Scottish Parliament Region: Highlands and Islands

Cases 201003473: Highland NHS Board

Summary of Investigation

Category

Health: Hospitals; clinical treatment; diagnosis; communication

Overview

The complainant (Mr C) raised a number of concerns that this brother (Mr A) had been inappropriately cared for and treated in Highland NHS Board (the Board) hospitals between February and October 2010.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) delayed in diagnosing Mr A's cancer, including a delay in Mr A being reviewed by Gastroenterology (*upheld*);

(b) inappropriately discharged Mr A from Caithness General Hospital on 9 June 2010 (*upheld*); and

(c) did not adequately communicate to Mr A the details of his diagnosis and prognosis (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review endoscopy waiting times, taking into account SIGN and NICE guidance, and report on what steps will be taken to address capacity issues to avoid delays such as that identified in this case;	15 February 2012
(ii) explain how cancelled endoscopies will be treated as adverse events;	21 December 2011
(iii) review the circumstances of Mr A's admission and discharge on 8 and 9 June 2010, with a specific focus on the potential for an inter-hospital transfer, and discharge criteria, and report on the lessons learned;	15 February 2012
(iv) review admission clerking and medical record-keeping at Hospital 1, to ensure it is in line with	15 February 2012

	current standards; and	
(v)	remind consultants of their responsibility to inform patients personally of their test results and likely consequences, and to note this in the medical records.	21 December 2011

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

Main Investigation Report

Introduction

1. The complainant (Mr C) raised a number of concerns that this brother (Mr A) had been inappropriately cared for and treated in Highland NHS Board (the Board) hospitals between February and October 2010.

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

(a) delayed in diagnosing Mr A's cancer, including a delay in Mr A being reviewed by Gastroenterology;

(b) inappropriately discharged Mr A from Caithness General Hospital (Hospital 1) on 9 June 2010; and

(c) did not adequately communicate to Mr A the details of his diagnosis and prognosis.

Investigation

3. The investigation of Mr C's complaint involved reviewing the documentation provided by him, making an enquiry of the Board and reviewing the documentation provided by them. In addition, my complaints reviewer sought the view of a consultant physician (the Adviser).

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

Background

5. Mr A was a 57-year-old man with a history of laryngeal cancer. He received treatment for this cancer which was completed in the summer of 2008. In early 2010 he experienced difficulty swallowing and, during the year, this worsened and he became dehydrated. Mr A was seen by staff in both Hospital 1 and Raigmore Hospital in Inverness (Hospital 2). Mr A died on 4 October 2010, the cause of death being recorded as carcinoma of the oesophagus and carcinoma of the larynx. In complaining to my office, Mr C said that Mr A felt let down by the Board, as his last six to eight weeks were an unpleasant experience that Mr A felt should have been managed better. Mr C's

view was that the Board needed to learn lessons about the rapid management of cancer care.

(a) The Board delayed in diagnosing Mr A's cancer, including a delay in Mr A being reviewed by Gastroenterology

6. In making his complaint to the Board, Mr C said that Mr A began to develop dysphagia in November 2009 but, as a layperson with no clinical awareness, he treated it as indigestion. Mr A was seen in Hospital 2 on 23 February 2010 and Mr C asked why, when referred by a Consultant Ear, Nose and Throat (ENT) Surgeon (Consultant 1) as a result, Mr A had not received an appointment to be seen by Gastroenterology by the time of his next follow-up with ENT. Mr C also complained that there had been an unsuccessful attempt to pass an oesophageal stent on 5 August 2010, which was meant to be attempted again on 13 August 2010. However, this second attempt was cancelled, although Mr A was not told this until very late.

7. In their response to Mr C's complaint, the Board said the clinical notes indicated that Consultant 1 made the decision to refer Mr A to Gastroenterology following a clinic appointment on 22 April 2010, and not as a result of the 23 February 2010 appointment. The Board said the clinical notes for 23 February 2010 indicated that Consultant 1 did not feel that a referral to Gastroenterology was necessary at that time. The Board said the notes for 22 April 2010 recorded that Mr A had complained of pain in his stomach and, at that point, a referral was made to a consultant gastroenterologist, who reviewed the referral on 26 April 2010 and requested an urgent gastroscopy appointment in Hospital 1. The Clinical Lead at Hospital 1 reviewed the referral on 27 April 2010 and the endoscopy was carried out by a locum consultant surgeon (Consultant 2) on 25 May 2010, which was the first available appointment for both urgent and routine appointments. The Board said that Mr A's case had raised organisational issues about endoscopy capacity, however, while a wait of four weeks rather than two for the endoscopy was longer than they would have wished, the delay would not have affected Mr A's treatment or outcome.

8. The Board said that Mr A was admitted to Hospital 2 on 4 May 2010 for laryngoscopy, biopsy, upper oesophagoscopy and an examination under anaesthetic of the tongue base. A biopsy was taken of the generalised oedemas region in his supraglottis, mainly on the left side. The biopsy showed no evidence of malignancy or dysplasia. The Board said it was planned to

continue to review Mr A in the ENT clinic. The endoscopy on 25 May 2010 showed that although there was some narrowing in Mr A's cardia, Consultant 2 was able to pass through this and at that time Mr A did not need stenting. Biopsies were taken during the gastroscopy which were inconclusive. Findings from previous examinations were discussed with Mr A at an ENT clinic on 27 May 2010. These were consistent with acute and chronically inflamed squamous mucosa with no evidence of malignancy or dysplasia. While in the ENT clinic, Mr A explained to staff that he had had an upper gastrointestinal (GI) endoscopy, and Gastroenterology were investigating further. Mr A's case was discussed at a GI Cancer Multi Disciplinary Meeting on 11 June 2010 and further investigations and treatment were set. A further endoscopy was carried out on 15 June 2010 at Hospital 1, and a referral made to a consultant in clinical oncology (Consultant 3) at Hospital 2.

9. Mr A was again seen in the ENT clinic on 24 June 2010 in Hospital 1, at which point he was still awaiting the results of his repeat upper GI endoscopy. He was referred on 28 June 2010 for an endoscopic ultrasound examination at Hospital 2. This was marked as urgent on 2 July 2010, and carried out on 5 August 2010, the day the Consultant Gastroenterologist/Physician performing the endoscopy returned from annual leave. The Board said while it was unfortunate that the stent could not be passed at the first attempt, it was not unusual. A different type of stent was ordered but it took several days to be delivered. This resulted in the cancellation of the 13 August 2010 appointment, with the stent being successfully inserted on 17 August 2010. The Board said they had learned from that event, and any possibility of cancelling an endoscopy on an in-patient would now be treated as an adverse event.

10. Mr A was seen by Consultant 3 on 18 August and 8 September 2010 at Hospital 2. He was also seen at an ENT clinic on 8 September 2010, at which appointment there were no concerns relating to Mr A's head and neck status. Mr A was, however, diagnosed with gastric neoplasm and was due to receive radiotherapy from Consultant 3. However, Mr A died on 4 October 2010 following a short course of palliative radiotherapy. Overall, the Board's view was that Mr A had been managed appropriately.

11. Mr C was not satisfied with the Board's response. He said that, according to a discussion with Mr A, there was an abdominal ultrasound scan on 2 June 2010, which showed a large intra-abdominal mass in the gastro-oesophageal region. Mr C said Mr A had told him that, during discussion of the

scan with medical staff, Mr A had been advised of the unreliability of the negative biopsies, as they may have missed the intended tissue for diagnostic histology.

12. In their response to Mr C's second complaint, the Board said Consultant 2 indicated that Mr A did not have an ultrasound scan on 2 June 2010, as instead he had a computerised tomography (CT) scan of his chest, abdomen and pelvis on 1 June 2010. The CT scan had been booked by Consultant 2 following Mr A's gastroscopy on 25 May 2010 when biopsies were taken. Consultant 2 received the result of the CT scan on 8 June 2010 which showed that there was not just a problem with a big mass in the gastric area, but also widespread mediastinal retrocrural and abdominal node enlargement. Mr A's case was discussed at the GI Cancer Multi Disciplinary Meeting on 11 June 2010, where the decision was made that Mr A needed a further GI endoscopy with biopsies, and he should be referred to Consultant 3 at Hospital 2. The Board said there was no delay between the results of the investigations and further management.

13. In addition, the Board confirmed that Mr A had a history of progressive dysphagia which, when he was admitted on 28 July 2010, was reported to have worsened over the previous two months. The emergency admission on 28 July 2010 with vomiting was, in fact, almost complete dysphagia. Transfer for further management at Hospital 2 was arranged for 2 August 2010. The Board said that the management and care of Mr A was appropriate and timely given the poor prognosis.

Advice received

14. The Adviser's view was that it was not acceptable to have an acknowledged delay of at least four weeks for upper GI endoscopy for urgent cases. The Adviser referred to Scottish Intercollegiate Guidelines Network (SIGN) National Clinical Guideline 87 on the management of oesophageal and gastric cancer, which said that the symptoms experienced by Mr A should have prompted early endoscopy. The Adviser also referred to the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 27, on referral guidelines for suspected cancer, and NICE Clinical Guideline 17 on dyspepsia, which said that a patient with an urgent referral should be seen within two weeks. In the Adviser's view, while SIGN 87 did not specifically mention waiting times, it was in synchrony with NICE 27 and 17.

15. The Adviser said that cancer was confirmed in the CT scan results which were available on 8 June 2010. Two endoscopies failed to obtain adequate histology and confirm the diagnosis and, consequently, the diagnosis of cancer was delayed. However, the Adviser was of the view that there was no misinformed interpretation of biopsy results. The Adviser said that an ultrasound guided upper GI endoscopy was required to target biopsies to obtain confirmatory histology, but this was not performed until 5 August 2010, following the GI Cancer Multi Disciplinary Meeting on 11 June 2010. The Adviser said that after the upper GI endoscopy had been undertaken by Consultant 2, and the CT scan confirmed either gastric or oesophageal cancer with disseminated metastatic spread, only palliative treatment was available to Mr A.

16. The Adviser's view was that Mr A's hospital care was, to some extent, disjointed, partly because he had two separate disease processes requiring input from different departments. It did not appear appropriate to the Adviser that Mr A underwent a laryngoscopy on 4 May 2010 whilst waiting for the delayed upper GI endoscopy that was eventually undertaken on 25 May 2010. The Adviser was also of the view that the management plan for Mr A between 11 June 2010 and 5 August 2010 was unclear. However, the Adviser concluded it seemed unlikely that the identified delays affected Mr A's overall outcome.

(a) Conclusion

17. It is clear there were unreasonable delays in this case. Of particular concern is the initial four-week delay for an urgent endoscopy referral. There was then a delay between 11 June and 5 August 2010 in carrying out a further endoscopy, with no clear management plan in place. There was a two-week delay in inserting an oesophageal stent. The CT scan confirmed cancer, however, two endoscopies failed to obtain adequate histology and corroborate the diagnosis. Consequently, the diagnosis of cancer was delayed. While the advice I have received is that the delays would most likely have not affected the outcome, the failures added to the distress and discomfort for Mr A and his family over the period. Therefore, I uphold this complaint.

(a) Recommendations

18. I recommend that the Board:	*Completion date*
(i) review endoscopy waiting times, taking into account SIGN and NICE guidance, and report on	15 February 2012

	what steps will be taken to address capacity issues to avoid delays such as that identified in this case; and	
(ii)	explain how cancelled endoscopies will be treated as adverse events.	21 December 2011

(b) The Board inappropriately discharged Mr A from Hospital 1 on 9 June 2010

19. In making his complaint to the Board, Mr C asked why, when Mr A was admitted to Hospital 1 on 8 June 2010 for rehydration because of difficulty swallowing, he was not transferred urgently to Hospital 2 for consideration of stenting and palliative chemotherapy/radiotherapy, which had apparently been discussed briefly as a possibility. Mr C was concerned that Mr A had been discharged from Hospital 1 following rehydration, as a time when his dysphagia was at a critical level.

20. In their response to Mr C's complaint, the Board said that Mr A was admitted to Hospital 1 on 8 June 2010 due to dehydration and difficulty swallowing. During his admission, Mr A's condition improved, he had no problem swallowing and could eat and drink small amounts. Therefore, Mr A was discharged on 9 June 2010 as he wanted to go home.

21. Mr C was not satisfied with the Board's response, in particular with the apparently clinically inconsistent statements that Mr A had no problem swallowing, but was only able to eat and drink small amounts. Mr C said that dysphagia severe enough to lead to dehydration would not resolve within 24 hours which, in Mr A's case, was borne out by the fact that he was only able to eat and drink small amounts on discharge.

22. In their response to Mr C's second complaint, the Board said Consultant 2 confirmed that when Mr A was admitted to Hospital 1 on 8 June 2010, he was slightly dehydrated. Mr A was not severely dehydrated as his blood pressure and pulse rate were normal. Mr A was admitted with difficulty swallowing, which turned out to be mostly a problem with regurgitation. The Board said that Mr A was discharged on 9 June 2010 at his request, under no pressure from medical staff. His blood pressure, pulse rate and urine output were normal. The Board said Consultant 2 understood Mr C's concerns, however, on 9 June 2010 he was following Mr A's wishes. In terms of the statements that Mr A had no problem swallowing, and was only able to eat and drink small amounts, the

Board said these were two separate issues. The first statement related to the oesophagus and oesophageal gastric junction, and it meant there was no barrier, or the barrier was small, and Mr A could swallow. The second statement was advice given to Mr A, as his stomach was too small, due to there being a huge mass present, and there was not a lot of space for food. Therefore, Mr A was advised to eat and drink small amounts, but often, to avoid vomiting. In the Board's view, the two statements were clinically consistent.

Advice received

23. The Adviser noted that there was relatively poor clerking, which was difficult to follow, for Mr A's admission on 8 June 2010, and the nursing records were more detailed and, therefore, more helpful than the medical records. Mr A was admitted because of a locum GP's concern regarding the risk of dehydration and Mr A's poor oral fluid intake. It was reported that Mr A was managing four cups of tea a day, but was regurgitating Fortisip. Mr A was very tired, thirsty, and fainted on standing. The Adviser said that Mr A remained on two anti-hypertensive blood pressure tablets, which was not appropriate. Intravenous fluids were administered as documented on the fluid chart, but this was not registered as a medical entry. Apparently, the intravenous cannula was temperamental and Mr A only received one litre of fluid, although more fluid was prescribed (one litre eight-hourly). Mr A's oral fluid intake was documented as 50 millilitres on 8 June 2010 and 380 millilitres on 9 June 2010, which the Adviser said was not adequate. Mr A's blood pressure climbed from 111/69 to 132/77 during his admission, but only three measurements were taken.

24. On 9 June 2010, it was documented that Mr A wanted to go home and, consequently, he was discharged the same day. The Adviser said it was important to note that, based on the available records, every time Mr A was in hospital he wanted to go home. However, that did not necessarily mean it was appropriate or safe for him to be discharged. Mr A's dysphagia had not resolved, and indeed dysphagia would not resolve within 24 hours if the underlying problem was cancer. Mr A was dehydrated on admission, with a raised blood urea and low blood pressure. The Adviser said it was unclear how insistent Mr A was that he went home, however, Mr A had not been carefully assessed prior to his discharge and no self-discharge form was completed. The Adviser said there was a responsibility for clinicians to ensure that a patient's discharge was safe. In Mr A's case, this was particularly important given that he was readmitted later with almost complete dysphagia, and before further investigations and treatment had been initiated.

25. The Adviser also said that, regarding the 8 June 2010 admission, the Board had said Mr A had no problem with swallowing and could eat and drink small amounts and, therefore, was discharged. The Adviser said this was inappropriate and not entirely correct, as the problem was not regurgitation. The Adviser's view was that Mr A required urgent attention and should have been referred to Hospital 2 an inter-hospital transfer.

(b) Conclusion

26. Mr A did not receive enough fluids during admission and his dysphagia had not resolved. There was no evidence that Mr A had been carefully assessed before discharge. It was recorded that Mr A wanted to go home, but no self-discharge form was completed. Mr A required urgent attention and probably should have been transferred to Hospital 2. Taking all of this into account, I uphold this complaint.

(b) Recommendations

27. I recommend that the Board:	*Completion date*
(i) review the circumstances of Mr A's admission and discharge on 8 and 9 June 2010, with a specific focus on the potential for an inter-hospital transfer and discharge criteria, and report on the lessons learned; and	15 February 2012
(ii) review admission clerking and medical record-keeping at Hospital 1, to ensure it is in line with current standards.	15 February 2012

(c) The Board did not adequately communicate to Mr A the details of his diagnosis and prognosis

28. Mr C said Mr A was only aware of his diagnosis and prognosis a few weeks before his death, by which time he was too weak to put his affairs in order. Mr C said Mr A appeared unaware of the seriousness of his condition until informed during his final admission in September 2010.

29. In responding to Mr C's complaints, the Board said Mr A was seen in the ENT clinic on 27 May 2010, at which time the findings from previous examinations were discussed with him. The Board also said that Mr A was informed of the result of the 1 June 2010 CT scan; and also the results of biopsies taken on 25 May 2010, which were inconclusive. Consultant 2 told

Mr A that, as his case was very complex, he would discuss it with colleagues at the GI Cancer Multi Disciplinary Meeting on 11 June 2010. The Board also said that copies of correspondence retained in Mr A's notes confirmed that he was informed that there were some serious concerns regarding something sinister in his stomach, although there was no histological confirmation based on the several biopsies taken from the stomach lesion at the time of his endoscopies.

30. Consultant 2 told my office that it was always his practice to inform a patient of their results before they left the endoscopy unit, and that he did so in this case in addition to filling out a CT scan request form with Mr A.

Advice received

31. The Adviser said there were a number of attempts to inform Mr A of his diagnosis, and there was documentation which showed that he was reluctant to accept the diagnosis. In the Adviser's view, consultants were responsible for informing patients of investigation results. On 28 June 2010, a Consultant Upper GI, Hepatobiliary and General Surgeon wrote to Mr A informing him that the results of endoscopies were sinister. On 9 June 2010, Consultant 2 explained to Mr A that the results of the CT scan were not fine and were indeed sinister. Consultant 3 tried to explain the situation to Mr A in September 2010, but recorded that he was not sure whether he had 'got through' to Mr A. Clinical records showed that, during an admission to Hospital 2 between 15 and 22 September 2010, Mr A was either unwilling or unable to accept the poor prognosis. Overall, the Adviser concluded that although attempts to inform Mr A of the suspected cancer were initially hindered by the failure to confirm cancer by histology, and then by Mr A's apparent reluctance to receive the news, communication with Mr A appeared to have been appropriate.

(c) Conclusion

32. There is no record of who told Mr A the results of the upper GI endoscopy from 25 May 2010. The Adviser said passing on and explaining the results was a consultant's responsibility. The Adviser noted that there were attempts to tell Mr A of the suspected cancer, however, these were hindered by the delay in confirming cancer by histology, as well as an apparent reluctance by Mr A to receive the news. Given that there was adequate evidence of the Board attempting to communicate with Mr A, on balance, I do not uphold this complaint.

(c) Recommendation

33. I recommend that the Board:	*Completion date*
(i) remind consultants of their responsibility to inform patients personally of their test results and likely consequences, and to note this in the medical records.	21 December 2011

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	The aggrieved, Mr C's brother
The Board	Highland NHS Board
Hospital 1	Caithness General Hospital, Wick
The Adviser	A clinical adviser to the Ombudsman
Hospital 2	Raigmore Hospital, Inverness
ENT	Ear, Nose and Throat
Consultant 1	A consultant ENT surgeon
Consultant 2	A locum consultant surgeon
Consultant 3	A consultant in clinical oncology
GI	Gastrointestinal
CT scan	Computerised tomography scan
SIGN	Scottish Intercollegiate Guidelines Network
NICE	National Institute for Health and Clinical Excellence

Annex 2

Glossary of terms

Biopsy	Removal of tissue sample for microscopic examination of thin slices of it
Cannula	A small tube inserted in to the veins
Carcinoma	Cancer that begins in the skin or in tissues that line or cover body organs
Cardia	The part of the stomach attached to the oesophagus
Chemotherapy	The use of anti-cancer drugs to destroy cancer cells
Computerised Tomography	A computerised tomography (CT) scan uses x-rays and a computer to create detailed images of the inside of the body
Dyspepsia	Pain or discomfort centred in the upper abdomen
Dysphagia	Difficulty swallowing
Dysplasia	An abnormality of development
Endoscopy	Using an instrument to examine the interior of a hollow organ or cavity of the body
Fortisip	A brand name for a nutritionally complete, high energy, ready to drink, milk shake style nutritional supplement, for the management of disease related malnutrition
Gastric	Relating to the stomach

Gastroenterology	The study of the digestive system and treatment of its disorders
Gastroscopy	Using an instrument to examine the inside of the stomach
Hepatobiliary	Relating to the liver, gallbladder, bile ducts, and/or bile
Histology	The study of the structures of tissue
Intravenous	Giving substances directly into a vein
Larynx	The part of the respiratory tract that contains the vocal chords, also known as the voicebox
Laryngoscopy	Using an instrument to examine the back of the nose, throat and vocal cords
Lesion	Any abnormal tissue found on or in an organism, usually damaged by disease or trauma
Malignancy	The tendency of medical condition, such as tumors, to become progressively worse
Mediastinal	The area between the lungs which is bounded by the spine, breastbone, and diaphragm
Metastatic	Metastasis is the spread of a disease from one organ or body part to another non-adjacent organ or body part
Neoplasm	An abnormal mass of tissue as a result of neoplasia. Neoplasia (new growth) is the abnormal proliferation of cells. The growth of neoplastic cells exceeds and is not

	coordinated with that of the normal tissues around it. The growth persists in the same excessive manner even after cessation of the stimuli. It usually causes a lump or tumor. Neoplasms may be benign, pre-malignant (carcinoma in situ) or malignant (cancer)
Node	Lymph nodes are small organs of the immune system, that exist throughout the body, including the stomach
Oedema	Fluid retention in the body
Oesophagus	A muscular tube through which food passes from the top of the throat to the stomach
Oesophagoscopy	Using an instrument to examine the oesophagus
Oncology	The study of cancer
Palliative	Palliative care is any form of care or treatment that attempts to reduce the severity of disease symptoms, rather than trying to stop, delay, or reverse progression of the disease itself or provide a cure
Radiotherapy	The use of high energy x-rays and similar rays (such as electrons) to treat disease
Retrocrural	Relating to a space within the mediastinum
Squamous mucosa	The cells that make up the inner lining of the oesophagus
Stent	A small tube used to prop open an artery, blood vessel or other duct

Supraglottis	The part of the larynx above the where the vocal cords are located
Urea	A waste product of many living organisms, and the major organic component of human urine

Annex 3

List of legislation and policies considered

NICE Clinical Guideline 27, on referral guidelines for suspected cancer

NICE Clinical Guideline 17 on dyspepsia

SIGN National Clinical Guideline 87 on the management of oesophageal and gastric cancer