SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: North East Scotland

Case ref: 201701938, Grampian NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C complained on behalf of his late mother (Mrs A) about the care and treatment she received from the Board. Mr C and his father (Mr B) complained that there was an unreasonable delay diagnosing that Mrs A had bowel cancer. In relation to an admission at Woodend Hospital towards the end of Mrs A's life, Mr C complained that the nursing care was unreasonable and that there was an unreasonable delay diagnosing internal bleeding.

We took independent advice from a consultant gastroenterologist, a registered nurse and a consultant geriatrician.

In relation to Mr C's complaint about delay in diagnosis of cancer, we found that inadequate investigations were carried out. We concluded that if the relevant clinical guidance regarding investigations had been followed, then Mrs A's cancer would have been diagnosed in 2013 rather than 2016. We noted that a number of failings contributed to the delay, including a failure to review the quality of previous investigations performed.

We concluded that the failings in the investigation of Mrs A's bowel symptoms likely had a significant impact on her ability to survive her illness. In addition to this, we also concluded that it was likely that with correct treatment Mrs A would not have had prolonged and profound anaemia and may not have developed a myocardial infarction. Finally, we were critical of the Board's investigation of the complaint and concluded that they had failed to provide a full and accurate response to the family. We upheld this complaint.

Following surgery in Aberdeen Royal Infirmary to remove a tumour in her bowel, Mrs A was transferred to Woodend Hospital for a period of rehabilitation. Mr C raised a number of concerns about the nursing care Mrs A received at Woodend Hospital. We found a number of failings in the nursing care Mrs A received during this admission. We were critical of the monitoring of Mrs A's condition and found there was no care plan for the management of her diabetes. Furthermore, there were failings in pressure ulcer management and also in falls prevention. We also

found failings in stoma care, noting there was no care plan or fluid balance monitoring. Finally, we noted that there was little evidence of family involvement in care planning and limited records of communication. We concluded that the nursing care was unreasonable and upheld the complaint.

Mr C also complained that there was a delay in diagnosing internal bleeding during the admission to Woodend Hospital. We found that medical staff reviewed Mrs A's condition reasonably during the admission and we did not identify an unreasonable delay in the diagnosis. While we recognised that there were issues with the nursing observations, we did not consider that these impacted on the ability of medical staff to diagnose Mrs A's condition. We did not uphold this aspect of Mr C's complaint.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	There was an unreasonable delay in diagnosing that Mrs A had cancer. The nursing care provided to Mrs A during the admission in Woodend Hospital was unreasonable. The Board did not investigate Mr C's complaint to a reasonable standard	Apologise to Mr C and Mr B for: • the unreasonable delay in diagnosing that Mrs A had cancer; • the failings in nursing care during the admission in Woodend Hospital; • the poor quality of the investigation of the complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology. By: 22 January 2019

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	Mrs A was not offered a repeat colonoscopy after an incomplete colonoscopy was performed in June 2013	Patients who have had an incomplete colonoscopy should be offered a repeat colonoscopy or another appropriate investigation in line with clinical guidelines	Evidence that the gastroenterology department have carried out an audit of current colonoscopy practice. This should include: • the proportion of incomplete colonoscopies over the last 12 months and the reasons for this; • the outcomes of incomplete colonoscopies, including whether repeat or follow on tests were arranged in line with national guidelines; and • in cases where the guidance was not followed regarding follow up tests, the action being taken to address this. Evidence that the Board have developed a local protocol to ensure that the national guidelines are followed when colonoscopy is incomplete so that appropriate follow-up tests are arranged By: 16 April 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	The documentation of the extent of completion of the colonoscopy was inadequate. It was unclear how it was established that the hepatic flexure was passed or whether a scope guide was used	Patient records should include details of how the extent of completion of a colonoscopy has been established. Where a scope guide is used, this should be documented	Evidence that the Board have taken action to ensure that the extent of completion of colonoscopies are adequately documented. (For instance, the Board might summarise documentation standards on a poster in the endoscopy department, or incorporate this into the colonoscopy reporting system) By: 19 March 2019
(a)	The incompleteness of the colonoscopy was not documented in the discharge letter from the admission in June 2013. There was no evidence of senior input into the discharge letter	All diagnoses, operations and procedures relevant to a patient's admission should be accurately documented in the discharge documentation. Discharge documentation should receive appropriate input or review from senior medical staff, and this should be documented	Evidence that the Board have reviewed the discharge documentation practice in place in the Gastroenterology Department to ensure that senior medical staff have appropriate input into discharge documentation By: 19 March 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	The quality of the colonoscopy in June 2013 was not reviewed at subsequent consultations in 2014 and 2015. A colonic cause for Mrs A's iron deficiency anaemia was not ruled out before iron therapy and capsule endoscopy were performed. The Board failed to investigate the possibility that the endoscopy capsule had been retained	The quality of colonoscopies should be appropriately reviewed and investigated at subsequent consultations. A colonic cause for iron deficiency anaemia should be excluded before prescribing iron therapy and performing capsule endoscopy. Where a patient reports that they have not passed an endoscopy capsule, investigation should be performed where there is a reasonable clinical suspicion of this complication	Evidence that the Gastroenterology Consultants involved in Mrs A's care have reflected on their practice in relation to the review and investigation of patients at subsequent consultations and in relation to investigating iron deficiency anaemia. Evidence that the Board have performed quality improvement work (for instance, development of written guidance or protocol) to ensure appropriate investigations are performed to exclude pathology outside the small bowel and to reduce the risk of a retained capsule. The Board should provide the SPSO with a copy of any guideline or protocol developed By: 16 April 2019

Complaint number	What we found	Outcome needed	What we need to see
(b)	Completion of NEWS monitoring charts was inconsistent and not in accordance with guidance. Mrs A had type 2 diabetes but there was no care plan as to how her condition should be monitored	NEWS charts should be completed to accurately reflect the patient's condition. Observations of a patient should be completed in line with the planned frequency in the patient's records. A care plan should be in place for patients with diabetes and monitoring should be performed in line with this	Evidence that the Board have reviewed the training needs of nursing staff in relation to: • completion of NEWS; and • diabetes monitoring. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019

Complaint number	What we found	Outcome needed	What we need to see
(b)	The assessment and management of pressure ulcer risk was inconsistent and incomplete	Patients should receive nursing care to prevent and manage pressure ulcers in line with relevant standards[1]	Evidence that the Board have reviewed the training needs of nursing staff in relation to the assessment and management of pressure ulcer risk. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019
(b)	It was unclear how information was shared when Mrs A transferred between hospitals	Relevant information about a patient's care should be transferred with a patient when the patient transfers between hospitals	Evidence that the Board have a clear pathway in place for inter-hospital patient transfers, which details how key information is shared between nurses in both hospitals By: 16 April 2019

[1] Since the time of the complaint, the following standards were introduced: *Prevention and Management of Pressure Ulcers Standards.* Healthcare Improvement Scotland (September 2016)

Complaint number	What we found	Outcome needed	What we need to see
(b)	There was no falls prevention care plan in place, despite the risks identified	Where a patient has been assessed as at risk of falling, a falls prevention care plan should be in place	Evidence that the Board have reviewed the approach to falls care planning in Woodend Hospital to make sure that risks are identified, and care plans are developed in conjunction with patients, and their family/carers as appropriate. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019
(b)	The management of Mrs A's stoma care was not reasonable. There was no stoma care plan in the records	Where a patient has a stoma a stoma care plan should be in place	Evidence that the Board have reviewed: • how stoma nurses advise and support stoma care for patients to ensure that there is a patient centred care plan which can be adhered to by all nurses; • the use of fluid balance charts at Woodend Hospital.

Complaint number	What we found	Outcome needed	What we need to see
	There was no fluid intake and output measurement in Woodend Hospital for Mrs A, despite her clinical condition	Fluid balance charts should be used to measure a patient's fluid intake and output	A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019
(b)	'Five Must Dos With Me' documented do not appear to have informed the care planning. Mrs A's family do not appear to have been involved and there are limited records of communication	Patients and their family/ significant others should be appropriately involved in care planning	Evidence that the Board have reviewed how the 'Five Must Dos With Me' inform care plans in Woodend Hospital and have reviewed how families and carers are involved and communicated with. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019

We are asking The Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board did not investigate Mr C's complaint to an acceptable standard	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and learning from complaints are used to drive service development and improvement	Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in investigating Mr B's and Mr C's complaints and meeting with the family and that they have reflected on the findings of this investigation. (For instance, a copy of a meeting note or summary of a discussion) By: 19 February 2019

Feedback

Response to SPSO investigation

Multiple enquiries were needed in order to obtain the records required by SPSO to carry out a full and detailed investigation. This led to increased work and lengthened the investigation time. I strongly encourage the Board to review the way evidence and responses are provided to SPSO. The Board should ensure that all the relevant records are provided to SPSO at the first request. Where additional enquiries are made by SPSO, the Board should provide the specific information requested and not duplicates of records already provided.

The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified.

We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mr C complained to me about a delay in diagnosing his mother's (Mrs A) bowel cancer. Mr C was also unhappy about aspects of the nursing and medical care provided to Mrs A during an admission at Woodend Hospital towards the end of her life. The complaints from Mr C I have investigated are that:

(a) there was an unreasonable delay in diagnosing that Mrs A had cancer (*upheld*);
(b) the nursing care provided to Mrs A during the admission in Woodend Hospital was unreasonable (*upheld*); and
(c) there was an unreasonable delay in diagnosing that Mrs A had internal bleeding (*not upheld*).

Investigation

2. With my complaints reviewer, I have carefully considered the evidence provided by Mr C and his family as well as the Board. I also received independent advice from a consultant gastroenterologist (Adviser 1), a registered nurse (Adviser 2) and a consultant geriatrician (Adviser 3).

3. I have decided to issue a public report on Mr C's complaint in view of the serious failings identified and the significant personal injustice, to both Mrs A and her family. It should be noted that while I have significant and serious concerns about aspects of Mrs A's care, there are areas of her treatment which I considered satisfactory.

4. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. However, I confirm that all the information available during the investigation has been considered. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) There was an unreasonable delay in diagnosing that Mrs A had cancer

Concerns raised by Mr C

5. In his complaint to my office, Mr C expressed concern that Mrs A's cancer was not diagnosed sooner given that a number of investigations were performed over a two year period. He felt that there had been a failure to properly diagnose Mrs A's cancer.

6. Mr C also questioned the Board's actions in relation to a capsule endoscopy procedure (a type of endoscopy which involves a patient swallowing a capsule that wirelessly transmits images of the inside of the stomach and digestive system) performed in October 2015. He said that the Board failed to appropriately investigate Mrs A's concerns when she reported that she had not passed the capsule.

What happened

7. On 17 June 2013, Mrs A was admitted to Aberdeen Royal Infirmary as an emergency with symptoms of upper abdominal pain and nausea. She was under the care of the surgical team and a number of investigations were carried out. On the day of admission (17 June), an x-ray of the abdomen was performed. A CT scan (computerised tomography scan – a type of scan that uses x-rays and a computer to create detailed images of the inside of the body) of the same region was performed the following day. The report from the CT scan stated that the hepatic flexure (a part of the colon next to the liver) was abnormally thickened.

8. On 20 June 2013, a colonoscopy (examination of the bowel with a camera on a flexible tube) was attempted by a middle grade doctor. The preparation of Mrs A's bowels was noted to be poor and neither biopsies nor images were taken. It was documented that there was no evidence of inflammation at the hepatic flexure and that the caecum (the first part of the large intestine) could not be viewed due to solid stool in the bowel.

9. On 21 June 2013, Mrs A was discharged and a brief letter was sent to her GP describing that a CT scan showed abnormal thickening of the bowel at the hepatic flexure, and that a subsequent colonoscopy showed no abnormalities. A diagnosis of 'non-specific abdominal pain' was reported and no further follow-up was planned.

10. On 20 March 2014, Mrs A's GP made an urgent referral to the Board for suspected upper gastrointestinal cancer, noting symptoms of indigestion and anaemia (a condition where a person has fewer red blood cells than normal or less haemoglobin (a constituent of red blood cells) than normal in each red blood cell).

11. In April 2014, an upper gastrointestinal endoscopy with biopsies was performed. A gastroenterologist wrote to Mrs A's GP on 9 May 2014 to report

that the biopsy result was normal with no evidence of coeliac disease. They referred to the colonoscopy the previous year and described that this had shown no abnormality. No further follow-up or investigations were planned at the time and it was recommended that Mrs A remain on long-term low dose of iron supplement.

12. Mrs A's GP made a further urgent referral to the Gastroenterology Department on 7 July 2015 to investigate iron deficiency anaemia despite oral iron therapy. Mrs A was reviewed in the Gastroenterology clinic on 19 August 2015 by a Consultant Gastroenterologist. They documented that the previous colonoscopy had been normal and arranged a capsule endoscopy, which was performed on 19 October 2015. The report from this investigation noted that bowel preparation was mostly satisfactory and there was no evidence of active or recent bleeding.

13. On 25 October 2015, Mrs A was admitted to Aberdeen Royal Infirmary as an emergency with chest pain. She was diagnosed with myocardial infarction (a heart attack) and after successful treatment she was discharged on 1 November 2015.

14. On 12 February 2016, Mrs A's GP made a further referral to the Gastroenterology Department which noted weight loss and changes in blood results and requested further review. Mrs A was admitted to Aberdeen Royal Infirmary on 22 February 2016. A physical examination, blood tests, chest x-ray and abdominal x-ray were performed. The latter of these tests indicated that the capsule endoscope was located at Mrs A's hepatic flexure. A CT scan was performed on 23 February 2016 and a colonoscopy with biopsy was performed on 24 February 2016. The findings of these tests showed that Mrs A had cancer at the hepatic flexure.

15. Mrs A was reviewed in the Rectal Surgery clinic on 30 March 2016 and the possibility of surgery was discussed with a Consultant Surgeon. A plan was made to operate in May; however, Mrs A experienced renal failure and hepatic impairment which delayed the procedure. Surgery to remove the tumour was performed on 9 June 2016.

16. After an initial period of post-operative care at Aberdeen Royal Infirmary, Mrs A was transferred to Woodend Hospital for rehabilitation on 28 June 2016. Mrs A's condition deteriorated while she was an in-patient at Woodend Hospital

and she was transferred back to Aberdeen Royal Infirmary on 7 July 2016. Sadly, she died later that day.

The Board's response

17. Mr B (Mrs A's husband) complained to the Board on 21 November 2016, raising a number of concerns about the care provided to Mrs A. He questioned why Mrs A's cancer was not diagnosed sooner given the number of different investigations carried out over a two year period. Mr B and his family met with Board staff on 12 January 2017. They were not satisfied with the explanation offered and on 24 March 2017 Mr C reiterated the family's concern about the delay in diagnosis. In their final written response to Mr C dated 19 June 2017, the Board said that it was their view that Mrs A was not misdiagnosed. The Board said that the location of the tumour within the bowel had been difficult to find. The Board explained that all the correct tests had been carried out, including a gastroscopy, colonoscopy and camera test, yet despite these tests the abnormality was not identified.

18. The Board provided my office with a copy of a statement written by a consultant gastroenterologist involved in Mrs A's care. In relation to the capsule endoscopy, it was noted that Mrs A called the department on 23 October 2015 (four days following the procedure) to advise that she had yet to pass the capsule. The Board explained that as Mrs A did not have any obstructive symptoms, and because of the previous negative colonoscopy, it was felt that the most likely scenario was that Mrs A had passed the capsule without knowing. The Board added that, to avoid unnecessary investigation, only patients where there was a significant degree of uncertainty about capsule passage, or where there were obstructive symptoms, were investigated with an x-ray. The Board noted that there were no subsequent calls from Mrs A regarding any symptoms.

Gastroenterology advice

19. Adviser 1 said that there were a number of pieces of clinical guidance that were relevant to their consideration of this complaint. In particular, they referred to:

- *Colorectal cancer: diagnosis and management.* NICE (National Institute for Health and Care Excellence) Clinical Guideline 131 (November 2011)
- *Openness and honesty when things go wrong: the professional duty of candour.* General Medical Council and Nursing and Midwifery Council (June 2015)

- *Quality Assurance Guidelines for Colonoscopy* NHS Bowel Cancer Screening Programme Publication Number 6 (February 2011)
- *Wireless capsule endoscopy for investigation of the small bowel.* NICE Interventional Procedures Guidance 101 (December 2004)

20. I asked Adviser 1 to comment on whether the investigations performed were reasonable or not.

The colonoscopy

21. Adviser 1 said that during Mrs A's acute presentation with abdominal pain and anaemia in June 2013 it was reasonable for a CT scan and a colonoscopy to be performed to investigate Mrs A's symptoms. Adviser 1 explained that there was a definite abnormality at Mrs A's hepatic flexure on her initial CT scan. The team then correctly tried to investigate this with a colonoscopy; however, the colonoscopy was not completed because the caecum was not reached. In addition, the preparation of the colonoscopy was inadequate as Mrs A's bowels were not sufficiently clear.

22. Adviser 1 said there was no documentation regarding whether a scope guide had been used when performing the colonoscopy. Accordingly, the extent of the colonoscopy examination was unclear and it was not clear how the doctor was sure the hepatic flexure had been passed. This was important since CT imaging indicated that pathological tissue was expected there. Adviser 1 summarised that there was, therefore, no assurance that the suspected pathological area of the colon had been reached.

23. While the colonoscopy report dated 20 June 2013 was clear that the preparation was poor and the caecum was not reached, this information was not communicated to the GP in the discharge letter dated 21 June 2013. Adviser 1 said that there was no evidence of senior input into the letter. The consultant should have written the final discharge letter correcting any errors or omissions and pointing out outstanding issues. There was also no evidence of any planned follow-up of the incomplete colonoscopy either during or after the admission. In particular, there was no documentation of the attempted colonoscopy being mentioned in ward rounds; documentation of any imaging review by a gastroenterologist or gastrointestinal surgeon at a multidisciplinary team meeting; nor documentation that Mrs A had been informed of the incompleteness of the colonoscopy.

24. Adviser 1 also noted evidence of a gap in the text of the report of the CT abdomen performed 18 June 2013 as it appeared that text was missing following '*there is currently only mildly distended...*'. They were unable to determine whether this had been noticed or subsequently corrected.

25. In the absence of a follow-up plan following incomplete colonoscopy, Adviser 1 noted that the change at the hepatic flexure was not further investigated as an out-patient nor on the subsequent presentation until Mrs A presented with the complications of her cancer in February 2016.

26. Adviser 1 referred to paragraph 1.1.1.5 of NICE Clinical Guideline 131 which recommends that secondary care clinicians:

'Offer patients who have had an incomplete colonoscopy:

- repeat colonoscopy or
- CT colonography, if the local radiology service can demonstrate competency in this technique or
- barium enema.'

27. Adviser 1 considered that if this guideline had been followed, and either a repeat colonoscopy up to caecum or a virtual (CT) colonoscopy had been performed then the cancer would have been diagnosed in 2013.

Iron therapy

28. Adviser 1 said that prior to recommending iron therapy for iron deficiency anaemia, colonic causes of the anaemia should have been excluded, which was not done in this case. In particular, when Mrs A subsequently presented with iron deficiency in April 2014, the large bowel should have been fully investigated; preferably with another attempt of a colonoscopy with better bowel preparation.

Capsule endoscopy

29. Adviser 1 said that, following Mrs A's referral back to the Gastroenterology Department in July 2015, it was not appropriate to perform a capsule endoscopy (in October 2015) to investigate the rare case of blood loss from the small bowel without reviewing the completeness of the prior investigation of Mrs A's colon. The doctor should have noticed that the previous investigations were not sufficient to exclude significant disease and blood loss from the large bowel.

30. Adviser 1 explained that most gastroenterology units would perform a second colonoscopy (and second upper gastrointestinal endoscopy (examination of the upper intestinal tract with a camera on a flexible tube)) unless completeness and very good views had been documented by an experienced operator performing the initial colonoscopy (which was not the case here). This would be to exclude abnormalities which might have been overlooked at initial colonoscopy.

31. Adviser 1 summarised that at the consultations in April 2014 and July 2015, the quality of the initial colonoscopy was not reviewed and it appeared that it was taken for granted that the whole of Mrs A's large bowel was normal.

32. Adviser 1 also said that once Mrs A notified staff that she had not passed the capsule, the clinical context should have been reviewed including the visualisation of her lower gastrointestinal tract with an incomplete colonoscopy. It was not appropriate to assume that there was no obstruction based on the earlier inadequate colonoscopy test.

33. In relation to the handling of the capsule endoscopy carried out in October 2015, Adviser 1 commented that the NICE Interventional Procedures Guidance on capsule endoscopy states that 1% of patients require surgery to remove the capsule, which is a complication rate high enough to be considered in Mrs A's case. It was, therefore, unreasonable that this possibility was not considered and not investigated. Adviser 1 stated that if an abdominal x-ray had been carried out to investigate capsule retention after Mrs A contacted the department (on 23 October 2015), the capsule would have been apparent in the abdomen which would have led to earlier investigation of the cause of capsule retention.

34. In addition, Adviser 1 stated that the report of the capsule endoscopy does not mention how complete passage of the small bowel was confirmed and this should have been reviewed at that time.

35. Adviser 1 noted that – after the capsule was identified on a subsequent x- ray of Mrs A's abdomen on 22 February 2016 – a CT was performed on 23 February 2016, following which Mrs A was diagnosed with cancer.

Summary

36. In summary, Adviser 1 said that there was an unreasonable delay in diagnosing Mrs A's cancer. The delay was unreasonable because normal

protocols for an abnormality in the large bowel were not followed after the initial failed colonoscopy. Delay in diagnosis subsequently resulted from a series of errors, including that the discharge letter dated 21 June 2013 failed to mention the incompleteness of the colonoscopy. Following this, the quality of the initial colonoscopy was not reviewed at subsequent consultations and the colonic causes for anaemia were not excluded before iron therapy and capsule endoscopy.

37. Adviser 1 explained that although staging CT and sample for histology had not been performed (given the cancer had not been diagnosed at the time) they considered it was possible that the cancer was operable in 2013 given that Mrs A had good mobility with no other known health issues. Furthermore, it was also likely that with correct treatment Mrs A would not have had prolonged and profound anaemia and possibly would not have developed a myocardial infarction. Adviser 1 considered, therefore, that the failings in investigation likely had a significant impact on Mrs A's ability to survive her illness.

38. Adviser 1 noted that Board staff met with Mrs A's family following receipt of the complaint and informed the family that

> 'all of the correct tests had been given to [Mrs A]'.

39. Adviser 1 was critical that the Board:

- failed to identify the deviation from national guidelines;
- did not inform the family about the abnormal finding on her CT in 2013; nor
- that they failed to investigate the abnormal finding on her CT appropriately.

40. Adviser 1 concluded that either the clinical evidence was not appropriately reviewed by the Board during the investigation of the complaint, or information was withheld from the family, contrary to the General Medical Council's professional duty of candour guidance which states:

> 'Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:
>
> - tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong

- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.'

(a) Decision

41. The basis on which I reach decisions is reasonableness. My investigations consider whether the actions taken, or not taken, were reasonable in view of the information available to those involved at the time in question.

42. Mr C complained that there was an unreasonable delay in the Board diagnosing Mrs A's cancer. In their investigation of Mr C's complaint, the Board did not identify a delay in diagnosis, noting that the location of the tumour within the bowel had been difficult to find.

43. The advice I have received and accept is that:

- following the incomplete colonoscopy performed on 20 June 2013, a repeat colonoscopy (or another investigation) should have been arranged in line with clinical guidance;
- if the clinical guidance had been followed and either a repeat colonoscopy up to caecum or a virtual (CT) colonoscopy had been performed, then Mrs A's cancer would have been diagnosed in 2013;
- the extent of the colonoscopy was not adequately documented and it was not clear how the doctor was sure that the hepatic flexure had been passed;
- there was a failure to inform the GP that the colonoscopy was incomplete;
- during subsequent consultations in 2014 and 2015 following further referrals from the GP – including an urgent referral for suspected upper gastrointestinal cancer – the quality of the colonoscopy in 2013 was not reviewed. As a result, a colonic cause for Mrs A's iron deficiency anaemia was not ruled out before iron therapy and capsule endoscopy were performed;
- when Mrs A reported that she had not passed the capsule endoscope, medical staff failed to investigate the possibility that the capsule had been retained;
- in addition to the delay in diagnosis of cancer, it is likely that with correct treatment Mrs A would not have had prolonged and profound anaemia and possibly would not have developed a myocardial infarction; and

- the failings in the investigation of Mrs A's bowel symptoms likely had a significant impact on Mrs A's ability to survive her illness.

44. While I am unable to reach a definitive conclusion about the impact of the delay in diagnosis on Mrs A's outcome, it is apparent that the failings in this case are both multiple and significant.

45. I am also concerned about the quality of the Board's investigation and response to Mr C's complaint. I accept Adviser 1's advice that this may indicate an issue with professional duty of candour. While I am unable to conclude definitively that this is the case, I am in no doubt that this is a significant failure in complaint handling. The national complaints handling guidance in place at the time stated that:

> 'At the investigation stage, staff should also be aiming to 'get it right first time'. Their goal is to establish all of the facts relevant to the points raised and provide a full, objective and proportionate response that represents the definitive position.'
>
> 'The investigating officer must approach the complaint with an open mind, being fair to all parties. The investigation should not be adversarial and should be conducted in a supportive, open and transparent atmosphere that demonstrates the principles of fairness and consistency.'

46. In this case, my view is that the Board's handling of this complaint was not consistent with this guidance. I do not consider that the investigation established all of the facts nor did it provide an adequate response. Given the significance of the matter of this complaint, Mrs A's family deserved a candid, full and accurate response to their complaint. I am very critical that the Board failed to provide this to them. This was also a missed opportunity to take appropriate learning and improvement from the complaint and leads me to call into question the Board's commitment to valuing and learning from complaints.

47. Based on the information the Board and Mr C have provided, and the advice I have received and accepted, I uphold this complaint and I make a number of recommendations for the Board.

(b) The nursing care provided to Mrs A during the admission in Woodend Hospital was unreasonable

Concerns raised by Mr C

48. In the complaints to the Board and my office, Mr C and his family raised concern that:

- Mrs A was neglected by nursing staff during the admission in Woodend Hospital;
- Mrs A had fallen during the admission, and it was unclear if this had been documented;
- there were issues with pressure ulcer care and care provided for Mrs A's stoma (an opening on the front of the abdomen made using surgery, which allows faeces to be collected in a pouch outside the body);
- the nursing care was poor on 7 July 2016, when Mr B attended the ward to find Mrs A screaming. Mr B recalled that no nurses were attending to Mrs A; when he questioned this with nursing staff, he was informed that Mrs A had not had a good night and that the situation had been due to a urine infection. Mr B felt that he should have been contacted if this was the case.

What happened

49. On 28 June 2016, Mrs A was transferred from Aberdeen Royal Infirmary to Woodend Hospital for rehabilitation. During her time at Aberdeen Royal Infirmary, Mrs A developed pressure ulcers on her left heel and at her sacrum (the large, triangular bone at the base of the spine). Following admission to Woodend Hospital, the wounds were dressed and Mrs A was provided with pressure-relieving boots to prevent further damage to her feet.

50. On 29 June 2016, Mrs A was reviewed by a dietitian who noted the plan to continue Mrs A's current dietary intake whilst monitoring and reviewing Mrs A's weight and nutritional intake. The following day, Mrs A was reviewed by a specialist stoma nurse and her stoma bag was changed.

51. On 1 July 2016, Mrs A became incontinent of urine and experienced pain in her left heel, for which pain relief medication was given. Swabs were taken from the pressure ulcers on 2 July 2016. On this same date, it was documented that Mrs A felt generally unwell, nauseous and that her bowels were not moving. Her oxygen saturation was between 90-91% and oxygen therapy was provided.

52. On 3 July 2016, it was documented that Mrs A's stomach was distended (swollen) and after review by a doctor an abdominal x-ray was planned. A referral to the tissue viability service was made. Mrs A was noted to be low in mood over the following two days. On 5 July 2016 it was noted that Mr B was unhappy with the delay in review by tissue viability and that he was informed that the ulcer would take time to heal.

53. On 6 July 2016, it was documented that Mrs A was very unwell and needed to be referred to the dietitian. It was noted that Mr B had complained about Mrs A's dressings and that an explanation was offered regarding the normal regularity for changing dressings.

54. On 7 July 2016, problems with Mrs A's blood sugar levels were documented; additional glucose and subsequently intravenous dextrose (a sugar solution administered directly into a vein) was given. Following discussion with the on-call surgical team, Mrs A was transferred to Aberdeen Royal Infirmary, where she died later that day.

The Board's response

55. During a meeting with the family on 12 January 2017, the Board explained that Mrs A was transferred to Woodend Hospital to try and improve her functional abilities to allow her to go home. The Board said that Mrs A had been experiencing delirium, which makes patients behave differently. The Board apologised that the ward did not call Mr B when Mrs A was distressed overnight (6 to 7 July) as this could have helped her to settle her agitation. The Board also noted that, more generally, the communication with the family could have been better and an apology was offered.

56. In relation to the pressure ulcer care, the Board said that photographs of the wounds were taken and sent to the tissue viability service for their opinion (rather than a physical review). The Board acknowledged that nurses should have communicated with the family about this matter and there should have been a handover between the nursing teams at Aberdeen Royal Infirmary and Woodend Hospital. The Board said that everything that could have been done in relation to skin care had been done, and the key learning was in relation to communication with families.

Nursing advice

57. Adviser 2 said that there were a number of published standards in place at the time that were relevant to their consideration of this complaint. In particular, they referred to:

- *Prevention and Management of Pressure Ulcers, Best Practice Statement*. NHS Healthcare Improvement Scotland (March 2009)
- *Food, Fluid and Nutritional Care in Hospitals, Clinical Standards.* NHS Quality Improvement Scotland (September 2003)
- *Care of Older People in Hospital, Standards.* NHS Healthcare Improvement Scotland (June 2015)
- *The Code: Professional standards of practice and behaviour for nurses and midwives*. Nursing and Midwifery Council (2015)

Monitoring and assessment

58. I asked Adviser 2 whether or not the records of the admission at Woodend Hospital demonstrated that nursing staff reasonably monitored Mrs A and escalated issues to medical staff where appropriate.

59. Adviser 2 found that NEWS (National Early Warning Score – a scoring system to measure a patient's level of illness) charts were completed on a daily basis from 30 June to 5 July 2016, and the score on these days varied between 0 and 2. There was no NEWS recorded on 6 July 2016; the following day NEWS increased and it was documented that the escalation plan had been used.

60. Adviser 2 noted that there were discrepancies between the written records and NEWS charts. In particular, there were references in the nursing notes to Mrs A feeling nauseous, yet these episodes were not recorded on the NEWS chart. Additionally, the pain score on the NEWS chart was recorded as 0 for each day from 30 June to 7 July, yet the notes referred to Mrs A complaining of pain in her heel and pain relief medication being administered. Furthermore, Mrs A had type 2 diabetes and her blood glucose levels were documented in the nursing notes on 6 and 7 July 2016, when this matter was escalated to the Nurse Specialist. However, Mrs A's blood glucose was not recorded on the NEWS chart, and there was also no care plan in place in relation to how the condition should be monitored.

61. Adviser 2 said it appeared in this case that the guidance on the NEWS chart was not followed, as Mrs A's monitoring observations were carried out less

frequently than advised: daily, rather than four hourly. It is possible the failure to carry out more regular observations may have led to inaccurate assessment of her overall condition and, consequently, failure to recognise deterioration over the eight days of her admission. Additionally, failure to accurately record pain and nausea levels may have led to poor management of these symptoms for Mrs A and increased levels of anxiety for her and her family.

Falls risk assessment

62. I then asked Adviser 2 whether or not the records showed that nursing staff appropriately managed Mrs A's risk of falling during the admission.

63. Adviser 2 noted that a Falls Risk Indicator document was completed on 2 July 2016 (four days following admission) and this identified that she was unsafe when standing or transferring and walking without supervision or assistance, also that she was in need of frequent supervised or assisted toileting. Since these indicators were affirmed, nursing staff should have referred to the Board's falls care plan; however, there was no evidence of a falls prevention care plan in place during the admission in Woodend Hospital. Furthermore, bedrails were recommended for use when Mrs A was in Aberdeen Royal Infirmary; however, there was no record of bedrails being used in Woodend Hospital.

64. Adviser 2 explained that as Mrs A was identified as at risk of falling, there should have been a care plan in place which detailed clearly how these risks would be reduced. In addition, if bedrails were utilised, there should have been documented evidence of why and how they were to be used, as well as discussion with Mrs A and her family. Adviser 2 referred to the Standards for Care of Older People in Hospital which provides the following criteria for the standard of care relating to falls prevention:

> ***11.1*** *A falls risk assessment is initiated within 24 hours of admission.*
>
> ***11.2*** *Patients with identified falls risk factors have a care plan for meeting those needs or mitigating those risks which:*
> *(a) is developed with the patient (and/or representative)*
> *(b) is shared in an appropriate format, and*
> *(c) includes a medicines review.*

11.3 *A clear falls prevention plan is documented and shared with the multidisciplinary team on discharge or transition between care settings.*

65. Adviser 2 said that there was no record of Mrs A having fallen during her admission in Woodend Hospital. However, a number of risk factors were identified on 2 July 2016. Without a clear plan of care as to how these risks would be managed, Mrs A was at increased risk of falling.

Pressure ulcer care

66. I then asked Adviser 2 whether or not the records showed that nursing staff at Woodend Hospital provided appropriate pressure ulcer care.

67. Adviser 2 said it was difficult to ascertain what information from Aberdeen Royal Infirmary was communicated to staff in Woodend Hospital at the time of Mrs A's admission. The records for the prior period of care in Aberdeen Royal Infirmary showed that Mrs A had pressure area risk assessment scores which consistently put her into the high-risk category. There was a pressure ulcer core care plan for Mrs A for pressure ulcer prevention during her time in Aberdeen Royal Infirmary and on this it was recorded that she had a grade 2 pressure ulcer (the second of four grades, involving partial loss of the layer of skin) to her left heel and sacrum on 10 June 2016. However, there was no evidence of a wound management chart in place during the admission in Aberdeen Royal Infirmary.

68. After her transfer to Woodend Hospital a SSKIN bundle (a five-step care plan for pressure ulcer prevention) was in place from 28 June to 7 July 2016. This stated that frequency of care delivery should be four hourly, yet the records appear to be only twice daily, morning and night. Additionally, unlike during the admission at Aberdeen Royal Infirmary, there was no core care plan for pressure ulcer prevention in Woodend Hospital included in the records. The written nursing notes document nursing care provided to heel and sacrum; however, the documentation was inconsistent. There is no evidence of accompanying care plans, no documentation of results from wound swabs and no record of the types of dressing used to dress the heel on 4 July 2016. On 5 July 2016, the records state that the tissue viability service had sent a care plan electronically and that this was shared with Mr B. However, Adviser 2 was unable to locate this care plan in the records provided.

69. Adviser 2 was critical of the pressure ulcer care at Woodend Hospital. They said that:

- There should have been a wound management chart in place in Woodend Hospital which detailed the grade of pressure ulcer, the management plan, the review dates and the ongoing evaluation. This information should have been transferred from Aberdeen Royal Infirmary with Mrs A when she was admitted to Woodend Hospital. This would enable staff to continue the same management plan as had been in place previously.
- There should have been daily recordings of Mrs A's pressure area risk assessment scores in Woodend Hospital and these should have informed her ongoing plan of care.
- If the tissue viability nurses provided advice and guidance on Mrs A's care, then this should have been recorded in the nursing record.
- Senior nurses in both hospitals should have had oversight of Mrs A's skin condition to ensure that the correct preventive actions were being taken. Frequency of care should have been at least four hourly rather than twice daily as recorded on the SSKIN bundle.

70. Adviser 2 noted that Mrs A had considerable risk factors for development of pressure ulcers, including type 2 diabetes, reduced mobility, oedema (retention of fluid in the spaces between cells of the body) and nutritional risk. With a clearer risk assessment and pressure ulcer prevention and management plan in place, there may have been more consistent assessment and reviewing of her skin condition. Adviser 2 commented that this may have led to improved overall care and prevention of the damage that ensued. In addition, the lack of involvement of Mrs A and her family in the planning of care may have led them to feel excluded and more anxious about what was happening.

Stoma care

71. I asked Adviser 2 whether or not the records showed that nursing staff at Woodend Hospital provided appropriate care for Mrs A's stoma site.

72. Adviser 2 said that the first mention of Mrs A's stoma in the nursing records at Woodend Hospital was on the night of 30 June 2016. The record stated 'stoma active, bag changed'. There was a record of a bowel chart which had one entry on 6 July 2016, whilst the checklist for elimination – bowels, was not completed.

73. Adviser 2 found no evidence of a care plan which detailed Mrs A's management plan for her stoma care. There was an entry in the records on 30 June 2016 that stated '*to measure output from fistula'* yet there was no record of this output being measured in the notes. There was also an entry in the nursing notes on the same date noting that Mr B should be asked if he wished to learn stoma care for following discharge, yet there was no further reference to discussion with Mrs A or with Mr B about her stoma and treatment plan. Finally, Adviser 2 said there were no fluid balance charts in the records relating to the admission in Woodend Hospital, except for one on 7 July 2016. Fluid balance charts were recorded during her time in Aberdeen Royal Infirmary, and these measured the outputs from her stoma.

74. Adviser 2 was critical of the stoma care. They said that:

- There should have been a clear care plan for Mrs A's stoma care which should have been transferred with her when she moved from Aberdeen Royal Infirmary to Woodend Hospital. This should have been informed by the Stoma Nurse and should have contained details of the type and size of stoma, the wound management regime, the types of bags and fittings used and the daily care regime, as well as communication with Mrs A, and her family where appropriate.
- There should also have been daily fluid intakes and outputs measured, especially in view of Mrs A's poor appetite and oedema.

75. Adviser 2 explained that the failure to have a clear care plan for Mrs A's stoma care may have led to inconsistent and poor quality care. It may also have reduced the opportunity to identify any emerging issues and risks. Failure to monitor Mrs A's fluid intake and output may also have reduced the chances of identifying her deteriorating condition.

Communication with family

76. Finally, I referred Adviser 2 to the concern about the care provided to Mrs A when she was distressed on in the morning of 7 July 2016. I asked Adviser 2 whether the evidence indicated that nursing staff responded appropriately to Mrs A's distress and explained the reasons for this distress to her family.

77. Adviser 2 said that there was no evidence in the nursing records that this incident took place. It was documented that Mrs A's blood glucose level was low and that nurses were monitoring this and attempting to give her additional oral glucose, which she refused. While Mr B had recalled he was advised that Mrs A

had a urine infection, there is no record in the nursing notes of any conversation with Mr B, or the family, about these issues.

78. Adviser 2 noted that, ideally, there should have been a record of how Mr B wanted to be involved with Mrs A's care and when he should be contacted. It was documented in the 'Five Must Do With Me' section of the nursing assessment documentation that Mrs A's husband and her sons mattered to her and she wanted to be kept informed about her own care. Adviser 2 said that, if Mrs A was distressed at this time – as Mr B's account indicated she had been – then Mr B should have been contacted. There should have been a record of communication with the family and how issues were discussed and resolved.

79. Adviser 2 described that failure to communicate effectively and to involve Mrs A's family appropriately in her care could have caused increased distress, isolation and anxiety for Mrs A at a time where her physical health was deteriorating. It may also have led to increased sense of frustration and concern for her family.

(b) Decision

80. Mr C complained that the nursing care provided to Mrs A during the admission at Woodend Hospital was unreasonable. The Board found that the communication with the family could have been improved and they apologised for this.

81. Further to the communication issues identified by the Board, the advice I have received and accept is that there were a number of failings in the nursing monitoring of Mrs A; the falls risk management; the assessment and management of pressure ulcer risk; and the stoma care. In particular, Adviser 2 said that:

- Use of NEWS charts for monitoring clinical condition was inconsistent and did not follow guidance.
- Mrs A had type 2 diabetes but there was no care plan as to how her condition should be monitored.
- The assessment and management of pressure ulcer risk was inconsistent and incomplete.
- It is unclear as to how information is shared when patients are being transferred from Aberdeen Royal Infirmary to Woodend Hospital.

- There does not appear to have been a falls prevention care plan in place, despite the risks identified.
- There was no stoma care plan in the records and management of Mrs A's stoma care appears poor.
- There was no fluid intake and output measurement in Woodend Hospital for Mrs A, despite her clinical condition.
- 'Five Must Dos With Me' documented do not appear to have informed the care planning. The family do not appear to have been involved and there are limited records of communication.

82. In view of the multiple failings in nursing care during the admission at Woodend Hospital I can only conclude that the nursing care was unreasonable. I fully understand the family's distress that, at such a difficult time for Mrs A and her family, her basic nursing needs were not met and that these failings may have contributed to increased levels of anxiety for Mrs A and her family at the time. It is also of concern that these failings may have led to a reduction in the chances of identifying Mrs A's deteriorating condition and makes me question to what extent Mrs A's dignity and wishes were considered.

83. I uphold this complaint and I make a number of recommendations in view of the issues I have highlighted.

(c) there was an unreasonable delay in diagnosing that Mrs A had internal bleeding

Concerns raised by Mr C

84. In his complaint to my office, Mr C expressed concern that staff in Woodend Hospital failed to diagnose that Mrs A had internal bleeding before she was transferred back to Aberdeen Royal Infirmary on 7 July 2017. He considered that medical staff missed signs of possible deterioration, including a lack of output from the stoma site early in the admission. Mr C felt that the medical care at Woodend Hospital was poorer than at Aberdeen Royal Infirmary and questioned whether the lack of CT scanning facilities at the former may have contributed to a delay in diagnosis.

The Board's response

85. In their final response letter dated 19 June 2017, the Board assured Mr C that the care provided at Woodend Hospital would not have been different from

Aberdeen Royal Infirmary. The Board explained that the internal bleeding had been caused by inflammation within the stomach.

Geriatric medicine advice

86. Adviser 3 described that Mrs A's health had been deteriorating even prior to the admission in Woodend Hospital, with concern clearly evident in the letter from medical staff to her GP on 9 June 2016. Adviser 3 also said that after Mrs A's operation and initial care, on 26 June 2016 she was reviewed by the Medicine for the Elderly Liaison Team in Aberdeen Royal Infirmary, who noted the complexity and severity of her health problems in a systematic way and planned her ongoing care in a rehabilitation setting.

87. On 28 June 2016, Mrs A was transferred to Woodend Hospital for rehabilitation. The handover documentation highlighted that, following treatment for her acute illness (including a blood transfusion for anaemia and an operation on her bowel), she was still not at a level where she could safely return home.

88. Adviser 3 said that the doctor who assessed Mrs A on admission to Woodend Hospital performed a thorough assessment of her problems and medical history to date. Her initial medical care at this time and over the following days was of a good standard. Doctors appropriately documented her medical problems and their plans to address these. Adviser 3 noted Mr C's concern that lack of stoma output could have indicated deterioration; however, they did not consider that the symptoms at the time were sufficient indication that internal bleeding had occurred, or was about to occur.

89. On 2 July 2016, abnormal results from blood tests and a deterioration in Mrs A's mood were noted. This prompted staff to undertake a specific review of her, which noted that she had a tender abdomen to palpation, nausea, as well as ongoing problems with fluid retention. As a result of these findings, laxatives were prescribed for her.

90. Mrs A was reviewed on 3 July when she was still noted to have ongoing abdominal symptoms and so an x-ray was organised. This was interpreted as showing no significant constipation or other abnormality.

91. Mrs A was reviewed on 4 July 2016 and staff noted 'uncomplaining of pain', but they remained concerned about her overall condition and mood. They investigated the possibility of infection, and found some potential evidence of this

in her wound swabs and urine cultures. Adviser 3 said the results of these tests were complex, but suggestive of the need for treatment with specific antibiotics.

92. Mrs A was reviewed by an old age psychiatrist on 5 July 2016, who suggested changes to her medication to improve her mood. Adviser 3 explained that this indicated that her physical health at this time was still good, as psychiatry staff are unable to assess people with significantly poor levels of physical health.

93. On 6 July 2016, Mrs A had symptoms of 'reflux' noted on a ward round, and was again found to have some non-specific abdominal tenderness when she was examined. Adviser 3 explained that these symptoms are not unusual in someone with Mrs A's type of operation and medication. Staff also spoke with her family about her heel wound. Adviser 3 reflected that there was nothing in the description of Mrs A's symptoms or clinical findings at this time that caused them to believe that her subsequent deterioration was missed by medical staff.

94. On 7 July 2016, Mrs A's condition deteriorated with a low blood sugar reading at 05:00 that required treatment. Staff also noted that she was 'pale' when she was reviewed at noon. They thought the antibiotic was potentially responsible for her symptoms, and this was changed.

95. An ultrasound scan (a scan that uses sound waves to create images of organs and structures inside the body) of Mrs A's abdomen was arranged and this showed abnormalities (fluid present) in her abdomen, and a distended stomach. She was transferred back to Aberdeen Royal Infirmary after discussion with the surgical team there. Adviser 3 said that Mrs A was very unwell at the time of her assessment in Aberdeen Royal Infirmary, and staff adopted a palliative approach to her care before she died shortly afterwards.

96. In the opinion of Adviser 3, the medical care in relation to this issue provided to Mrs A at Woodend Hospital was reasonable. There were frequent and detailed reviews by medical staff who noted changes in her condition. They performed investigations such as blood tests and x-rays promptly, and these were noted and acted on appropriately.

97. Adviser 3 considered that there was no undue delay in diagnosing internal bleeding. Once the ultrasound showed abnormalities, these were acted upon, and Mrs A's care was discussed with the surgical team who arranged her transfer back to Aberdeen Royal Infirmary. Adviser 3 said they did not think there was a

point in time when the deterioration was so obvious to staff, that they should have recognised this sooner. Adviser 3 recognised that Adviser 2 had identified issues with the frequency of nursing observations and care. Adviser 3 did not consider that these issues impacted on the ability of medical staff to care for Mrs A, to the extent that medical staff missed signs of internal bleeding.

98. Adviser 3 noted Mr C's concerns about the lack of availability of CT at Woodend Hospital. They explained that CT scanning would have provided similar information to the ultrasound, such that the lack of this imaging modality was not relevant in this instance.

99. Adviser 3 summarised that Mrs A suffered ongoing problems after complex surgery, but this outcome was a recognised complication of surgery, particularly in frail older adults. Adviser 3 concluded that Mrs A deteriorated despite the medical care provided, rather than because of a lack of it.

(c) Decision

100. Mr C complained that there was an unreasonable delay in the Board diagnosing that Mrs A had internal bleeding. In their final written response to Mr C's complaint dated 19 June 2017, the Board said that Mrs A received the same standard of medical treatment at Woodend Hospital compared to Aberdeen Royal Infirmary. The Board did not identify issues with the way the internal bleeding was managed.

101. The advice I have received and accept is that:

- medical staff performed frequent and detailed reviews of Mrs A during the admission and the medical care was of a reasonable standard;
- there was not an undue delay in diagnosing internal bleeding;
- although there were issues with frequency of nursing observations and care, these did not impact on the ability of medical staff to identify internal bleeding; and
- the lack of a CT scanning facility at Woodend Hospital was not a factor in this case.

102. I do not underestimate how distressing this period of care was for Mrs A and her family. While I have concluded that failings earlier in Mrs A's care could have contributed to the poor outcome, I am unable to conclude that at this point in her care there was an unreasonable delay in diagnosing internal bleeding. Having

considered the evidence provided by Mr C and the Board, along with the professional advice I have received, I do not uphold this complaint.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mr C:

Complaint number	What we found	What the organisation should do	What we need to see
(a) and (b)	There was an unreasonable delay in diagnosing that Mrs A had cancer. The nursing care provided to Mrs A during the admission in Woodend Hospital was unreasonable. The Board did not investigate Mr C's complaint to a reasonable standard	Apologise to Mr C and Mr B for: • the unreasonable delay in diagnosing that Mrs A had cancer; • the failings in nursing care during the admission in Woodend Hospital; • the poor quality of the investigation of the complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance	A copy or record of the apology By: 22 January 2019

We are asking The Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	Mrs A was not offered a repeat colonoscopy after an incomplete colonoscopy was performed in June 2013	Patients who have had an incomplete colonoscopy should be offered a repeat colonoscopy or another appropriate investigation in line with clinical guidelines	Evidence that the gastroenterology department have carried out an audit of current colonoscopy practice. This should include: • the proportion of incomplete colonoscopies over the last 12 months and the reasons for this; • the outcomes of incomplete colonoscopies, including whether repeat or follow on tests were arranged in line with national guidelines; and • in cases where the guidance was not followed regarding follow up tests, the action being taken to address this. Evidence that the Board have developed a local protocol to ensure that the national guidelines are followed when colonoscopy is incomplete so that appropriate follow up tests are arranged By: 16 April 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	The documentation of the extent of completion of the colonoscopy was inadequate. It was unclear how it was established that the hepatic flexure was passed or whether a scope guide was used	Patient records should include details of how the extent of completion of a colonoscopy has been established. Where a scope guide is used, this should be documented	Evidence that the Board have taken action to ensure that the extent of completion of colonoscopies are adequately documented. (For instance, the Board might summarise documentation standards on a poster in the endoscopy department, or incorporate this into the colonoscopy reporting system) By: 19 March 2019
(a)	The incompleteness of the colonoscopy was not documented in the discharge letter from the admission in June 2013. There was no evidence of senior input into the discharge letter	All diagnoses, operations and procedures relevant to a patient's admission should be accurately documented in the discharge documentation. Discharge documentation should receive appropriate input or review from senior medical staff, and this should be documented	Evidence that the Board have reviewed the discharge documentation practice in place in the Gastroenterology Department to ensure that senior medical staff have appropriate input into discharge documentation By: 19 March 2019

Complaint number	What we found	Outcome needed	What we need to see
(a)	The quality of the colonoscopy in June 2013 was not reviewed at subsequent consultations in 2014 and 2015. A colonic cause for Mrs A's iron deficiency anaemia was not ruled out before iron therapy and capsule endoscopy were performed. The Board failed to investigate the possibility that the endoscopy capsule had been retained	The quality of colonoscopies should be appropriately reviewed and investigated at subsequent consultations. A colonic cause for iron deficiency anaemia should be excluded before prescribing iron therapy and performing capsule endoscopy. Where a patient reports that they have not passed an endoscopy capsule, investigation should be performed where there is a reasonable clinical suspicion of this complication	Evidence that the Gastroenterology Consultants involved in Mrs A's care have reflected on their practice in relation to the review and investigation of patients at subsequent consultations and in relation to investigating iron deficiency anaemia. Evidence that the Board have performed quality improvement work (for instance, development of written guidance or protocol) to ensure appropriate investigations are performed to exclude pathology outside the small bowel and to reduce the risk of a retained capsule. The Board should provide the SPSO with a copy of any guideline or protocol developed By: 16 April 2019

Complaint number	What we found	Outcome needed	What we need to see
(b)	Completion of NEWS monitoring charts was inconsistent and not in accordance with guidance. Mrs A had type 2 diabetes but there was no care plan as to how her condition should be monitored	NEWS charts should be completed to accurately reflect the patient's condition. Observations of a patient should be completed in line with the planned frequency in the patient's records. A care plan should be in place for patients with diabetes and monitoring should be performed in line with this	Evidence that the Board have reviewed the training needs of nursing staff in relation to: • completion of NEWS; and • diabetes monitoring. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019

Complaint number	What we found	Outcome needed	What we need to see
(b)	The assessment and management of pressure ulcer risk was inconsistent and incomplete	Patients should receive nursing care to prevent and manage pressure ulcers in line with relevant standards[2]	Evidence that the Board have reviewed the training needs of nursing staff in relation to the assessment and management of pressure ulcer risk. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019
(b)	It was unclear how information was shared when Mrs A transferred between hospitals	Relevant information about a patient's care should be transferred with a patient when the patient transfers between hospitals	Evidence that the Board have a clear pathway in place for inter-hospital patient transfers, which details how key information is shared between nurses in both hospitals By: 16 April 2019

[2] Since the time of the complaint, the following standards were introduced: *Prevention and Management of Pressure Ulcers Standards.* Healthcare Improvement Scotland (September 2016)

Complaint number	What we found	Outcome needed	What we need to see
(b)	There was no falls prevention care plan in place, despite the risks identified	Where a patient has been assessed as at risk of falling, a falls prevention care plan should be in place	Evidence that the Board have reviewed the approach to falls care planning in Woodend Hospital to make sure that risks are identified, and care plans are developed in conjunction with patients, and their family/carers as appropriate. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019
(b)	The management of Mrs A's stoma care was not reasonable. There was no stoma care plan in the records	Where a patient has a stoma a stoma care plan should be in place	Evidence that the Board have reviewed: • how stoma nurses advise and support stoma care for patients to ensure that there is a patient centred care plan which can be adhered to by all nurses; • the use of fluid balance charts at Woodend Hospital

Complaint number	What we found	Outcome needed	What we need to see
	There was no fluid intake and output measurement in Woodend Hospital for Mrs A, despite her clinical condition	Fluid balance charts should be used to measure a patient's fluid intake and output	A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019
(b)	'Five Must Dos With Me' documented do not appear to have informed the care planning. Mrs A's family do not appear to have been involved and there are limited records of communication	Patients and their family/ significant others should be appropriately involved in care planning	Evidence that the Board have reviewed how the Five Must Dos With Me inform care plans in Woodend Hospital and have reviewed how families and carers are involved and communicated with. A copy of an improvement plan to address the issues identified, which details any training, practice development or other intervention planned By: 16 April 2019

We are asking The Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a)	The Board did not investigate Mr C's complaint to an acceptable standard	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and learning from complaints are used to drive service development and improvement	Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in investigating Mr B's and Mr C's complaints and meeting with the family and that they have reflected on the findings of this investigation. (For instance, a copy of a meeting note or summary of a discussion) By: 19 February 2019

Feedback

Response to SPSO investigation

Multiple enquiries were needed in order to obtain the records required by SPSO to carry out a full and detailed investigation. This led to increased work and lengthened the investigation time. I strongly encourage the Board to review the way evidence and responses are provided to SPSO. The Board should ensure that all the relevant records are provided to SPSO at the first request. Where additional enquiries are made by SPSO, the Board should provide the specific information requested and not duplicates of records already provided.

Terms used in the report **Annex 1**

Adviser 1	a consultant gastroenterologist
Adviser 2	a registered nurse
Adviser 3	a consultant geriatrician
anaemia	a condition where a person has fewer red blood cells than normal or less haemoglobin (a constituent of red blood cells) than normal in each red blood cell
the Board	Grampian NHS Board
caecum	the first part of the large intestine
capsule endoscopy	a type of endoscopy which involves a patient swallowing a capsule that wirelessly transmits images of the inside of the stomach and digestive system
colonoscopy	examination of the bowel with a camera on a flexible tube
CT scan	a (computerised tomography) scan uses x-rays and a computer to create detailed images of the inside of the body
distended	swollen
hepatic flexure	a part of the colon next to the liver
Mr B	Mrs A's husband
Mr C	the complainant
Mrs A	the aggrieved

myocardial infarction	heart attack
NEWS	National Early Warning Score – a scoring system to measure a patient's level of illness
oedema	retention of fluid in the spaces between cells of the body
pathological	caused by disease
sacrum	the large, triangular bone at the base of the spine
SSKIN	a five-step care plan for pressure ulcer prevention
stoma	an opening on the front of the abdomen made using surgery, which allows faeces to be collected in a pouch outside the body
ultrasound scan	a scan that uses sound waves to create images of organs and structures inside the body
upper gastrointestinal endoscopy	examination of the upper intestinal tract with a camera on a flexible tube

List of legislation and policies considered **Annex 2**

Colorectal cancer: diagnosis and management. National Institute for Health and Care Excellence Clinical Guideline 131 (November 2011)

Openness and honesty when things go wrong: the professional duty of candour. General Medical Council and Nursing and Midwifery Council (June 2015)

Quality Assurance Guidelines for Colonoscopy. NHS Bowel Cancer Screening Programme Publication Number 6 (February 2011)

Wireless capsule endoscopy for investigation of the small bowel. National Institute for Health and Care Excellence Interventional Procedures Guidance 101 (December 2004)

Prevention and Management of Pressure Ulcers, Best Practice Statement. NHS Healthcare Improvement Scotland (March 2009)

Prevention and Management of Pressure Ulcers Standards. Healthcare Improvement Scotland (September 2016)

The Code: Professional standards of practice and behaviour for nurses and midwives. Nursing and Midwifery Council (2015)

Food, Fluid and Nutritional Care in Hospitals, Clinical Standards. NHS Quality Improvement Scotland (September 2003)

Care of Older People in Hospital, Standards. NHS Healthcare Improvement Scotland (June 2015)