised regarding the level of cardiological input following Mrs A's heart attack and it has been identified that insufficient cardiological follow-up was put in place following Mrs A's discharge.

52. In summary, Mrs A suffered the complication of an intra-abdominal bleed following the initial surgery and, prior to the subsequent visit to theatre which was necessitated by this complication, she suffered a heart attack. As the advice I have received has been critical of the delay in identifying the bleed and also of the cardiological input following Mrs A's heart attack, I uphold this complaint.

(c) Recommendations

53. The Ombudsman recommends that the Board:

(i) reflect on the delay in identifying Mrs A's intra-abdominal bleed and implement an action to address this failure;

(ii) ensure that a proper multi-disciplinary approach to patient care is in place and seen to be effective; and

(iii) apologise to Mr C for the failings identified in this report.

(d) Mrs A was discharged prematurely from the Hospital

54. In his letter to the Board of 14 August 2007, Mr C noted that Mrs A was not due to be discharged until 6 July 2007 and he questioned who had made the decision to discharge her early and why. He also asked what criteria had been used for risk assessment upon Mrs A's discharge and he wondered whether there had been any pressure on the hospital to release Mrs A's bed.

55. In their letter of 24 January 2008, the Board reassured Mr C that Mrs A was discharged home after discussion with the multi-disciplinary team involved with her care. They advised that, on the day of discharge, Mrs A was reported to have been feeling well, mobilising and eating and drinking. They confirmed that they had contacted Bed Management who advised that there had been bed availability at that time and they assured Mr C that bed availability within the Hospital had no influence on Mrs A's discharge. They stated that the gynaecology team were guided by the cardiology team involved with Mrs A's care and that, on 4 July 2007, Mrs A had spoken with the staff regarding her discharge and she had discussed the support that was available to her at home.

Finally, the Board advised that, at the request of the nursing staff, the cardiac rehabilitation nurse visited Mrs A on the ward on the day of her discharge and she explained that she would refer her to the community cardiac rehabilitation nurse.

56. In his letter of 26 February 2008, Mr C stated that the Board had omitted to mention that the cardiac rehabilitation nurse had also stated that Mrs A had appeared vague and confused regarding her heart attack. Mr C also noted that, in Mrs A's medical records from 4 July 2007, Mrs A was also described by a nurse as being vague and confused. Finally, Mr C noted that Mrs A had not been eating and drinking much and he questioned what level had to be attained before a patient would be classed as mobilising, eating and drinking.

57. In the Board's response of 25 March 2008, they stated that they would not consider it unusual for a patient to be vague and confused regarding a heart attack. They said that it was often the case that patients are unable to give a clear account of a cardiac event.

58. The Board confirmed that, prior to Mrs A's discharge, she was eating and drinking sufficient amounts to be feeling well and mobilising around the ward. They confirmed that, had her fluid intake been insufficient, this would have been reflected in her blood results and they assured Mr C that her blood results had indicated that she was well hydrated. The Board acknowledged that it was difficult to ascertain what a patient would normally eat at home to compare dietary intake in hospital, however, they advised that, when staff remove a patient's meal tray, they would note if the patient was not eating. They stated that a food chart would be commenced to record dietary intake if they had cause for concern and they confirmed that this had not been the case with Mrs A.

59. In my telephone discussion with Mr C on 24 September 2009, I asked if he had been involved in any discussions leading up to the decision to discharge Mrs A and he confirmed that he had not. He advised that his brother-in-law had been alerted to the fact that Mrs A was to be discharged and he had expressed his concern as to whether she was well enough for this.

60. Upon reviewing the records, Adviser 1 noted that Mrs A was recorded to have been well during the ward round of 5 July 2007. He also noted that discussion had taken place with the cardiologist on 4 July 2007 and it was

advised that there was no need for review. Adviser 1 stated that appropriate measures seemed to have been taken for follow-up with the district nurses after discharge. From a gynaecological point of view, he concluded that Mrs A's discharge seemed appropriate.

61. In commenting on this matter, Adviser 2 noted that Mrs A's heart attack occurred on 27 June 2007 and at the time of her discharge on 5 July 2007, eight days later, her cardiovascular status had appeared to be stable. He, therefore, stated that, from a cardiological point of view, the timing of the discharge could be regarded as appropriate. He did raise concerns regarding the standard of cardiological follow-up following discharge, however, this has been addressed under complaint (c).

(d) Conclusion

62. The expert advice which I have received indicates that Mrs A's discharge was appropriate from both gynaecological and cardiological points of view. I, therefore, conclude that the timing of the discharge was reasonable and I do not uphold this complaint.

Annex 1

Explanation of abbreviations used

Mrs A	The complainant
The Hospital	The Royal Infirmary of Edinburgh
Mr C	The aggrieved (the complainant's late mother)
The Board	Lothian NHS Board
Adviser 1	One of the Ombudsman's obstetrics and gynaecology advisers
Adviser 2	One of the Ombudsman's cardiology advisers
The College	Royal College of Obstetricians and Gynaecologists
ECG	Electrocardiogram
RMI	Low risk of malignancy
The Consultant	The surgeon who operated on Mrs A

Annex 2

Glossary of terms

Term	Definition
Anaemia	A decrease in the normal number of red blood cells or less than the normal quantity of haemoglobin in the blood
Atrial fibrillation	An abnormal heart pattern
Bilateral salpingo-oophorectomy	The removal of both ovaries and fallopian tubes
Coronary angioplasty	Wire and balloon procedure on the coronary arteries
Diagnostic coronary angiography	Procedure that uses a special dye (inserted via a catheter) along with x-rays to identify blockages in the coronary arteries
Echocardiogram	An ultrasound imaging of the heart
Electrocardiogram (ECG)	A test that records the electrical activity of the heart
Gelofusin	A blood expander
Haemoglobin	The coloured pigment inside red blood cells that carries oxygen round the body
High-density lipoprotein/low-density lipoprotein	The proportion of good cholesterol to bad cholesterol
Intra-abdominal bleeding	Bleeding within the abdomen
Laparoscopy	Where operations in the abdomen are performed through small incisions (keyhole surgery)

Laparotomy	Surgical procedure involving an incision through the abdominal wall to gain access into the abdominal cavity
Lipid levels	Level of fatty acids and cholesterol in the blood
Omental biopsy	The removal of a portion of the omentum for pathological examination
Omentectomy	Surgical removal of the omentum
Omentum	Large fold of peritoneum that hangs down from the stomach
Peritoneal washings	A procedure where saline is introduced into the peritoneal cavity. The fluid is then removed by suction and examined for malignant cells
Pulmonary embolisms	A blockage of the main artery of the lung
Sinus rhythm	The normal beating of the heart, as measured by an ECG
Statin	A drug used to reduce cholesterol level
Suture	A stitch used by doctors and surgeons to hold tissue together
Tachycardia	Increased heart rate
Thrombosis	The formation of a blood clot inside a blood vessel
Total abdominal hysterectomy	The removal of the uterus and cervix through a cut in the lower abdomen
Triglyceride	A form of fat made in the body

Troponin	A chemical released when heart muscles cells are damaged
Ureter	Muscular duct that propels urine from the kidneys to the urinary bladder

Annex 3

List of legislation and policies considered

Royal College of Obstetricians and Gynaecologists, Guidelines number 34, Ovarian Cysts in Post-menopausal women, October 2003

Royal College of Obstetricians and Gynaecologists Clinical Governance Advice Number 6, October 2004

Royal College of Obstetricians and Gynaecologists Document, Abdominal Hysterectomy for Heavy Periods, Consent Advice 4, October 2004[1]

Management of Acute Coronary Syndromes in the Elderly, Canadian College of Cardiology Consensus Document

Acute Coronary Care in the Elderly, Circulation 2007; 115: 2549-69

[1] Although this advice note makes reference to hysterectomy for heavy periods, Adviser 1 has noted that the contained advice concerning complication rates is appropriate to Mrs A's case