Scottish Parliament Region: Glasgow

Case 200702628: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Out-of-hours general practitioner service; hospital in-patient care

Overview

The complainant raised a number of concerns about the care and treatment of an 80-year-old woman (Mrs A), on behalf of Mrs A's son. Mrs A was admitted to the Royal Alexandra Hospital (the Hospital), in the area of Greater Glasgow and Clyde NHS Board (the Board), in September 2006 with stomach pain and constipation. The complainant said the admission should have been made several days earlier and that the inadequate treatment received in the Hospital might have contributed to Mrs A's death later that month in the Hospital.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) out-of-hours doctors should have admitted Mrs A to the Hospital earlier (*not upheld*);

(b) Mrs A's care and treatment in the Hospital were inadequate *(upheld*); and

(c) the Board lost some of Mrs A's medical records (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) ensure that all appropriate healthcare professionals in the Board's hospitals are made aware of the appropriate management of constipation in older people; and

(ii) reflect on the lessons learnt from this complaint and take appropriate action to help avoid a recurrence.

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

Main Investigation Report

Introduction

1. The complainant (Ms C) raised a number of concerns about the care and treatment of an 80-year-old woman (Mrs A), on behalf of Mrs A's son (Mr A). Mrs A was admitted to the Royal Alexandra Hospital (the Hospital), in the area of Greater Glasgow and Clyde NHS Board (the Board), in September 2006 with stomach pain and constipation. Ms C said the admission should have been made several days earlier and that the inadequate treatment received in the Hospital might have contributed to Mrs A's death later that month in the Hospital. A reminder of the abbreviations in this report is in the annex.

2. The complaints from Ms C which I have investigated are that:
(a) out-of-hours doctors should have admitted Mrs A to the Hospital earlier; and
(b) Mrs A's care and treatment in the Hospital were inadequate.

3. As the investigation progressed, it became clear that there were no accident and emergency (A&E) department medical records for 12 September 2006 in respect of Mrs A. Therefore, the investigation additionally considered the fact that:
(c) the Board lost some of Mrs A's medical records.

Investigation

4. I was assisted in the investigation by two advisers (the Advisers), a general practitioner (GP) and a consultant physician in the care of the elderly. Their role was to explain, and provide an unbiased comment on, aspects of the complaint. We examined the complaint correspondence provided by Ms C, information provided by the Board (which included Mrs A's Hospital and out-of-hours clinical records) and Mrs A's GP records. In line with the practice of the Ombudsman's office, the standard by which the events were judged was whether they were reasonable. By that, I mean whether the decisions and actions taken were within a range of what would have been considered to be acceptable practice at the time in question. The purpose of the investigation was to use the information provided to try to establish what happened and then to consider whether what happened fell within this range of reasonable practice.

5. I have not included in this report every detail investigated. In particular, I have not recorded details which are known to Ms C, Mr A and the Board, are

not in dispute or do not have any particular relevance to my conclusions. I am satisfied that no matter of significance has been overlooked in the investigation. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) Out-of-hours doctors should have admitted Mrs A to the Hospital earlier

6. Mrs A was reporting stomach pain and had had constipation for about ten days. Ms C explained that out-of-hours doctors visited Mrs A several times between 14 and 16 September 2006 but failed to admit her to hospital until a final visit on 16 September. Ms C complained that this delay was too long because of Mrs A's pain and suffering.

7. I should explain that the service for access to a GP out of normal hours is run by NHS 24. NHS 24 work with each health board to provide, together, an out-of-hours service for patients who are ill when their GP practice are closed and who feel they need medical attention or advice before the practice re-opens. When a patient or carer phones NHS 24, an adviser will request information about the patient's condition and may (amongst other things and depending on the circumstances) give information and advice, ask the patient to go to a particular centre to see an out-of-hours doctor face to face, advise the patient to contact their GP when their practice re-opens, refer to an out-of-hours doctor to arrange to visit the patient at home, or advise the patient to go to A&E.

8. The summary below uses information from the clinical records of Mrs A's GP practice (the Practice) and NHS 24 to show what happened until her admission to the Hospital:

September 2006

- 7–16: Mrs A was seen seven times by the Practice. This was at first because of a chest infection, although this improved;
- 12: constipation and pain in the general area of the stomach were first referred to in the Practice records;
- 12: later that day, the family arranged an ambulance for Mrs A, who was examined by A&E and discharged that day. The Practice were informed by letter by the Hospital;
- 13: the Practice visited and examined Mrs A. Constipation was confirmed by a rectal examination and medication was given;

- 14, evening: an out-of-hours doctor was arranged and visited Mrs A at home. He recorded that suppositories had been given that day by the district nurse for the constipation, without effect, and that Mrs A had severe stomach pain, which had been worsening for the past two to three hours, and had had constipation for ten days. His notes say he advised the Practice to see her during Practice hours to re-assess her, adding, 'family requesting [hospital] admission. suggest better not admitted late at night, would add to distress with little benefit';
- 15: the Practice visited Mrs A at home. The clinical records indicate that there had been no bowel movement, that there was lower abdominal pain and that a mini-enema was arranged for the constipation through the district nurse;
- 15, evening: an out-of-hours doctor was arranged and visited Mrs A at home. He examined her, noting constipation for ten days, despite medication, and stomach pains, and his notes asked the Practice to re-assess her during Practice hours, commenting that hospital admission might be necessary;
- 16: the Practice visited Mrs A at home, recording that the bowels had moved overnight, that treatment of constipation was to be continued and that there had been some pain that morning;
- 16: in answer to a further call, an out-of-hours doctor visited later that day. A detailed examination was made, lower abdominal pain, pain on urination, constipation and weight loss were recorded and a Practice referral was advised for investigation of the weight loss;
- 16: a visit by a different out-of-hours doctor later that day reported that Mr A no longer felt able to cope with his mother as she was now incontinent of urine and that the doctor, therefore, arranged an ambulance. Mrs A was then admitted to A&E.

9. In a letter to Ms C in June 2007, the Board explained the out-of-hours visits in more detail, giving the doctors' views and detailing the examinations and treatment.

(a) Conclusion

10. As explained at paragraph 7, NHS 24 have a number of options to consider when deciding an appropriate course of action for a patient. Essentially, they have to decide whether it would be appropriate for the patient to wait until the patient's own GP practice re-opens and the patient can be seen

by a doctor who is more likely to know him or her and who will have access to the full GP clinical records. For example, an out-of-hours doctor would not be likely to admit a patient to hospital unless there were strong clinical grounds for not waiting until the patient's own GP practice were available to make that decision. This makes their role somewhat different to the role of a patient's own GP practice. The advice I have received from the Advisers is that the actions of the out-of-hours doctors were reasonable as appropriate examinations and treatment were given, the situation was closely monitored and home visits were made. The bowel movement which was reported to Mrs A's own GP on 16 September 2006 would have been a reassuring sign of improvement, although, sensibly, the GP noted that treatment for constipation should continue. Once Mrs A's son considered that the situation was more than he could cope with, hospital admission was arranged.

11. The Advisers considered that, to some extent, one could argue for and against hospital referral by the out-of-hours doctors. However, they consider that, on balance, the out-of-hours doctors' actions were within the range of reasonable, acceptable, practice described at paragraph 4. In other words, it was reasonable for earlier hospital admission not to be arranged. I should add that it is not the practice of this office to judge doctors' actions by the use of hindsight. In other words, our conclusions are not based on how things later turned out for a patient. The approach of the office is to consider what evidence and information (for example) were available to a doctor at the time in question and whether the doctor's actions were reasonably based on that information. This is because that is the only information on which the doctor could have based his or her decisions at the time. I should also point out that, at complaint (b), I conclude that the Hospital should have taken earlier action. However, that does not affect this conclusion about the out-of-hours doctors: the point is that, faced with the information available to them about Mrs A's condition, and bearing in mind the role of the out-of-hours service, the out-of-hours doctors acted reasonably in not admitting Mrs A to the Hospital earlier. In the circumstances, I do not uphold complaint (a).

(b) Mrs A's care and treatment in the Hospital were inadequate

12. Mrs A was admitted, with stomach pain and some constipation, to A&E on 12 September 2006 because her son felt the urinary incontinence which she had developed was difficult to manage. She had a lung condition for which she took oxygen at home and she was temporarily taking antibiotics which the Practice had prescribed for the chest infection mentioned near the start of

paragraph 8. A&E noted Mrs A as having a 24-hour history of lower abdominal pain and no bowel movements for two weeks until that day. As examination and blood tests revealed no problem, and medication was reported as relieving the pain, A&E discharged her that day and informed the Practice.

13. Ms C complained that, despite being taken to A&E on 12 September 2006 with constant stomach pain, Mrs A was discharged the same day and that A&E did not do a x-ray that day. She said Mrs A might still be alive if admission as an in-patient and a x-ray and ultrasound examination had been arranged that day. On 16 September 2006, Mrs A was readmitted to A&E, from where she was admitted to a ward as an in-patient. Various examinations and tests were done, and, very sadly, she died in the Hospital on 24 September 2006. In essence, the complaint was that late in-patient admission and late diagnosis of the cause of the stomach pain might have contributed to Mrs A's death.

14. As there were no A&E medical records for 12 September 2006 (see complaint (c)), it is not possible to know clearly what happened in A&E. However, in a letter of 21 June 2007 to Ms C, the Board said that an A&E doctor found, through rectal examination, that the rectum was full of faeces. The Advisers consider that an abdominal x-ray would have been advisable to back up that finding and that an appropriate clinical approach on 12 September 2006 for such an elderly, frail, patient would have been bowel clearance with oral medication and enema. A x-ray would have confirmed that constipation was the cause of the abdominal pain.

15. In their letter of 21 June 2007 to Ms C, the Board said it was very unlikely that a x-ray would have made any difference to Mrs A's management. However, the Advisers could not see that there had been any real management. For example, there was no evidence of enema or oral laxative as having been given, nor any evidence even that Mrs A was given any advice about the constipation. In a letter to me, the Board strongly disagreed with the Advisers' views about the need for x-rays on 12 September 2006, giving detailed explanations and quoting guidance from the Royal College of Radiologists. The Board did not consider that Mrs A fitted into the category for x-ray as given in that guidance - saying, for example, that Mrs A did not have an 'acute abdomen', which, they said, was a generally accepted term to mean a developing emergency which would require probable surgery. As the Board pointed out, Mrs A's lung condition meant that surgery was not going to be an option. The Advisers considered the Board's arguments in detail. However,

they maintain their original view. For them, the important point is that the extent or seriousness of Mrs A's constipation could have been clarified by a x-ray on 12 September 2006. In other words, they consider that there was a medical reason for doing a x-ray because the result of such x-ray would have indicated the need for in-patient admission and/or more vigorous treatment. In respect of the argument about 'acute abdomen', the Advisers consider that chronic constipation, aggravated by abdominal pain, in an elderly, frail, person, is a medical acute abdomen, which also requires intervention (in-patient admission, enema, oral laxative). The Advisers consider that these form special circumstances which did put Mrs A into an appropriate category for x-ray. However, they acknowledge that different medical opinions exist in the medical profession about the value of abdominal x-ray to assess the degree of constipation in older people and they acknowledge that the Board continue to feel strongly about their own view.

16. In short, the Advisers consider that it was inappropriate for such an elderly, frail, patient to be given so little appropriate management. They also consider that the decision to discharge on 12 September 2006 was inappropriate. However, they would have been prepared to accept the discharge if appropriate alternative action had been taken. For example, they consider that the poor decision to discharge was made worse by the fact that Mrs A was discharged without proper advice and without proper arrangements for follow-up, such as a request for her GP to review her. (Instead, the discharge letter to the Practice merely suggested that the Practice might want to arrange a review at an out-patient clinic of the Hospital.) In a letter to me, the Board indicated that their A&E staff strove to achieve best care and refuted the Advisers' suggestion that the A&E care had not been of an appropriate standard. They said that, in their opinion, Mrs A 'was appropriately assessed, investigated and treated at the time of her visit to A&E on the 12th September 2006'. The Advisers found these views particularly disappointing as they indicated that no lessons had been learnt from Mrs A's experiences.

17. As explained at paragraph 8, Mrs A was re-admitted to A&E on 16 September 2006. From A&E, she was admitted onto a ward as an in-patient, and I give here a brief summary of the next week or so. A urine infection was revealed on admission. Constipation and abdominal pain continued. X-rays and ultrasound scan were done, revealing what seemed like a mass on the right side of the pelvis, with faeces (in the colon), gallstones and loops of bowel, which were filled with fluid. It was not possible from this to

make a clear diagnosis, so a doctor recorded possible diagnoses of diverticulitis, cholecystitis or ischaemic bowel. He considered that non-surgical management (such as antibiotics, giving fluid through the veins and giving pain relief) was the best option as Mrs A's lung condition effectively ruled out surgery as an option. A note in the medical records for 22 September 2006 suggests possible abdominal sepsis (severe infection). On the night of 23 to 24 September, Mrs A collapsed, a doctor examined her, and more blood tests were done, revealing worsening kidney function, for which a catheter was arranged for urination purposes, and fluids were increased. She was seen by medical staff throughout the night and was recorded at 06:00 on 24 September as 'uncomplaining but looks very unwell'. The note also referred to 'no bowel sounds', which I shall return to in the next paragraph. Sadly, Mrs A died early that afternoon. The main causes of death listed by the doctor on the death certificate were intra-abdominal sepsis and Mrs A's lung condition.

18. I summarise here the Advisers' comments about Mrs A's care and treatment following her admission onto a ward:

> 'The diagnosis of constipation and urine infection was correct. However, the abdominal pain continued, it did not respond to pain relieving drugs, it was associated with a rise in the white blood cell count, the constipation persisted and there was some vomiting. We consider that this state of affairs should perhaps have led to questioning of this simple diagnosis. By the time of the review on 22 September 2006, it is clear that the septic nature of the abdominal signs was becoming more apparent. We note the Board's comments (letter of 21 June 2007 to Ms C) that the x-rays and ultrasound scan 'did nothing to help the diagnosis of her underlying problem'. We find this difficult to understand because the x-ray showed distended loops of colon and faecal masses in the caecum and lower colon (ie severe constipation) and the scan showed multiple fluid-filled loops (ie bowel obstruction or ileus – a situation where the bowel cannot contract to move faeces along its passage because it is paralysed, for example by sepsis, and is, therefore, obstructed). The signs of abdominal distension and tenderness, plus the scan result, indicated that the bowel was already not working properly (fluid was sitting in loops of gut that could not contract to move faeces along its route). The doctor's note (see paragraph 17) of 'no bowel sounds' confirms this. Mrs A's collapse on the night of 23 to 24 September 2006 indicated that septic shock had set in.

The death certificate appropriately lists intra-abdominal sepsis as the main cause of death, but we do not consider that the Hospital acknowledged the events leading up to that diagnosis. The treatment of antibiotics and suction for what was increasingly looking like intra-abdominal sepsis through a perforation (ie hole) in the gut, was entirely appropriate clinical treatment. And we acknowledge that there is a very high death rate from this in older people, even when it is treated. However, we consider that A&E's lack of confirmation (by x-ray) on 12 September 2006 that constipation was the cause of the abdominal pain and the lack of appropriate treatment at that point shifted the likelihood towards progressive bowel stagnation and a probable eventual perforation.

We would also say that we consider the attempts to clear Mrs A's bowels were rather weak: Movicol was used in the wrong dosage for bowel clearance, and lactulose was not a good choice of laxative in this situation as it takes days to be effective, and, in any case, the doses given were very small. We acknowledge that the Board consider that they took appropriate action.

In short, we consider that there was inadequate treatment of Mrs A's constipation and a lack of acknowledgement by the Hospital of various significant signs and symptoms.

Finally, we should add that, despite the shortcomings in Mrs A's care and treatment, it is not possible to say whether they caused her death. We acknowledge that Mr A has a different opinion'.

(b) Conclusion

19. This has been a difficult case to consider, partly because of the Board's inability to provide full A&E records for 12 September 2006. The Advisers and I also acknowledge that doctors often have a range of options when considering a patient's treatment – several or all of which may be appropriate options. Even taking this into account, however, the Advisers are of the firm view that: in-patient admission on 12 September 2006 would have been a far more appropriate option; even with a discharge on 12 September, there should have been more vigorous management on that day; the discharge on 12 September was not adequately managed; and management during the admission which started on 16 September 2006 was not adequate. (I should stress that we are not concluding that all older patients with constipation should be admitted as in-

patients.) I accept the Advisers' advice. In all the circumstances, I uphold complaint (b).

(b) Recommendations

20. The Ombudsman recommends that the Board:

(iii) ensure that all appropriate healthcare professionals in the Board's hospitals are made aware of the appropriate management of constipation in older people; and

(iv) reflect on the lessons learnt from this complaint and take appropriate action to help avoid a recurrence.

(c) The Board lost some of Mrs A's medical records

21. I should explain that, generally, the phrase 'clinical records' is taken to mean all of a patient's records at a GP practice or hospital (whoever has produced them) whereas 'medical records' means records written by doctors and 'nursing records' means records written by nursing staff. For 12 September 2006, the only A&E clinical records which the Board sent to me were nursing records and the A&E discharge letter to Mrs A's GP. In other words, the A&E medical records were missing. The loss only came to light when I asked the Board for the clinical records. The Board described to me the detailed, but unsuccessful, search which they then made for the missing records. Such a loss is unacceptable. I invited the Board to tell me of any action taken in respect of the loss. However, instead of doing so, they merely apologised, which suggests that no action was thought necessary.

(c) Conclusion

22. In all the circumstances, I uphold complaint (c). The Ombudsman takes the security of clinical records seriously and was concerned that the Board did not seem to consider it would be appropriate to take action about the loss. However, he is very pleased that the Board have now reported major action, as below:

- all A&E attendances for 12 September 2006 are being checked to ensure that no other patients' records for that date are missing;
- procedures have been changed, so that a patient's A&E record will remain within A&E, even when the patient is moved elsewhere;
- the procedures for A&E records in all the Board's other A&E departments are being reviewed, and best practice advice will be disseminated to all sites; and

- off-site storage of old A&E records is being reviewed to ensure easy access if required.

This is very welcome, and the Ombudsman does not consider that any recommendations for other action are required regarding complaint (c).

23. 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

Ms C	The complainant
Mrs A	Mr A's mother
Mr A	The person on whose behalf the complaint was made
The Hospital	The Royal Alexandra Hospital
The Board	Greater Glasgow and Clyde NHS Board
A&E	Hospital accident and emergency department
The Advisers	Two medical advisers to the Ombudsman
GP/s	General practitioner/s
The Practice	Mrs A's GP practice