Scottish Parliament Region: North East Scotland

Case 200503032: Grampian NHS Board

Summary of Investigation

Category

Health: Hospitals

Overview

The complainant (Mr C) raised a concern that staff at Aberdeen Royal Infirmary (the Hospital) had failed to remove a wound drain before he was discharged on 14 April 2005 following an operation and the length of time it took for his complaint to be investigated.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff failed to ensure the wound drain was removed prior to discharge *(upheld)*; and

(b) there was inadequate complaints handling *(upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 7 March 2006, the Ombudsman received a complaint from the complainant (Mr C) that staff had discharged him from Aberdeen Royal Infirmary (the Hospital) on 14 April 2005 without removing a wound drain and that he had to return to the Hospital to have it removed. He also complained about the way staff at Grampian NHS Board (the Board) dealt with his complaint.

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

(a) staff failed to ensure the wound drain was removed prior to discharge; and

(b) there was inadequate complaints handling.

Investigation

3. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I made a written enquiry of the Board. I sought advice from one of the Ombudsman's professional advisers (the Adviser) regarding the clinical aspect of this complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mr C and the Board were given an opportunity to comment on the draft of this report.

(a) Staff failed to ensure the wound drain was removed prior to discharge

5. Mr C wrote to the Board on 15 July 2005 and complained about the treatment he received at the Hospital following an operation for repair of right sided hydrocele (fluid around the testicle) on 13 April 2005. According to Mr C the following day at the ward round a doctor said 'where is the drain' but did not investigate the matter further. Mr C did not know what was meant by this and he was discharged that day. On 29 April 2005, Mr C's General Practitioner (the GP) discovered a stitch at the wound site and that there was some tissue which had to be cauterised. Mr C saw the practice nurse on a twice weekly basis for treatment until 10 June 2005 when it was noticed there was a foreign body in the wound. The GP immediately sent Mr C back to the Hospital where the object, which turned out to be a surgical drain, was removed. Mr C complained

that he had suffered a distressing experience and discomfort. He wanted a thorough investigation and a formal apology.

6. The Urology Consultant who was responsible for Mr C's treatment (the Consultant) wrote to Mr C on 18 August 2005 and formally apologised for the treatment which he had received following the operation on 13 April 2005. The Consultant also enclosed a copy of letters which he had written to the GP for information. [Note; in a letter to the GP dated 11 July 2005 the Consultant stated: 'The nursing notes in the post-operative period distinctly mention that the wound drain has fallen out. This is the information which was conveyed during the ward round to my middle grade doctors. I would have expected them to have found out this error by following the routine and expected step of inspecting the wound before discharging the patient. However, this was not followed and the patient was discharged with the drain intact. I performed a discharge summary from the hospital notes which obviously was an error as it did not mention anything about the drain being left intact. I understand the ward sister has been informed of this error. I have asked my SHO, who happened to be the operating surgeon, to fill in a risk assessment form so that this incident could be discussed and lessons learned by everybody.']. The Consultant also explained that he had discussed the matter in detail with Mr C at a clinic appointment and told him that the operative site had healed up nicely and no further problems were anticipated. The Consultant also said he would let the Complaints Team deal with the complaint in line with normal procedures.

7. The Adviser reviewed the papers and records and suggested that I obtain further information from the Board as to what their investigation entailed and to attempt to establish the circumstances which occurred prior to Mr C's discharge on 14 April 2005.

8. The Board's Chief Executive (the Chief Executive) wrote to me on 19 September 2006. He explained that the Unit Nurse Manager, who had taken up post since the incident, had investigated the matter and found that at the time nursing staff were not formally interviewed and no statements were taken. There was no documentary evidence that the wound was inspected by nursing staff which would support the entry in the nursing records 'corrugated drain fell out over the course of the night' or that such information was passed over from the night staff to the day staff. The Chief Executive said that this had been an erroneous conclusion on the part of the nursing staff and one which does not have a satisfactory explanation. The Chief Executive continued that the

Consultant did not conduct a formal investigative procedure but followed good clinical practice recommendations. Although he did not take any formal statements or record any such responses from the personnel involved in the clinical care of Mr C, the Consultant did establish the chain of events which were well documented in his correspondence to Mr C and the GP. The incident was also highlighted at the urology risk management meeting and a recommendation made that the medical staff needed to be more vigilant in the post operative care of wound drains. This point was certainly disseminated to all the junior medical staff who were working in the department at the time during one of the post-graduate meetings. However, this was not formally documented in a verifiable format.

9. The Chief Executive said that the Consultant's review of Mr C's case notes did not uncover an exchange between Mr C and the doctor at the ward round. It was assumed that after the question by the doctor 'where is the drain', it is likely that nursing staff might just have confirmed the nursing record entry that the drain had fallen out. At that stage good clinical practice would have dictated that the doctor check the status of the drain before accepting such a statement at its face value. Unfortunately this obviously did not take place and this lapse was brought to the notice of all junior doctors working in the unit at that time as a learning point on an informal basis.

10. The Adviser was of the opinion that the Chief Executive had provided a satisfactory response to my enquiry.

(a) Conclusion

11. Clearly there had been a failing in that the wound drain was not removed prior to Mr C's discharge from the Hospital. Due to the time which has elapsed since the event it has not been possible to establish the circumstances which resulted in the entry in the nursing records that the drain had fallen out. It is possible that the doctor who saw Mr C at the ward round either accepted the nursing record entry as being accurate and failed to examine the wound site or did not notice the wound drain was still in the wound. Understandably Mr C found this a distressing experience and wanted a thorough investigation. However, it was only during the Ombudsman's investigation that the Board wrote to Mr C with a full explanation and apology (see paragraph 17). Accordingly I have decided to uphold this aspect of the complaint. I am pleased to note the action taken by the Consultant in arranging for a risk assessment to be completed so that discussions could take place to prevent a repeat

occurrence. I have noted that staff have already been reminded to be vigilant in the post-operative care of wound drains and that Mr C also received an apology from the Consultant for the error.

(a) Recommendation

12. The Ombudsman has no recommendations to make.

(b) Inadequate complaints handling

National Guidance

13. The NHS Complaints Procedure guidance was reviewed on 1 April 2005. Paragraph 57 explains that it is important that a timely and effective response is provided in order to resolve a complaint, and to avoid escalation. An investigation should be completed, where possible, within 20 working days following receipt of the complaint. If that is not possible then the complainant should be informed of the reason for the delay. Paragraph 58 goes on to explain that where it might be necessary to extend the investigation to more that 40 days the complainant should be provided with an explanation and given the opportunity to contact the Ombudsman. Paragraph 63 sets out that the complaints process should be completed by the Chief Executive reviewing the case to ensure that all necessary investigations and actions have been taken. If the Chief Executive is satisfied that the complaints process is complete, they should issue a letter to the person making the complaint.

14. The sequence of events was as follows:

15 July 2005 - Mr C formally complained to the Board.

18 July 2005 - A complaints officer at the Board (the Complaints Officer) acknowledged the complaint.

16 August 2005 - The Consultant saw Mr C at his clinic and wrote to him on 18 August 2005 enclosing copy letters to the GP.

24 August 2005 - The Complaints Officer wrote to Mr C and explained the issues were still being investigated but it was hoped a response could be issued in the near future.

13 September 2005 - The Complaints Officer wrote to Mr C and explained that the investigation was continuing but key personnel were on annual leave and further discussions would be required before the investigation

report could be completed. A request was made for an extension until 27 September 2005. An option was given that Mr C could approach the Ombudsman if he felt the delay was unacceptable.

5 October 2005 - The Chief Executive wrote to Mr C with the formal response to his complaint. He had understood that Mr C had spoken to the Complaints Officer about a forthcoming appointment at the urology clinic and arrangements had been made for Mr C to discuss his concerns with the Consultant. The Chief Executive understood that the Consultant was able to address the issues which had been raised and the Consultant had written to Mr C enclosing copies of correspondence to the GP.

15. In his letter to the Ombudsman, Mr C complained about the way the Complaints Department dealt with his complaint.

16. In his letter to me of 19 September 2006, the Chief Executive said that there had been a lapse in the normal complaints procedure. The Consultant had initially picked up the lapse in Mr C's clinical management and had met him and explained the series of events in great detail and he understood Mr C was satisfied with the explanation. After Mr C's complaint letter was received, Mr C contacted the Complaints Team on 5 August 2005 as he was concerned that he had a clinic appointment with the Consultant on 16 August 2005 and that he would like to speak to the Consultant before that date. However, the Consultant was on leave, therefore, the complaint was discussed on 16 August 2005. The Chief Executive said that Mr C contacted the Complaints Team on 18 October 2005 to advise that he was not happy with the wording of the final response letter. In his view, Mr C did not indicate that he was unhappy with the content of the letter or that he had any outstanding concerns.

17. The Chief Executive continued that the complaint was investigated by the Service Manager for the Urology Department and the report provided by the Consultant to the GP was not shared with the Complaints Team and this was an omission. Recent reorganisation of the services delivered by the Acute Sector of the Board has tightened the administration of the complaints procedure and both Assistant General Managers now have a crucial role in approving letters of response to complainants. The Chief Executive enclosed a copy of a letter issued to Mr C on 19 September 2006 in which it was explained what action had been taken as a result of his complaint and an apology for the errors which had been identified.

(b) Conclusions

18. In this case it was the Consultant who noted the failure to remove the wound drain and wrote to the GP on 11 July 2005 which was prior to Mr C's written complaint. Mr C complained to the Board on 15 July 2005, he saw the Consultant on 16 August 2005 who explained what had happened and gave him a copy of his letter to the GP and said the Complaints Team would deal with the complaint in line with normal procedures. The response from the Chief Executive of 5 October 2005 was merely that it was believed the matter had been resolved as the Consultant had spoken to Mr C and provided him with an explanation and a copy of his letter to the GP.

19. Clearly Mr C was still expecting some form of formal response from the Board and I can fully understand his expectations. While Mr C did obtain some information from the Consultant it was not until the Chief Executive's letter of 19 September 2006 (after the Ombudsman's office had been involved) that he received a detailed explanation and an apology for the failings which had been identified. I uphold this aspect of the complaint. However, I am pleased to note that the Board have taken action regarding the administration of the complaints procedure.

(b) Recommendation

20. The Ombudsman has no recommendations to make.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Hospital	Aberdeen Royal Infirmary
The Board	Grampian NHS Board
The Adviser	The Ombudsman's professional adviser
The GP	Mr C's General Practitioner
The Consultant	The Consultant Urologist responsible for Mr C's treatment
The Chief Executive	The Chief Executive of the Board
The Complaints Officer	A Complaints Officer at the Board