**Scottish Parliament Region: Glasgow**

**Case 200901216: Greater Glasgow and Clyde NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; Gynaecology

***Overview***

The complainant (Ms C) raised a number of concerns about the care and treatment she received from Greater Glasgow and Clyde NHS Board (the Board) following treatment on 7 and 9 September 2008 for a medical termination of pregnancy (MTOP). Ms C also complained that she had received contradictory information regarding bleeding and that her complaint response from the Board contained inaccurate information.

***Specific complaints and conclusions***

The complaints which have been investigated are that the Board did not provide:

(a) adequate care and treatment to Ms C after a MTOP (*upheld*);
(b) clear written guidance to Ms C about the expected duration of bleeding after the MTOP (*upheld*); and
(c) accurate information to Ms C in their complaint responses (*upheld*).

***Redress and recommendations***

The Ombudsman recommends that the Board:

(i) apologise to Ms C for the inadequate care and treatment provided to her after the MTOP;
(ii) devise a protocol for the management of retained products of conception following a MTOP; and
(iii) apologise to Ms C for failing to provide her with accurate information in their complaint responses.

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

## Main Investigation Report

### Introduction

1. On 22 June 2009, the Ombudsman received a complaint from Ms C about the care and treatment provided to her by a clinic run by the Sandyford Initiative (the Clinic), the Western Infirmary (Hospital 1) and the Southern General Hospital (Hospital 2) after she underwent a medical termination of pregnancy (MTOP). Ms C received treatment for the MTOP on 7 and 9 September 2008. However, on 13 October 2008 Ms C also underwent a surgical evacuation of retained products of conception (ERPC). During the period of time between these two procedures, Ms C had raised concerns about continual bleeding with a Consultant Gynaecologist (the Consultant) at Hospital 1 on 22 September 2008; a doctor at the Clinic on 24 September 2008; and a doctor at Hospital 2 on 2 and 10 October 2008. Ms C also made complaints about being given conflicting information about bleeding following the MTOP and that Greater Glasgow and Clyde NHS Board (the Board)'s written responses to her complaints contained inaccurate information.

2. Ms C had initially complained to the Board on 18 February 2009 but remained dissatisfied with the responses so complained to the Ombudsman's office.

3. The complaints from Ms C which I have investigated are that the Board did not provide:

(a) adequate care and treatment to Ms C after a MTOP;
(b) clear written guidance to Ms C about the expected duration of bleeding after the MTOP; and
(c) accurate information to Ms C in their complaint responses.

### Investigation

4. Investigation of this complaint involved obtaining and reviewing the Board's complaint correspondence alongside Ms C's correspondence and clinical records. Further information on the Board's guidelines on managing MTOP was obtained. My investigator then sought the views of a specialist adviser to the Ombudsman in gynaecology (the Adviser) and discussed aspects of the case with Ms C.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the

abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2. Ms C and the Board were given an opportunity to comment on a draft of this report.

*Medical background*

6. On 22 August 2008 Ms C carried out a home pregnancy test which indicated that she was pregnant despite having being fitted with an intrauterine contraceptive device (IUCD) in 2004. Ms C sought advice from NHS24 and then attended the Clinic the following day where she was given an appointment to attend the Termination of Pregnancy Assessment and Referral service (TOPAR) on 8 September 2008.

7. On 24 August 2008 Ms C attended Hospital 2 as she was experiencing abdominal pains and was concerned at having to wait until 8 September 2008 for the TOPAR appointment at the Clinic. The medical records document that Ms C was examined the following day and there was no IUCD seen. Ms C thereafter saw her general practitioner (GP) who referred her to the Social Gynaecology clinic at Hospital 2.

8. On 1 September 2008 Ms C was seen by a specialist registrar in gynaecology at Hospital 2 where she consented to having the MTOP. A scan was thereafter performed and confirmed that Ms C was six weeks and three days pregnant.

9. The treatment for the MTOP took place at Hospital 2 on 7 and 9 September 2008 when Ms C was seven and a half weeks pregnant. The Adviser told me that a MTOP involves treatment initially with a drug Mifepristone which primes the uterus so that a miscarriage is induced by the administration of the second drug Misoprostol. The Adviser commented that these drugs were appropriately administered within the appropriate timescale on 7 and 9 September 2008 respectively. The nursing staff documented that a small piece of tissue was passed and that a follow-up scan was required in order to check whether Ms C's uterus was empty.

10. On 22 September 2008 Ms C attended Hospital 1 for the follow-up appointment and was seen by the Consultant who performed a transabdominal ultrasound scan. The medical records make reference to the small amount of tissue which was passed at the time of the MTOP but stated that no retained products of conception (RPOC) were seen during the scan. It was noted in the

records that Ms C was still experiencing some vaginal bleeding which was reducing and reassurance was given that it should settle in due course. The medical records also indicate that Ms C was advised to contact the department again if the bleeding increased.

11. On 24 September 2008 Ms C attended for colposcopy at the Clinic. The medical records document that the doctor saw clear evidence of RPOC present within the cervical os which were removed and sent to Histology for analysing. The Histology report on 2 October 2008 confirmed - 'multiple tissue fragments with the largest piece measuring 22 x 13 x 8mm'.

12. On 2 October 2008 Ms C attended Hospital 2 as she remained concerned about continual vaginal bleeding. Ms C informed the attending doctor that products of conception were detected when she attended the Clinic for colposcopy despite the earlier transabdominal scan on 22 September 2008 showing no RPOC. The doctor carried out both a transabdominal scan and a transvaginal scan where clot and tissue measuring around 1centimetre in size were detected. The medical records document that Ms C was given reassurance. It was also noted that Ms C did not need an ERPC.

13. On 10 October 2008 Ms C saw her GP regarding her ongoing concerns with vaginal bleeding. On the advice of her GP, Ms C attended Hospital 2. A further transvaginal ultrasound scan was performed and showed the presence of 1.5 centimetres of RPOC. The medical records document that the options of either managing the bleeding conservatively (non-surgically) or by having an operation were explained to Ms C. Ms C then decided to proceed with ERPC which took place on 13 October 2008 and it was noted that minimal products of conception were detected. Ms C's bleeding and symptoms thereafter settled.

**(a) The Board did not provide adequate care and treatment to Ms C after a MTOP**

14. Ms C complained that the trauma of terminating her pregnancy was prolonged by the level of care and treatment she had received following the MTOP. Specifically, Ms C said that on 2 October 2008, staff at Hospital 2 had expressed concern that a transabdominal scan had been performed rather than a transvaginal scan at Hospital 1 on 22 September 2008. Ms C said that she had experienced difficulties in convincing staff at Hospital 1 on 22 September 2008 and staff at Hospital 2 on 2 October 2008 that vaginal bleeding had not abated. Ms C also told me that she telephoned Hospital 2's

Gynaecology department on several occasions but felt there was a lack of assistance despite being told to contact them if she experienced any problems. However, I was unable to reach a decision on Ms C's concerns about the telephone conversations with Hospital 2 due to a lack of corroborative evidence.

15. In response to the complaint, the Consultant who carried out the transabdominal scan on 22 September 2008 stated:

> 'I clearly had no suspicions that there was a significant amount of tissue present which I was unable to visualise on the abdominal scan at that time; otherwise I would have carried out a vaginal scan. We have the facility to do a transvaginal scan at the Western clinic if indicated. My history taking at that visit did not lead me to feel concerned about the amount of bleeding that [Ms C] was experiencing. Here my documentation and my impression formed is at odds with what [Ms C] describes in her letter where she states that the bleeding had not become any less since she was discharged from [Hospital 2]. I obviously have not detected her level of concern at this stage and I apologise for that.'

16. The Consultant also stated:

> 'With regard to future management of similar cases and learning points I think this case highlights the need for good and supportive communication with patients. I suspect that we do not have a clear guideline for management of retained products after TOP (termination of pregnancy) and this should be addressed.'

17. The Board subsequently told me that they had integrated the service between the Sandyford Initiative and the hospital based services in 2005/6 in order to ensure greater cooperation, consistency and equity of access in their termination of pregnancy (TOP) services. The Board further stated that a group involving all of the relevant services was convened in 2007 which remains active.

18. In the Adviser's consideration of the complaint, he told me that Hospital 2 acted in accordance with the Board's MTOP protocol when referring Ms C for a follow-up scan when products of conception appeared incomplete. However, in the Adviser's opinion, a transvaginal scan is a superior method of detecting RPOC and should have been offered by Hospital 1 at the follow-up appointment on 22 September 2008 instead of a transabdominal scan.

19. Additionally, the Adviser commented that there was further opportunity to offer a transvaginal scan at or around the time RPOC were identified on 24 September 2008 by the Clinic. It is unclear from the records whether any advice was given to Ms C at this appointment about what to do if bleeding continued or whether a further scan should be undertaken. The Adviser said that it would have been good practice for a transvaginal scan to have been performed as the examination had suggested there had been significant tissue remaining after TOP.

20. It is also the Adviser's view that although a transvaginal scan was undertaken on 2 October 2008 by Hospital 2, the option of an ERPC did not appear to have been discussed with Ms C when she attended Hospital 2 with ongoing concerns with bleeding. The Adviser told me that the advice and reassurance given to Ms C would have been reasonable had the scan findings of 1 centimetre of tissue been taken in isolation - as this might reasonably be expected to be passed. However, the Adviser stated that the advice and reassurance did not appear to have taken into consideration the length of time that Ms C had been bleeding and the opportunity to have an ERPC should have been discussed. It was not until Ms C presented again at Hospital 2 on 10 October 2008 that this surgical procedure was offered.

21. The Adviser concluded that although conservative management (non-surgical intervention) has a role to play with the management of retained tissue, appropriate notice should have been taken of the full history and Ms C's wishes under the circumstances. In the Advisers opinion, most of Ms C's concerns could have been addressed if a protocol for the management of retained products had been in place.

22. In response to the Adviser's comments, the Board subsequently expressed to me that a number of assessment options were available when Ms C was seen on 22 September 2008 at Hospital 1. The Board have acknowledged that earlier surgical ERPC may have resulted had a different option been selected. The Board stated:

> 'It is our Clinical Director's opinion that there were a number of opportunities to modify the clinical course and this may have resulted in a faster resolution of [Ms C]'s symptoms and this opportunity was lost.'

23. The General Medical Council has specific guidance about patients having a right to information about their condition and the treatment options available to

them. The document '*Consent: patients and doctors making decisions together*' (2 June 2008) states:

> 'You must work in partnership with your patients. You should discuss with them their condition and treatment options in a way they can understand, and respect their right to make decisions about their care. You should see getting their consent as an important part of the process of discussion and decision-making, rather than as something that happens in isolation.
>
> You must give patients the information they want or need about:
> (c) options for treating or managing the condition, including the option not to treat.'

*(a) Conclusion*

24. I welcome the measures the Board referred to as evidence of earlier attempts to provide a more cohesive approach to their maternity and gynaecology services across the region. However, I share the views of the Consultant and our Adviser in that a protocol should be implemented in order to provide standardised information and a more consistent level of care.

25. Based on the evidence above, I am satisfied that there were earlier opportunities for the medical staff to have offered or carried out alternative methods of investigation and treatment when Ms C presented with ongoing vaginal bleeding. There is a likelihood that these alternatives could have led to earlier resolution of the bleeding. For these reasons I uphold Ms C's complaint.

*(a) Recommendations*

26. I recommend that the Board:

(i) apologises to Ms C for the inadequate care and treatment provided to her after the MTOP; and

(ii) devise a protocol for the management of RPOC following a MTOP.

**(b) The Board did not provide clear written guidance to Ms C about the expected duration of bleeding after the MTOP**

27. Ms C complained that she received conflicting information from Hospital 1 and Hospital 2 about how much bleeding to expect after a MTOP had been undertaken. Ms C said Hospital 2 had given her literature advising that bleeding should have slowed down each day, and stopped within ten to 12 days following the MTOP. However, Ms C said that the Consultant at Hospital 1 had

assured her this was not the case as bleeding could last another couple of weeks.

28. My investigator obtained a copy of the literature which Ms C had referred to in her complaint in order to examine the wording of the advice. I noted that the literature was a letter informing Ms C of the appointments at Hospital 2's Gynaecology ward for the MTOP on 7 and 9 September 2008. The letter also provided advice to patients and stated:

> 'It is normal to bleed for up to 12 days after the procedure. If you have heavy bleeding or painful abdominal cramps, or if you are worried, please telephone the Nurse in Charge of Ward 49/50.'

29. The Adviser reviewed the wording of the appointment letter in comparison with the verbal advice Ms C had received from the Consultant. The Adviser considered that there was a degree of contradiction regarding the length of time bleeding was expected to last after a MTOP. However, the Adviser further commented that the appointment letter also gave appropriate advice if bleeding were to increase.

30. Ms C told me that she did not receive any other written guidance from either Hospital 1 or Hospital 2 regarding information about MTOP. Therefore, my investigator asked the Board to provide me with a copy of any information leaflets they distribute to patients, other than the advice given in the appointment letter. My investigator subsequently received two leaflets which had been in circulation at this time – one of the leaflets concentrated on MTOP and the other dealt with TOP in general. The MTOP leaflet provided the following advice:

> 'You may bleed for 2 to 3 weeks following the termination. However, some women bleed less than this, while others may bleed up until their next period.'

31. Ms C examined the leaflets and told me that she had never seen them before despite the Board informing me that it is standard practice for them to be distributed. I noted from the medical records that the 'Checklist' section on the 'Integrated Care Pathway' paperwork, completed in relation to an appointment Ms C had at Hospital 2 on 1 September 2008, did not indicate whether the risks of MTOP, such as RPOC, were discussed with Ms C or whether a leaflet reflecting this information was provided.

32. In response to the issue regarding the contradictory advice, the Board have told me they have recognised that inconsistency in both written and oral communication between individual sites needed to be addressed. The Board further stated that they will raise awareness with staff regarding the advice they give to patients and ensure the TOP group review all of the relevant documentation.

33. In response to my concerns about completion of the checklist on the Integrated Care Pathway paperwork, the Board have said that they had identified inconsistencies in the completion of the 'Checklist' section by their clinicians. The Board have since discussed the matter with the relevant clinicians and a review of the whole Integrated Care Pathway documentation is underway. The Board also commented:

> 'The Obstetric & Gynaecology Department performs intermittent documentation audits that review note keeping and promote improvement through several communication channels. We will undertake an audit of our TOP documentation in light of this investigation. The intervention will be staff education on the importance of accurate documentation.'

*(b) Conclusion*

34. I fully appreciate that this was an extremely distressing time for Ms C and recognise her frustration at receiving unclear advice regarding bleeding after a MTOP. I agree with the Adviser that there was a degree of contradiction in the advice given by the Consultant in comparison with the advice given in the appointment letter, even although the letter contained brief guidance if bleeding increased. I welcome the steps the Board have taken in engaging with their clinicians about the advice they give to patients and for undertaking a review of all their written information on TOP. However, there is sufficient evidence to suggest that the Board failed to follow their procedures in giving out the appropriate leaflets and documenting that advice had been given regarding the risks of a MTOP. In view of these points, I uphold Ms C's complaint. As the Board are carrying out a review of the advice they give out to patients, I do not make any recommendations.

**(c) The Board did not provide accurate information to Ms C in their complaint responses**

35. Ms C initially complained to the Board on 18 February 2009 and received a response from the Sandyford Initiative dated 12 March 2008 and a separate response from the Women and Children's Directorate dated 6 April 2009

regarding her treatment at both hospitals. Ms C then wrote a further letter to the Board expressing concerns that a pregnancy test had not taken place at the Clinic on 23 August 2008 and that the Women and Children's Directorate had referred to the ERPC taking place on 30 October 2008 instead of 13 October 2008.

36. Ms C received a response from the Women and Children's Directorate dated 10 June 2009 which apologised for their earlier response containing a typographical error regarding the date of the ERPC. However, Ms C did not receive a response from the Sandyford Initiative regarding her concerns about the medical records containing information about a pregnancy test carried out at the Clinic.

37. Ms C told me that the Sandyford Initiative's complaint response suggested that she could contact them again if any outstanding issues remained. Their letter stated:

> 'If you are not satisfied with my response we will make every effort to address any outstanding concerns you may have, if you let me know what these are.'

Ms C's indicated in her second letter that she had sent copies to both the Sandyford Initative and the Women and Children's Directorate. However, the Board told me that the Sandyford Initiative had no record of the second letter within their complaint file. Therefore, the Sandyford Initiative are unclear whether or not it was received by the department.

38. Ms C confirmed to me that she had carried out two home pregnancy tests before attending the Clinic on 23 August 2008. My investigator examined the medical record from the Clinic appointment but could not see any reference to a pregnancy test being carried out at the Clinic. The note read 'did home PDT last night and again this am which were both positive'.

39. This suggested to me that the Board had misinterpreted the complaint response rather than the medical records being inaccurate. The Board had previously told me that they could not offer a reason or any further information to support that a pregnancy test had been carried out at the Clinic.

40. However, during the course of my investigation the Board subsequently reviewed the wording of the clinical note and have agreed the record reflects

that Ms C had performed two home pregnancy tests prior to attending the Clinic.

*(c) Conclusion*

41. Although there was a delay in Ms C receiving a response to her concerns about the date of the ERPC, the Board apologised and provided clarification that the medical records reflected the correct date.

42. I am unable to establish the reason why the Sandyford Initiative had not received a copy of Ms C's second letter. Therefore, I am unable to provide further comment.

43. However, in my view, it is important that responses to complaints are clear and accurate because failures in this respect undermine confidence in the professionalism of the NHS. Therefore, I uphold Ms C's complaint.

*(c) Recommendation*

44. I recommend that the Board apologise to Ms C for not providing accurate information in their complaint response regarding a pregnancy test that had not taken place at the Clinic.

45. 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**

| | |
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| Ms C | The complainant |
| The Clinic | A clinic run by the Sandyford Initiative |
| Hospital 1 | The Western Infirmary |
| Hospital 2 | The Southern General Hospital |
| MTOP | Medical termination of pregnancy |
| ERPC | Evacuation of retained products of conception |
| The Consultant | A consultant gynaecologist at Hospital 1 |
| The Board | Greater Glasgow and Clyde NHS Board |
| The Adviser | A specialist adviser to the Ombudsman |
| IUCD | Intrauterine contraceptive device |
| TOPAR | Termination of Pregnancy Assessment and Referral – a service run by the Sandyford Initiative |
| GP | General practitioner |
| RPOC | Retained products of conception |
| TOP | Termination of pregnancy |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Cervical os | The opening of the uterine cervix |
| Colposcopy | A medical diagnostic procedure detailed examination of the cervix |
| Histology | The study of the structures of tissue |
| Intrauterine contraceptive device (IUCD) | Method of contraception |
| Medical termination of pregnancy (MTOP) | Treatment initially with a drug Mifepristone which primes the uterus so that a miscarriage is induced by the administration of the second drug Misoprostol |
| Mifepristone | A drug used in a medical termination of pregnancy |
| Misoprostol | A drug used in a medical termination of pregnancy |
| Sandyford Initiative | Family Planning and Reproductive Health - provides a range of services including referral for termination of pregnancy |
| Transabdominal ultrasound scan | An external scan to examine the organs in the abdomen |
| Transvaginal ultrasound scan | An internal scan used for looking at organs and structures within the pelvic area |