Scottish Parliament Region: Glasgow

Case 200600345: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital

Overview

The complainant, Ms C, an advocacy worker complaining on behalf of a woman (Mrs A), raised concerns regarding the care and treatment provided to Mrs A in respect of her bowel operation at the Royal Alexandra Hospital (the Hospital) on 24 February 2003. Mrs A was unhappy with the lack of information provided to her, her family and her general practitioner (the GP), the timing of her discharge, the failure to timeously diagnose an abscess in her bowel and the failure to arrange a follow-up appointment. The specific points of complaint are listed below.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was insufficient communication by the surgical team with regard to operative risks, the complications that arose and the information provided to the GP following discharge (*upheld*);

(b) following the operation, Mrs A was discharged prematurely from the Hospital (*upheld*);

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde NHS Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor. However, the recommendations within this report are directed towards Greater Glasgow and Clyde NHS Board.

(c) the clinicians involved failed to diagnose an abscess in Mrs A's bowel within a reasonable time-frame *(upheld)*; and

(d) a follow-up appointment was not arranged after Mrs A was discharged (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) consider the way that they currently record episodes of communication. As a minimum, they should remind staff of the importance of recording significant communication episodes between clinical staff and their patients and their carers. These records should include the time and date of such episodes, the parties present, matters discussed and the patient/carer's understanding of the same;

(ii) consider introducing measures to ensure that any known complications of surgery which occur, and any resultant consequences, are recorded on the discharge sheet and sent to patients' GPs in a timely manner;

(iii) inform the Ombudsman of any changes that they have made in response to the Scottish Executive Health Department's guidance 'A Good Practice Guide on Consent for Health Professionals in NHSScotland' (June 2006); and

(iv) consider introducing measures to ensure that biopsy results following local trans-anal surgery are reviewed urgently and any full thickness perforation is specifically recorded in the case notes. When such perforations are recorded and the patient is still in hospital, the Board should take steps to ensure that the patient is not discharged until reviewed by a senior surgeon. When any such results are received after a patient has been discharged, these should be reported immediately to the patient's GP and an urgent review by the surgical team should be arranged.

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

Main Investigation Report

Introduction

1. On 3 May 2006, the Ombudsman received a complaint from an advocacy worker (referred to in this report as Ms C) on behalf of a woman (referred to in this report as Mrs A) regarding the care and treatment Mrs A received at the Royal Alexandra Hospital (the Hospital).

2. On 24 February 2003 Mrs A underwent surgery to remove polyps (see Annex 2) from her bowel. The surgeon (Doctor 1) encountered complications during the operation and Mrs A required a blood transfusion and had to be returned to the theatre on two occasions. Following her discharge from the Hospital, Mrs A experienced incontinence and severe pain and was subsequently found to have a rectal abscess which was caused by a perforated bowel. She was re-admitted and underwent emergency surgery on 28 March 2003.

3. Mrs A expressed dissatisfaction with the standard of care she received and she expressed particular concern regarding the lack of communication she experienced throughout her treatment. She had exhausted the former Argyll and Clyde NHS Board (the Board)'s internal complaints process.

4. The complaints from Ms C which I have investigated are that:

(a) there was insufficient communication by the surgical team with regard to operative risks, the complications that arose and the information provided to Mrs A's general practitioner (the GP) following discharge;

(b) following the operation, Mrs A was discharged prematurely from the Hospital;

(c) the clinicians involved failed to diagnose an abscess in Mrs A's bowel within a reasonable time-frame; and

(d) a follow-up appointment was not arranged after Mrs A was discharged.

Investigation

5. In writing this report I have had access to Mrs A's medical records and the complaints correspondence with the Hospital. In addition, I obtained advice from one of the Ombudsman's surgical advisers (the Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs A and the Board were given an opportunity to comment on a draft of this report.

(a) There was insufficient communication by the surgical team with regard to operative risks, the complications that arose and the information provided to the GP following discharge

7. Mr A wrote to the Hospital on 9 April 2003 and highlighted his concerns regarding his wife's treatment. He advised that, prior to the operation, Mrs A was told that there was a slight chance of some bleeding after the operation. He stated that he subsequently met with another surgeon (Doctor 2) on 4 April 2003 and was informed that the operation was high-risk and the method used, fulguration using diathermy (see Annex 2), was not one which he practiced. In his letter, Mr A questioned why Doctor 1 would carry out such an operation and not tell them of the risks involved. On commenting on the draft report, Doctor 1 stated that, although he has now ceased to use the fulguration method, it served him well for over 10 years and he has used it successfully to rid patients of difficult polyps, with a number of these patients consequently avoiding the need for laparotomies and permanent colostomies (see Annex 2).

8. Mr A also advised that Mrs A suffered a major haemorrhage during the operation which was almost fatal and she had to receive a large transfusion of blood. She was returned to the operating theatre on two occasions, once after the initial operation and then again the following morning. Mr A stated that he was not contacted by any member of the clinical staff and when he telephoned to enquire, the ward staff would only tell him that Mrs A was not back from theatre yet. He said he called back again around four hours after Mrs A was due back in the ward and was advised that she was in the recovery room. Mr A stated that this was the most information he received regarding Mrs A's medical condition. On commenting on the draft report, Doctor 1 confirmed that Mrs A suffered a major bleed which required transfusion, however, he advised that, whilst this was a significant problem, it was dealt with with relative ease and at no point did he consider it to be life threatening.

9. In his letter, Mr A also stated that the GP received a letter from Doctor 1's assistant, which was dated 4 March 2003, however, it took around three weeks to arrive and did not give any detailed information about the procedure. Mr A stated his belief that this flow of information was not acceptable to himself and his family and he advised that he never received an explanation as to why

Mrs A nearly died. He also pointed out that he still did not know whether the procedure was carried out by Doctor 1 himself, or a registrar. On commenting on the draft report, Doctor 1 fully agreed that Mrs A's GP should have been informed about the bowel perforation, however, he stated that all other relevant facts were provided. He also stated that he clearly recalls telling Mr A that he would be carrying out each of the operations himself and he reiterated that an explanation as to why Mrs A nearly died was not given as it was never his belief that her life was at risk.

10. In relation to the information provided to the GP and Mrs A's condition following discharge, Mr A added that the GP had no notes on what had happened and was unable to provide much assistance.

11. Finally, Mr A advised that Doctor 1 spoke with Mrs A in the High Dependency Unit following the operation and he believed the language he used to have been inappropriate when discussing the complications that had arisen. Mr A did concede that Doctor 1 apologised to Mrs A, however, she was recovering from the operation and could not recall the sentiment. At the time of writing, Mr A advised that Doctor 1 had not met with himself or his family to offer an explanation, although a meeting was scheduled to take place the following day.

12. In the Board's response of 26 June 2003, Doctor 1 did not respond to the specific points, however, he advised of his belief that the complainants were satisfied with the outcome of their meeting with him on 10 April 2003 (no meeting notes are on file).

13. Within the Board's response, Doctor 2 confirmed that fulguration using diathermy was an established, but older, technique which he does not use in his own practice and he instead opts for endoscopic laser ablation (see Annex 2). He confirmed that both procedures carry risks, however, he did not comment on the alleged lack of prior explanation of risk in Mrs A's case. On commenting on the draft report, Doctor 1 disagreed that fulguration is an out of date procedure and he referred to a paper which was published in 2005 in a well respected peer review journal, recommending the use of this method in selected patients and commenting on its relative safety.

14. Mrs A and her family met with the Board's Patient Liaison Manager on 24 March 2004 and advised that they were dissatisfied with the response to

their complaint as they did not perceive the complaint to have been resolved following the meeting with Doctor 1. They reiterated their concern that the perforated bowel was not communicated to them or the GP upon discharge and they restated their belief that the GP would have been able to offer better assistance and arrange a more urgent re-admission had she been advised.

15. In the Board's response of 5 July 2004, they advised that Doctor 1 had been focussing his efforts on treating the bleeding and he advised that perforations were a well recognised problem with this type of treatment and they usually settled down without further problems. On this basis he did not feel the need to discuss it with Mrs A, however, he acknowledged that it would have been better to inform the GP and he apologised for this oversight.

16. Ms C wrote to the Board on 29 July 2004, reiterating Mrs A's concerns that neither her nor the GP were advised of the perforation and requesting that the complaint be taken to an Independent Review (see Annex 2). Ms C also stated that Mrs A was incontinent prior to leaving the Hospital and she was not advised that this was not a normal occurrence after such surgery.

17. Whilst considering the request for an Independent Review, the Board sought clinical advice from a Consultant Surgeon (Doctor 3), however, he could only make limited comment from the evidence available to him. He did acknowledge that the GP should have been informed of the bowel perforation, however, he noted that the impact of this might have been minimised had the two week follow-up appointment been arranged and he also noted that Doctor 1 had recognised, and apologised, for the oversight.

18. With regards to Mrs A's incontinence, Doctor 3 stated that this was indeed a recognised problem after such a surgical procedure and, as such, should have been discussed with Mrs A before, and after, the operation. Doctor 3 was unable to add any further comment as he was not in possession of the relevant medical and nursing records.

19. In the Independent Lay Complaints Convener (the Convener)'s letter of 4 April 2005, she advised of her decision to take no further action regarding the failure to inform the GP of the perforation. She deemed that this had been addressed in the Board's response of 5 July 2004 and there was nothing further that could be added.

20. With regards to the information provided in relation to Mrs A's incontinence, the Convener advised that she was referring this back to the Board. She stated that she would be asking them to look at why Mrs A was apparently not told of the possibility of incontinence and whether lessons could be learned from this regarding how, and in what format, information could be given to patients about possible post-operative problems.

21. In the Board's response of 20 December 2005, they advised that Doctor 1 had no recollection of Mrs A being incontinent while an in-patient and he could not recall it being brought to his attention. The Board stated that there were several ways in which patients were made aware of possible post-operative complications. They advised that the doctor would be expected to discuss this with the patient during the out-patient consultation at which the option of surgery was proposed and again at the point where formal signed consent was obtained from the patient. They further advised that, for a growing number of surgical conditions, the patient would also be provided with support and advice from a specialist nurse and that information would also be provided to patients in leaflet form, either specific to the operation or in general regarding major surgery. Finally, the Board stated that these practices were governed by an increasing body of guidelines and protocols and were reviewed in light of these and of experience and feedback.

22. In a letter received by the Ombudsman on 3 May 2006, Ms C advised that Mrs A remained dissatisfied with the outcome of her complaint and she copied all the relevant correspondence to highlight her concerns.

23. During the course of the investigation, independent surgical advice was sought and the Adviser observed that the reference to Mrs A being informed that there was a chance of slight bleeding was the only reference on file pointing to a discussion regarding operative risks. He advised that the consent form in the medical records was of an old style and that there was no specific mention of treatment options or possible complications. He then referred to the 1998 GMC booklet *'Seeking patient's consent: the ethical considerations'* which contained a section entitled 'Providing sufficient information' and it laid out that patients may want to or ought to know 'options for treatment' and 'details of what [they] might experience during or after the procedure including common and serious side effects'. The Adviser, therefore, concluded that, in the absence of any documentation, the consent process in Mrs A's case was unreasonable.

24. Similarly, the Adviser noted that there was no documentation relating to a discussion regarding the bleeding Mrs A experienced. Whilst he acknowledged that Mr A's initial complaint letter would indicate that some sort of discussion took place the morning after the operation, the Adviser suggested that it may have been appropriate to have followed this up with further communication once Mrs A had more fully recovered from the anaesthetic. He recognised that it is difficult to resolve differences in individuals' recollections of a verbal exchange, however, he felt that both the failure to document discussions and the failure to allow Mrs A an opportunity to discuss the complications further fell short of reasonable practice.

25. The Adviser suggested that informing the GP of the perforation at the time of discharge could possibly have allowed Mrs A to be more closely observed, perhaps resulting in a more timely discharge and lessening the severity of Mrs A's condition. In light of this, the Adviser recommended that any known complication of surgery that has occurred, together with the potential consequences, should be listed on a discharge sheet and sent to the GP in a timely manner.

26. The Adviser also recommended that the medical case notes should contain a summary sheet, recording all significant communication episodes between clinical staff and patients and their carers. He stated that this should include the content of any communication, the parties present, the date and time of the episode and the patient/carer's understanding of any information imparted to them.

27. On 16 June 2006, the Scottish Executive Health Department[2] issued new guidance on consent. Entitled 'A Good Practice Guide on Consent for Health Professionals in NHSScotland', this guidance replaced the previous guidance 'A Guide to Consent to Examination, Investigation, Treatment or Operation' which was published in 1992. The new guidance listed clinicians' responsibilities and these responsibilities included the requirement to 'provide the relevant verbal and written information to [the] patient at an appropriate time to allow them to make an informed decision. This should include the benefits

[2] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive. The latter term is used in this report as it applied at the time of the events to which the report relates.

and risks'. Also included was the clinician's requirement to 'record within the patient's health record the verbal and written information provided to [the] patient, which should include alternatives'.

(a) Conclusion

28. The advice which I have received and accept indicates that the communication between the surgical team and Mrs A, the documentation of the communication and the consent process and also the lack of information provided to the GP were all unreasonable and I, therefore, uphold this complaint.

(a) Recommendations

29. In line with the Adviser's comments, the Ombudsman recommends that the Board:

(i) consider the way that they currently record episodes of communication. As a minimum, they should remind staff of the importance of recording significant communication episodes between clinical staff and their patients and their carers. These records should include the time and date of such episodes, the parties present, matters discussed and the patient/carer's understanding of the same;

(ii) consider introducing measures to ensure that any known complications of surgery which occur, and any resultant consequences, are recorded on the discharge sheet and sent to patients' GPs in a timely manner; and

(iii) inform the Ombudsman of any changes that they have made in response to the Scottish Executive Health Department's guidance 'A Good Practice Guide on Consent for Health Professionals in NHSScotland' (June 2006).

(b) Following the operation, Mrs A was discharged prematurely from the Hospital

30. In his letter of 9 April 2003, Mr A advised that Mrs A had great difficulty walking and was in pain when she was discharged. He stated the she was told to go home by nursing staff and she did not see a doctor and Mr A questioned whether this was normal procedure. He further advised that Mrs A was incontinent when she got home and suffered a lot of distress and he believed that the diagnosis of a perforation in her bowel indicated that she was not fit to have been discharged.

31. In the meeting with the Patient Liaison Manager on 24 March 2004, Mrs A and her family reiterated that Mrs A did not see a doctor on the day she was

discharged. Mrs A was at the toilet during the doctor's ward round and when she returned to her bed, another patient advised her that the doctor had said she was fit for discharge. They questioned whether it was normal practice for the patient not to be examined or physically seen by a doctor prior to being discharged.

32. As stated in paragraph 12, Doctor 1 offered little response in the Board's letter of 26 June 2003, however, when it was recognised that the complainants remained dissatisfied following their meeting with him, he contributed to the Board's response of 5 July 2004. This letter communicated Doctor 1's advice that Mrs A had been kept in hospital for seven days following her procedure, whereas the normal time period to keep patients in after uncomplicated similar surgery would be overnight. He stated that this decision was based on Mrs A's bleeding complication and that the only other symptom was a slightly elevated temperature.

33. Doctor 1 noted that Mrs A had been seen over the weekend by one of the medical staff with no problems recorded and on the morning of the discharge she was apyrexial (see Annex 2) and the nursing staff did not report any particular problems. Doctor 1 then acknowledged that, given subsequent events, it was unfortunate that Mrs A was not seen by a doctor, however, he was of the opinion that the decision to discharge that day would have been the same even if Mrs A had not been in the toilet at the time of the ward round.

34. The issue of Mrs A's discharge was not picked up again until the Board's response of 10 December 2005, in which Doctor 1 stated that he had no recollection of Mrs A being incontinent while an in-patient. He made it clear that he would not normally send patients home if they were incontinent, irrespective of their wishes, and certainly not without a plan of action to help them with this distressing symptom.

35. The Adviser observed that Mrs A was discharged on 3 March 2003, seven days after her surgery. However, the medical case notes made no reference to her clinical condition following an entry dated 28 February 2003, which indicated that she was still on oxygen therapy. The Adviser stated that there was no record of the perforation in the medical notes at that stage, however, he observed that Mrs A had a spiked fever of 38.7C on 28 February 2003 and 38.2C on 2 March 2003. In light of the surgical team's knowledge that she had suffered a rectal perforation, the Adviser was of the opinion that Mrs A should

not have been discharged until more than one recording of a normal temperature had been achieved. In his opinion, the timing of the discharge was unreasonable and contributed to the delay in diagnosing the subsequent abscess.

36. The Adviser recommended that biopsy reports are reviewed urgently after local trans-anal surgery and any full thickness perforation is specifically recorded in the case notes. He stated that patients still in hospital when such results come through should not be discharged until a senior surgeon has reviewed them. If the patient has already been discharged prior to such results being received, the Adviser suggested that they should immediately be reported to the patient's GP and an urgent review of the patient should take place by the surgical team.

(b) Conclusion

37. The advice provided indicated that the timing of the discharge, in light of the surgical team's awareness of the perforation and of Mrs A's spiking fever, was inappropriate and I, therefore, uphold this complaint.

(b) Recommendation

38. The Ombudsman recommends that the Board consider introducing measures to ensure that biopsy results following local trans-anal surgery are reviewed urgently and any full thickness perforation is specifically recorded in the case notes. When such perforations are recorded and the patient is still in hospital, the Board should take steps to ensure that the patient is not discharged until reviewed by a senior surgeon. When any such results are received after a patient has been discharged, these should be reported immediately to the patient's GP and an urgent review by the surgical team should be arranged.

(c) The clinicians involved failed to diagnose an abscess in Mrs A's bowel within a reasonable time-frame

39. Mr A noted in his letter of 9 April 2003 that, following her discharge, Mrs A's pain became so severe that a GP gave her morphine to allow her to rest. However, later that evening, she was still suffering from severe bowel pain and an emergency GP arrived and arranged an ambulance to take her to Accident and Emergency, despite her fear and reluctance to return to the Hospital.

40. Following her re-admission, Mrs A underwent an emergency operation to treat an abscess in her rectum, caused by the perforated bowel. Mr A was advised that Mrs A was very seriously ill and that her condition could have been life-threatening. Mr A was unhappy that the abscess was caused by the February operation and yet was not picked up for five weeks and he questioned why Mrs A was not re-examined prior to being discharged. On commenting on the draft report, Mrs A stated that Mr A had been advised that her condition was life threatening, however, as noted in paragraphs 8 and 9, Doctor 1 did not perceive this to be the case.

41. In her meeting with the Patient Liaison Manager of 24 March 2004, Mrs A advised that, during their prior meeting with Doctor 1, he had confirmed that the original biopsy had clearly shown that the bowel was perforated. Mrs A asked why no further tests were run to establish whether or not she was fit to be discharged.

42. In the Board's response of 5 July 2004, they advised that, in the days following the operation, Mrs A had recovered from her bleeding problems and was recovering at a normal pace. Furthermore, they indicated that her blood tests showed no signs of infection or sepsis, which would have been an early indicator of an abscess. Doctor 1 noted that Mrs A had been keen for discharge and he had been delaying this to allow prolonged observation, as opposed to allowing her home early.

43. As stated in paragraph 15, the Board advised that Doctor 1 had been focussing his efforts on treating the bleeding and he stated that perforations usually settled down without further problems and, as such, they had not given him cause for concern.

44. Ms C reiterated Mrs A's concerns in a letter dated 29 July 2004 and an Independent Review was requested. Doctor 3 advised the Convener that the discharge summary of 5 March 2003 did not indicate any symptoms suggestive of rectal perforation or infection during the course of admission. He stated that it did describe the post-operative complication of bleeding but did not mention rectal perforation.

45. Doctor 3 advised that rectal perforation after trans-anal surgery is a recognised complication which is usually managed without further surgical intervention. He stated that the management of this complication depends on

the patient's general condition and in many cases, no specific treatment measures are necessary. He also stated, however, that knowledge of a perforation is important as it would raise the clinician's suspicions if signs of deterioration occurred and this, in turn, would allow early recognition of potential problems and minimise their impact. Doctor 3 observed that the pathology report of 26 February 2003 clearly indicated that a full thickness perforation of the rectal wall had occurred, however, he was not in possession of the surgical notes and it was, therefore, unclear whether or not the pathology report had been available to the surgical team during Mrs A's admission.

46. The Convener returned this issue for further local resolution and she asked the Board to particularly examine the pathology report of 26 February 2003 to try and establish whether the clinical team were aware of the result, had interpreted it correctly and noted it prior to Mrs A's discharge.

47. In the Board's response of 20 December 2005, they advised that Doctor 1 and his team were fully aware that the pathology report had indicated that Mrs A's bowel had been perforated, however, they felt that the only test necessary during her period of hospitalisation were daily blood tests to monitor for signs of sepsis. Doctor 1 did recall that Mrs A's white blood count had been raised at one point, however, he noted that it had settled back down.

48. Doctor 1 emphasised that perforations of the rectum such as Mrs A experienced are generally treated conservatively and he was of the opinion that drastic procedures, such as performing a colostomy, would not have made any difference to subsequent events. He stated his belief that the reason Mrs A developed a pelvic abscess was that he was required to put a stitch in place because of the bleeding and this may have prevented the perforation healing from the bottom up, as would normally be the case. He believed it to have been a combination of events which led to the abscess forming.

49. Finally, within the Board's response, Doctor 1 recalled that Mrs A had been very keen to be discharged as early as possible due to the concerns she had regarding the cleanliness of the ward.

50. The Adviser noted that there was no record of the perforation anywhere at the time of discharge on 3 March 2003, however, he also noted that the surgical team had been aware of the perforation. He stated his opinion that the timing of Mrs A's discharge was unreasonable and also his belief that this contributed to

the delay in diagnosing her subsequent pelvic abscess. He advised that, had the discharge not taken place and the significance of the spiking fever been recognised, earlier treatment could have been provided and the impact of the sepsis could have been reduced, either by more timely treatment or prevention of the pelvic abscess. He did add, however, that it was not possible to determine retrospectively that this would have been the case or to establish whether the fever that occurred prior to discharge was connected to the subsequent pelvic abscess.

(c) Conclusion

51. This issue seems to link into the previous issue regarding the timing of the discharge, in that it seems to have contributed to the delayed diagnosis of the pelvic abscess. Whilst the Adviser was not able to determine an exact link between the two, it seems reasonable to assume that an earlier diagnosis could have been achieved, had Mrs A remained as an in-patient and her deterioration been observed more closely. In addition, I note that there may also be a link to the lack of information provided to the GP, as a full knowledge of the complications which had occurred may have allowed the GP to intervene sooner and allow an earlier diagnosis to have been reached. As I have accepted the Adviser's advice that the timing of Mrs A's discharge and the communication with the GP were both unreasonable I, therefore, in turn, find the delay in diagnosing her pelvic abscess unreasonable and I uphold this complaint.

(c) Recommendation

52. Whilst I uphold this complaint, I do not make any specific recommendation and I would refer the Board to my earlier recommendations in paragraphs 29 and 38 respectively.

(d) A follow-up appointment was not arranged after Mrs A was discharged

53. During their meeting with the Patient Liaison Manager on 24 March 2004, the question was raised as to why Mrs A never received a follow-up appointment when she was advised, upon discharge, that this would have been the case.

54. In the Board's response of 5 July 2004, they said that the plan on discharge was for Mrs A to be reviewed in two weeks at Doctor 1's clinic. Doctor 1 apologised for the fact that Mrs A did not receive this appointment,

however, he could offer no explanation as to why this happened. The Board noted that the details regarding this arrangement were mentioned in the discharge letter to the GP.

55. In Ms C's letter of 29 July 2004, she stated that Mrs A had been advised by nursing and administration staff that a letter would be forwarded to the GP and an appointment card for the out-patients' clinic would be sent to her with an appointment to be seen within two weeks of her discharge. She said that this was not carried out, noted that Doctor 1 could offer no explanation as to why, and requested that the complaint be taken to an Independent Review.

56. In her response of 8 September 2004, the Convener said that she was asking the Hospital to investigate further why Mrs A did not receive a follow-up appointment, specifically to explain what administrative procedures were in place to ensure such appointments were sent out and why they appeared to have failed in Mrs A's case. In addition, she stated that she would ask whether lessons could be learned from Mrs A's experience to prevent a similar incident recurring.

57. The Surgical Directorate Manager responded to the questions raised by the Convener in a memo dated 22 November 2004 and the contents of this were communicated to Ms C in the Board's response of 25 November 2004. The response advised that the procedure for arranging out-patient clinic appointments, following discharge, involved the doctor instructing the nursing staff when making the decision to discharge, the nursing staff instructing the ward clerk to make the arrangements and the ward clerk arranging the appointment via telephone contact with the Medical Records Department. They said that the subsequent introduction of a new computer system enabled the ward clerk to make the appointment directly.

58. The Board said that there appeared to have been a breakdown of communication in Mrs A's case or an oversight at some stage in the process. They extended sincere apologies for this but stated that, unfortunately, it had not been possible to determine where the fault occurred. They advised that the new computer system simplified the latter stage of the process, however, Mrs A's appointment instructions may not have reached that stage. They stated that the appointment was mentioned in the letter to the GP, however, there is no mention in the nursing notes recorded in the case record. The Surgical

Directorate Manager noted, however, that the instruction to arrange an appointment may not always have been recorded in the nursing notes.

59. The Board further advised that there was a tick-box discharge planning checklist within the nursing notes and, in order to aid communication, guard against oversight and enhance record-keeping, the Surgical Directorate Manager had proposed to the Discharge Planning Manager that a new box for 'clinic appointment' be added to the checklist at the earliest opportunity. I have confirmed with the Board that this proposal was indeed implemented.

60. Within the clinical advice he provided on 15 October 2004, in respect of the request for an Independent Review, Doctor 3 also commented briefly on the failure to arrange a follow-up appointment in relation to the failure to inform the GP of the bowel perforation. He stated that the GP should have been informed of the perforation in the discharge letter, however, had the two week follow-up appointment taken place, some of the subsequent problems that developed may have been avoided.

61. The Adviser noted that the discharge letter of 5 March 2003 stated 'we shall see her back in the clinic in a couple of weeks'. He stated, therefore, that the surgical team had planned a follow-up appointment, but one was not made and this was a clear administrative error.

(d) Conclusion

62. There was an administrative error or oversight or breakdown in communication which caused the proposed follow-up appointment to have been overlooked, however, the Board have been unable to determine exactly where the fault occurred. Whilst this is unfortunate, I do note that the Board consequently implemented a proposal for a new tick-box to be added to the discharge checklist, prompting an out-patient follow-up appointment to be arranged. In addition, they have advised that a new computer system was subsequently adopted and they are hopeful that both these changes will guard against a similar future oversight. In this case, prior to our involvement, the Board have accepted that there were errors, have apologised to Mrs A and have taken reasonable steps to ensure that similar errors do not re-occur. I, therefore, do not uphold this complaint. I do note that the oversight may have effected the timescale for diagnosing Mrs A's abscess, however, this has been addressed in the previous issue.

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

Annex 1

Explanation of abbreviations used

Ms C	The complainant – an advocacy worker representing the aggrieved
Mrs A	The aggrieved
The Hospital	The Royal Alexandra Hospital, Paisley
Doctor 1	Consultant Surgeon who operated on Mrs A on 24 February 2003
The Board	Argyll & Clyde NHS Board (now Greater Glasgow & Clyde NHS Board)
The GP	Mrs A's general practitioner
The Adviser	The surgical adviser to the Ombudsman
Mr A	Husband of the aggrieved
Doctor 2	Consultant Surgeon who met with Mrs A's family on 4 April 2003
Doctor 3	Consultant Surgeon who provided clinical advice in respect of the request for an Independent Review
The Convener	The Independent Lay Complaints Convener appointed to consider the request for an Independent Review

Annex 2

Glossary of terms

Apyrexial	Without fever
Colostomy	Surgical construction of an artificial anus between the colon (large intestine) and the surface of the abdomen
Endoscopic laser ablation	Removing of internal biological tissue using a laser
Fulguration using diathermy	Localised tissue burning using a high frequency electric current
Independent Review	Former second stage of previous NHS complaints process
Laparotomy	Surgical incision through the abdominal wall
Polyp	An abnormal growth of tissue
Rectal abscess	An accumulation of pus in the rectal area