Scottish Parliament Region: Central Scotland

Case 200901320: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly; clinical treatment; diagnosis

Overview

The complainant, Mr C, raised a number of concerns about the care and treatment provided to his mother, Mrs A, by Lanarkshire NHS Board (the Board). Mr C was concerned that there had been delays in Mrs A's treatment, incorrect diagnosis of her bowel problems, poor communication and poor complaints handling.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was an unacceptable delay in performing triple heart bypass surgery on Mrs A (*not upheld*);

(b) there was an incorrect diagnosis of Mrs A's bowel problems (*not upheld)*;

(c) there was inadequate communication between Monklands Hospital (Hospital 3) and Mrs A's General Practitioner and Hospital 3 and other hospitals involved in her care (*upheld*); and

(d) the complaint to the Board raised by Mrs A's MSP was not handled properly (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) apologise to Mrs A for the failures identified under head of complaint (b);	04 August 2010
(ii) remind their staff to ensure that written and typed notes are made contemporaneously after any clinical admission or out-patient visit; and	18 August 2010
(iii) apologise to Mrs A for the communication failures highlighted at paragraphs 43 to 45.	04 August 2010

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

Main Investigation Report

Introduction

1. On 29 June 2009, I received a complaint from Mr C, on behalf of his mother (Mrs A) about the care and treatment she received from Lanarkshire NHS Board (the Board).

2. Mrs A is a 70-year-old woman, with a history of kidney, bowel and heart problems. Between 2006 and 2009, Mrs A attended Hairmyres Hospital (Hospital 1), Western Infirmary Glasgow (Hospital 2) and Monklands Hospital (Hospital 3).

3. Mr C was concerned that there had been delays in Mrs A's treatment, incorrect diagnosis of her bowel problems, poor communication and poor complaints handling.

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

(a) there was an unacceptable delay in performing triple heart bypass surgery on Mrs A;

(b) there was an incorrect diagnosis of Mrs A's bowel problems;

(c) there was inadequate communication between Hospital 3 and Mrs A's General Practitioner and Hospital 3 and other hospitals involved in her care; and

(d) the complaint to the Board raised by Mrs A's MSP was not handled properly.

Investigation

5. As part of my investigation of this complaint, my complaints reviewer examined all the complaints correspondence relating to Mrs A's care and treatment and examined copies of Mrs A's clinical records. My complaints reviewer also asked one of my clinical advisers (the Adviser) to review the clinical records and let him know whether the Board had acted reasonably in relation to Mr C's complaints.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Chronology of events

7. In providing my complaints reviewer with his advice on the complaint, the Adviser set out a chronology of relevant medical events. This is detailed at paragraphs 8 to 21 below and only includes events which the Adviser considered to have a bearing on Mr C's complaint.

8. On 3 May 2006, Mrs A attended a consultant cardiologist (Doctor 1) at Hospital 1, following a referral from her GP. It was noted that she had a history of peripheral vascular disease (a narrowing or blockage of the arteries that produces intermittent pain in the legs and arms), hypertension (high blood pressure) and angina (a condition caused when the supply of oxygen-rich blood to the heart becomes restricted). Given her symptoms, Doctor 1 decided that Mrs A should have an angiography (a test used to find out information about the coronary arteries) but arranged to check her renal (kidney) function as a precursor to this.

9. On 10 May 2006, Doctor 1 received the results of the renal function tests, which revealed a significant deterioration in Mrs A's kidney function. As a result, it was decided to put the angiography on hold until an ultrasound scan of her kidneys was performed.

10. Between June and September 2006, Mrs A attended Hospital 3 on a number of occasions in order to monitor her kidney function.

11. On 20 September 2006, Doctor 1 decided to proceed with an angiography as Mrs A's renal function had improved and become stable. The angiography was subsequently carried out and this revealed severe three vessel coronary (heart) disease.

12. By February 2007 and following a review of the angiography, it was decided that a coronary artery bypass graft (CABG – open heart surgery to treat coronary artery disease) would be required rather than performing an angioplasty (a procedure to open narrowed or blocked blood vessels that supply blood to the heart). On 26 February 2007, Mrs A was reviewed at Hospital 1 by a cardiac surgeon (Doctor 2) who accepted Mrs A for a CABG operation, pending a further renal review to determine Mrs A's suitability for this operation.

13. On 9 May 2007, Mrs A attended a pre-admission clinic at Hospital 2 prior to her forthcoming CABG surgery. On 22 June 2007, Mrs A was reviewed by

renal physicians at Hospital 3. As a result, she was deemed fit for the CABG operation.

14. On 30 July 2007, Mrs A was admitted to Hospital 3 with collapse, low blood pressure and abdominal pain. The initial working diagnosis was ischaemic gut. A colonoscopy was performed. This showed inflammation of the colon. However, a mesenteric angiogram (a test to examine the arteries in the intestine) was normal, effectively ruling out ischaemic gut. On 20 August 2007, Mrs A was transferred from Hospital 3 to Hospital 2 for the CABG surgery.

15. Hospital 2 was unprepared for Mrs A's transfer. A letter from Doctor 2 referring to the transfer stated:

> 'About three weeks ago [Mrs A] was admitted to [Hospital 3] with acute abdominal pain and collapse. She had diarrhoea and a drop in haemoglobin [iron-containing protein that attaches to red blood cells]. A diagnosis of mesenteric ischemia [narrowing or blockage of arteries supplying the intestines] was made …
>
> Remarkably, without this history being conveyed to us, she was transferred directly from [Hospital 3] to the Cardiothoracic Unit [at Hospital 2] to have her bypass surgery performed …
>
> I think we are now at the stage of reconsidering her best treatment option. Although we felt that bypass surgery was the optimum approach back in February, as things change so much, it might be safer to consider an angioplasty option to achieve partial revascularisation [the process of restoring the flow of oxygen and nutrients to the heart] to help her symptoms. I am sure that this is the safest option now.'

16. On 22 August 2007, following her discharge from Hospital 2, Mrs A was referred for an out-patient appointment to be reviewed by Doctor 1 at Hospital 1. In October 2007, an angioplasty was successfully performed on two of Mrs A's coronary arteries.

17. In January 2008, Mrs A was admitted to Hospital 3 with abdominal pain. The Adviser noted that there were very few surgical notes relating to this admission and no discharge summary relating to Mrs A's discharge.

18. On 11 April 2008, Mrs A was reviewed by a consultant surgeon (Doctor 3) at Hospital 3. The diagnosis of Mrs A's abdominal pain was now said to be known severe diverticular disease (a condition affecting the large bowel or colon). The documented plan was for a laparoscopic sigmoid colectomy (Colectomy) (a minimally intrusive operation to remove an area of the bowel that may be diseased) to be performed.

19. On 28 November 2008, following a referral by Doctor 3, Mrs A was seen by an anaesthetist at Hospital 3 to determine her suitability for Colectomy. Mrs A was deemed fit for surgery.

20. On 27 January 2009, Mrs A attended Hospital 3 for a computerised tomography scan of her colon (a CT scan – a scan that takes a series a x-rays and uses a computer to put them together). The scan result was normal. The Adviser noted that he could find no record in the notes regarding why the scan was requested.

21. On 10 March 2009, Mrs A was admitted to Hospital 3 for a Colectomy. The consent form failed to mention diagnostic laparoscopy, however, this was the procedure which went ahead. The diagnostic laparoscopy was then performed, however this found no pathology (impairment of the normal state or function of the body) and, therefore, no Colectomy was performed.

(a) There was an unacceptable delay in performing triple heart bypass surgery on Mrs A

22. In correspondence submitted to the Ombudsman's office as part of his complaint, Mr C said Mrs A was due to have triple heart bypass surgery and that this treatment was delayed as a result of uncertainty regarding Mrs A's bowel condition. The treatment was subsequently not carried out and instead Mrs A underwent angioplasty (see paragraph 16).

23. My complaints reviewer asked the Adviser to comment on this complaint. He said there were no unacceptable delays in the entire pathway from initial referral with a cardiological (heart) problem (May 2006) to final intervention (October 2007).

24. The Adviser explained that an angiography was appropriately deferred whilst a renal review was carried out. Subsequently, when CABG surgery was

decided upon, this was also deferred appropriately whilst a renal opinion was sought.

25. The Adviser said that the requests for medical opinions on Mrs A's renal function between deciding to perform the angiography and carrying it out, and between deciding on CABG surgery and the planned operation, were reasonable and correct. He said that once the decision was taken not to proceed with CABG surgery due to Mrs A's abdominal pain, there was again a necessary delay prior to the angioplasty being performed.

26. The Adviser clarified that Mrs A could have had either CABG surgery or an angioplasty. He explained that CABG surgery aimed to revascularise all vessels that were graftable. He said angioplasty was different and was not an attempt to mimic CABG surgery by an alternative approach. He explained that, instead, angioplasty involved identifying those vessels which could be safely stretched at a single sitting, without undue risk and with satisfactory control of symptoms, and subjecting them to balloon dilation/stenting (using a wire mesh tube to prop open an artery that has recently been cleared using an angioplasty).

27. The Adviser made clear that angioplasty was often a multi-usage procedure and also often involved a pragmatic targeting of some of the diseased vessels only. He said that the key point in relation to Mrs A's treatment was that the angioplasty approach was correctly deemed to be safer and more efficacious than an operation where all three vessels would have been bypassed. The Adviser said when the angioplasty was carried out successfully, Mrs A did not require further cardiac surgery.

28. Consequently, the Adviser said that, although the time period from presentation of Mrs A's symptoms to intervention was long, the reasons for this were appropriate.

(a) Conclusion

29. In light of the Adviser's comments, I am satisfied that there was no undue delay in treating Mrs A's heart problems. I note that there was a significant period of time between Mrs A's symptoms first presenting and an intervention being carried out and I can, therefore, appreciate why Mr C would have felt Mrs A was not being treated quickly enough. However, I agree with the

Adviser's view that there were good reasons for this and that there were no unacceptable delays. Consequently, I do not uphold this complaint.

(b) There was an incorrect diagnosis of Mrs A's bowel problems

30. In correspondence submitted to the Ombudsman's office as part of his complaint, Mr C said that following Mrs A's collapse in July 2007 she was told by Doctor 3 that she had an ischemic bowel (a narrowing or blockage of the arteries that supply blood to the intestines). He said that, subsequently, diverticular disease was also raised as a possible diagnosis but that, eventually, it was found to be neither of these.

31. In responding to the complaint raised by Mrs A's MSP, the Board said that Mrs A presented to Doctor 3 with left iliac fossa pain (pain in lower left abdomen). They said that she underwent a colonoscopy (a procedure used to see inside the colon) and a CT scan but the results of these remained inconclusive. They said a diagnosis of ischemic bowel came as an exclusion diagnosis (a diagnosis made by excluding all other known diseases). They explained that a diagnosis of possible diverticular disease was another possible condition behind the symptoms Mrs A was experiencing.

32. The Board explained that a diagnostic laparoscopy was carried out in March 2009 in order to explain unequivocally Mrs A's symptoms. They said that if bowel pathology was indicated, Doctor 3 then planned to proceed with a bowel resection (removal of part of the bowel). They said, however, that no pathology was found and that Doctor 3, therefore, felt that he could not proceed with a major procedure for Mrs A, which could have resulted in complications.

33. My complaints reviewer asked the Adviser to comment on the complaint. Paragraphs 8 to 21 above note the relevant medical chronology and also highlight some of the Adviser's concerns in relation to Hospital 3's record-keeping and communication with Mrs A. In providing my complaints reviewer with his advice, the Adviser commented on these issues in detail and said that the exact course of Mrs A's medical condition had been difficult to understand due to the highly disorganised manner in which photocopies of the medical records had been filed. He said, in addition, that there was a paucity of hand-written medical documentation and this was most marked by a total lack of handwritten surgical out-patient documentation. The Adviser said he was highly critical of this shortcoming.

34. The Adviser also noted that, in relation to Mrs A's consultation with Doctor 3 in April 2008 (see paragraph 18), there was no written record of this clinic visit, no documentation in the notes as to how the diagnosis of severe diverticular disease was given to Mrs A, no record as to how the various treatment options for the disease were relayed to her and no record of how the various risks and benefits of Colectomy were communicated. The Adviser also noted that at no stage in any part of the case record was there any mention of the need to perform a diagnostic laparoscopy (an operation to look at the abdominal and pelvic organs using a small telescope) prior to removing the colon.

35. The Adviser pointed out that by February 2009 a CT scan, colonoscopy and mesenteric angiography had all been carried out but had failed to find any significant pathology. This did not support Doctor 3's diagnosis that Mrs A had severe diverticular disease. He said that the diagnostic uncertainty and the need for a diagnostic laparoscopy in March 2009, rather than a Colectomy for severe diverticular disease, should have been explained to Mrs A at this time. However, the Adviser pointed out that Mrs A was unaware that this was the procedure that would be carried out. He noted that Mrs A had been prepared for (and ultimately consented to) a Colectomy for severe diverticular disease.

36. The Adviser said that the fact that Mrs A was not provided with appropriate explanations of the fact that there was uncertainty about her diagnosis and that a diagnostic laparoscopy was required in order to address this uncertainty was, in his view, the root cause of the complaint. He said that there was a lack of documentation, particularly by Doctor 3, regarding the communication between himself and Mrs A and this constituted a significant shortfall in the standard of care provided to her.

37. The Adviser noted, however, that the management of Mrs A's bowel condition was reasonable. While the procedures referred to in paragraph 35 did not support the diagnosis of severe diverticular disease, he considered that the initial diagnosis (of diverticular disease) was supported by inflammation seen on colonoscopy. In his view, the issue was not so much how the bowel condition was treated, as the way in which communication with Mrs A occurred. The Adviser told me that the communication around this aspect of her care and treatment was unreasonable.

(b) Conclusion

38. I note that, in considering Mrs A's bowel condition, the Board explored several possible diagnoses, including ischemic bowel and diverticular disease. I note that the Board carried out a number of tests in order to determine the cause of Mrs A's pain but that this could not ultimately be found. Finally, I note the Adviser's view that the clinical management of Mrs A's bowel condition was not unreasonable.

39. Having carefully considered the Adviser's advice, I am satisfied that the clinical management of Mrs A's bowel condition was appropriate. Although the Board explored several possible diagnoses in treating Mrs A, there is no evidence that an incorrect diagnosis was made. In light of this, I do not uphold the complaint.

40. While I am not upholding the complaint, I am concerned about the way in which the Board communicated with Mrs A. It is clear that communication with her was poor and that the uncertainty surrounding the nature of her bowel condition and how it would be treated was not explained to her sufficiently clearly. These problems appear to be at the root of Mr C's complaint and represent significant failings. I am also concerned to note the poor standard of record-keeping evidenced in Mrs A's records. The Adviser is highly critical of this shortcoming and I agree with his assessment. My recommendations below address these issues.

(b) Recommendations

41.	I recommend that the Board:	*Completion date*
(i)	apologise to Mrs A for the failures highlighted above; and	04 August 2010
(ii)	remind their staff to ensure that written and typed notes are made contemporaneously after any clinical admission or out-patient visit.	18 August 2010

(c) There was inadequate communication between Hospital 3 and Mrs A's General Practitioner and Hospital 3 and other hospitals involved in her care

42. In correspondence submitted to the Ombudsman's office with his complaint, Mr C said he was concerned that there was a lack of communication between Hospital 3 and others involved in Mrs A's care. In his view, this resulted in a lack of coordination in Mrs A's treatment.

43. My complaints reviewer asked the Adviser to comment on this complaint. He said that there was a lack of communication on the part of Hospital 3 when Mrs A was transferred to Hospital 2 in August 2007. He said that although there was a typed transfer letter dated on the day of the transfer stating that Mrs A had been investigated for abdominal pain, there should have been communication between the medical teams that this transfer was to take place. He said it was almost inconceivable that Mrs A should have been transferred from a medical team across to another hospital for elective surgery without any communication prior to her actually arriving on the surgical ward. The Adviser noted, however, that this is what happened. He said this constituted a significant failure in medical communication on Hospital 3's part.

44. The Adviser said that, in addition, Doctor 2 decided that, in light of the recent admission for abdominal pain, angioplasty rather than CABG surgery was now appropriate. The Adviser said that if Hospital 3 had told Hospital 2 about the admission for abdominal pain prior to the transfer, then the admission to Hospital 2 would not have been necessary. He said, therefore, that the shortfall in communication had a significant impact on Mrs A.

45. The Adviser also said that he could find no evidence of a discharge summary being sent to Mrs A's GP following Mrs A's admission in January 2008 with abdominal pain.

46. In commenting on a draft of this report, the Board pointed out that the nursing records made several references to Mrs A's upcoming transfer. This included an entry on 15 August 2007 stating that Hospital 2 had been contacted to cancel a pre-assessment appointment and that the date of the admission was to be amended, and an entry on 18 August 2007 stating that staff at Hospital 2 had requested a change to Mrs A's medication in preparation for her operation. The Board said that, while they accepted that the records suggested that communication from Hospital 3 was from nursing staff, communication had taken place.

47. I have carefully considered the Board's comments and it is clear from the nursing records that there was some communication between Hospital 3 and Hospital 2. However, it is not clear that Mrs A's condition was adequately communicated to Hospital 2. As a result, I am satisfied that the Adviser's

comments about the lack of communication between medical teams prior to transfer – and the impact this had on Mrs A – remain valid.

(c) Conclusion

48. The Adviser has pointed out that there was a significant breakdown in communication on Hospital 3's part when they transferred Mrs A to Hospital 2 and that this had had an impact on Mrs A. I can also understand why Mr C considers that this resulted in a lack of co-ordination in Mrs A's treatment. The Adviser also pointed out that Hospital 3 failed to send a discharge summary to Mrs A's GP on one occasion. In light of this, I uphold the complaint.

(c) Recommendation

49. I recommend that the Board	*Completion date*
(i) apologise to Mrs A for the communication failures highlighted at paragraphs 43 to 45.	04 August 2010

(d) The complaint to the Board raised by Mrs A's MSP was not handled properly

50. Mrs A's MSP wrote to the Board on 24 March 2009 outlining Mrs A's recent medical history and asking for an answer to six points of complaint. The Board acknowledged this letter on 25 March 2009. The Board investigated the complaint and sought statements from three members of staff. The Board provided their formal response to the complaint on 14 April 2009. This letter provided a general response to the issues raised by Mrs A's MSP and went on to answer each of the six specific points of complaint which had been raised.

51. Mr C wrote to Mrs A's MSP on 29 May 2009, expressing dissatisfaction at the Board's response. He did not consider that the complaint had been properly addressed. Mrs A's MSP's office subsequently advised Mr C to raise a complaint with the Ombudsman.

52. Under the NHS complaints procedure, complaints should be acknowledged or an initial response issued in writing within three working days of receipt. An investigation of a complaint should be completed, wherever possible, within 20 working days following the date of receipt of the response. Where it appears that the 20 day target will not be met, the person making the complaint must be informed of the reason for the delay and an indication given of when a response should be expected. The investigation should not normally be extended by more than a further 20 working days.

(d) Conclusion

53. I appreciate that Mr C was unhappy with the response made to Mrs A's complaint and that he felt it was lacking in detail and failed to understand Mrs A's medical history. Having reviewed the complaints correspondence, however, my view is that the Board's response to Mrs A's complaint was adequate. A general response to the complaint was provided and investigated and statements were obtained from staff involved, as well as addressing the six specific points that had been raised. While Mr C obviously disagrees with the Board's decision on the complaint, my view is that the complaint was handled properly, in that it was investigated appropriately and each of the points raised was responded to. In addition, the response times set out under the NHS complaints procedure were adhered to and the complaint was investigated in line with this procedure. Consequently, I do not uphold this complaint.

54. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs A	The aggrieved
The Board	Lanarkshire NHS Board
Hospital 1	Hairmyres Hospital
Hospital 2	Western Infirmary, Glasgow
Hospital 3	Monklands Hospital
The Adviser	One of the Ombudsman's medical advisers
Doctor 1	A consultant cardiologist at Hospital 1
CABG	Coronary artery bypass graft
Doctor 2	A cardiac surgeon at Hospitals 1 and 2
Doctor 3	A consultant surgeon at Hospital 3
CT scan	A computerised tomography scan
Colectomy	laparoscopic sigmoid colectomy

Annex 2

Glossary of terms

Angina	A condition caused when the supply of oxygen-rich blood to the heart becomes restricted
Angiography	A test used to find out information about the coronary arteries
Angioplasty	A procedure to open narrowed or blocked blood vessels that supply blood to the heart
Bowel resection	Removal of part of the bowel
Cardiological problem	Heart problem
Colonoscopy	A procedure used to see inside the colon
Computerised tomography (CT) scan	A scan that takes a series of x-rays and uses a computer to put them together
Coronary artery bypass graft (CABG)	Open heart surgery to treat coronary artery disease
Diagnostic laparoscopy	An operation to look at the abdominal and pelvic organs using a small telescope
Diverticular disease	A condition affecting the large bowel or colon
Exclusion diagnosis	A diagnosis made by excluding all other known diseases
Haemoglobin	Iron-containing protein which attaches to red blood cells
Hypertension	High blood pressure

Ischemic bowel	A narrowing or blockage of arteries supplying the intestines
Laparoscopic sigmoid colectomy	A minimally intrusive operation to remove an area of the bowel which may be diseased
Left iliac fossa pain	Pain in the lower left abdomen
Mesenteric ischemia	A narrowing or blockage of arteries supplying the intestines
Mesenteric angiography	A test to examine the arteries in the intestines
Pathology	Impairment of the normal state or functioning of the body
Peripheral vascular disease	A narrowing or blockage of the arteries which produces intermittent pain in the legs and arms
Renal function	Kidney function
Revascularisation	The process of restoring the flow of oxygen and nutrients to the heart
Stenting	Using a wire mesh tube to prop open an artery which has recently been cleared using an angioplasty