Case 200501277: Lothian NHS Board

Summary of Investigation

Category
Health: Hospital; diagnosis and Accident and Emergency

Overview
The complainant, Ms C, complained that she was given conflicting information regarding the diagnosis of her condition and the need for her to have an operation. Ms C made a further complaint about what happened when she attended the Accident and Emergency department (the Department).

Specific complaints and conclusions
The complaints which have been investigated are that:

(a) between December 2004 and June 2005, Ms C was given conflicting information regarding her diagnosis and treatment (*upheld*); and

(b) Ms C was not treated in a reasonable manner when she attended the Department on 4 June 2005 (*not upheld*).

Redress and recommendations
The Ombudsman recommends that the Board:

(i) apologise to Ms C for the shortcomings identified in this report;

(ii) consider offering Ms C further clinical investigation, including imaging of the biliary tract, under the care of a consultant not previously involved with her care, that they liaise with the psychiatric team who provide support for Ms C;

(iii) share a copy of this report with Consultant 1; and

(iv) ensure that there are appropriate procedures for safe storage, filing and tracking of clinical notes in the Department, to ensure they are available for retrieval and reference in future. She asks that the Board notify her of the action taken in this regard.

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

Main Investigation Report

Introduction

1. Ms C complained to Lothian NHS Board (the Board) on 27 April 2005 about the confusion surrounding her diagnosis and proposed treatment for gallstones. The General Manager wrote to Ms C on 8 June 2005 and apologised for conflicting advice being given. Ms C continued to have symptoms and attended the Accident and Emergency department (the Department) on 4 June 2005 with abdominal pain and rectal bleeding. However, after being seen by a doctor, the police were called and Ms C was removed from the Department. Ms C subsequently complained to the Ombudsman.

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

    1. between December 2004 and June 2005, Ms C was given conflicting information regarding her diagnosis and treatment; and
    1. Ms C was not treated in a reasonable manner when she attended the Department on 4 June 2005.

Investigation

3. In order to investigate this complaint I have had access to Ms C's hospital records and the correspondence relating to the complaint. I have made enquiries of the Board and corresponded with Ms C. I have received advice from three advisers, a hospital consultant (Adviser 1), a consultant in Emergency Medicine (Adviser 2) and a nursing adviser (Adviser 3). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) Between December 2004 and June 2005, Ms C was given conflicting information regarding her diagnosis and treatment

4. Ms C was referred by her GP to a consultant general surgeon (Consultant 1) on 14 December 2004, with symptoms of abdominal pain and nausea. In his letter, the GP also said that Ms C had 'documented gallstones on ultrasound' and listed her medical and psychiatric history. Ms C's GP asked that Ms C be seen quickly, as she had already waited to be seen by another hospital who decided that she should be referred to Consultant 1. Ms C was seen by Consultant 1 on 15 February 2005 who agreed that her symptoms were consistent with gallstones and listed her for an urgent surgical treatment

(cholecystomy or removal of the gall bladder). Ms C, however, consulted a second consultant, an upper gastrointestinal tract surgeon (Consultant 2) to obtain a second, private opinion. Consultant 2 wrote to Ms C on 16 March 2005 stating that he could not find any scan showing gallstones in her records. Since her liver function tests were normal he did not recommend cholecystomy. Ms C contacted Consultant 1 to cancel her operation.

5. Consultant 1 saw Ms C again in out-patients on 8 June 2005 following which he wrote to her GP. He said that Ms C was demanding that she have a cholecystomy but he did not think that was appropriate because of the combination of Ms C's psychiatric illness and the dispute over her ultrasound findings.

6. Ms C subsequently changed her GP, who re-referred her to Consultant 1 by letter of 10 June 2005 because of further abdominal pain and her continuing concerns about her gallbladder. Consultant 1 wrote to Ms C's new GP on 6 July 2005. He stated that his reasons for not wishing to proceed with the operation were a lack of definite clinical and radiological evidence of symptomatic gallstone disease, problems with previously trying to admit Ms C for gallbladder surgery and the fact that Ms C had formally complained about him. Ms C considered that she was being denied appropriate care because of her psychiatric history.

7. Adviser 1 said that he had fully and carefully reviewed the clinical notes, reports, investigations and the clinical and complaint correspondence. Adviser 1 said that the standard of clinical record-keeping and clinical correspondence is entirely appropriate. Adviser 1 said that the entries in the clinical record of relevance were:

- report of an ultrasound examination on 12 October 2004 which reported that there was no intrahepatic duct dilation and the common bile duct was normal in calibre. The gallbladder contained several small calculi but there was no gallbladder wall thickening;
- abnormalities in the 2003 liver function tests consistent with biliary tract disease. Adviser 1 said that the abnormalities consisted of a minor rise in alkaline phosphatase and GGT [Gamma-glutamyl transferase = test which helps to detect liver disease and bile duct injury]. Adviser 1 said that these enzymes are normally present in a low level in the blood but at increased levels when the flow of bile is impaired, for example, by a gallstone. Although the enzymes could be increased by certain drugs e.g. phenelzine

Adviser 1 considered that the fact that Ms C was still taking phenelzine after the enzymes had returned to normal implied that the drug was not the cause;

- correspondence from the Specialist Registrar in the Psychiatric Team dated 9 July 2003 and 24 September 2003.

8. With regard to Ms C's psychiatric history, Adviser 1 said that there is no measure of 'normal behaviour' since that would vary with circumstances or perceived circumstances. The best predictor of behaviour is how an individual has behaved previously. According to the psychiatric correspondence, Ms C has had episodes of depression and is of an anxious disposition. She is anxious and agitated about her medical care. Throughout her life she has attended a number of doctors for second and third opinions. Ms C took medication in a chaotic fashion. Adviser 1 said that these comments are all contained in Ms C's clinical records over a year before her referral to Consultant 1. Adviser 1 said that Ms C's behaviour following her diagnosis and listing for cholecystomy was consistent with her previous behaviour and, to an extent, predictable. Adviser 1 said that such behaviour was normal for Ms C.

9. Adviser 1 said that a complaint against a doctor is, of itself, insufficient grounds to deny any required treatment. If, however, the professional relationship has broken down, then referral to another consultant is the appropriate course of action. Adviser 1 said that the presence of any psychiatric disorder is peripheral to Ms C's physical management and, although her behaviour may be irritating or exasperating, that should not be allowed to interfere with her standard of care.

10. Adviser 1 went on to comment that Consultant 2 was wrong in his assertion that there was no report indicating the presence of gallstones (see paragraph 7(a)). The abdominal ultrasound carried out on 12 October 2004 was reported as showing several small calculi (stones) within the gallbladder. Adviser 1 said that report may now be of limited value as, being small, these gallstones may have passed spontaneously. However, once the gallbladder has demonstrated its ability to form stones, further stones are likely to recur. Ms C should, therefore, have been offered further clinical investigation, including imaging of the biliary tract, as there was insufficient data in the available clinical records to allow a robust assessment of the significance of Ms C's previously abnormal liver function tests.

(a) Conclusion

11. It appears that there certainly was confusion about whether or not Ms C had gallstones or required to have her gallbladder removed. The advice I have received, however, is that based on the clinical records there was evidence of the presence of gallstones and that, while these may have passed spontaneously, Ms C should have been offered further clinical investigation. However, this was not arranged by Consultant 1 when he saw Ms C at his clinic. Although the Board apologised in the letter of 8 June 2005, no action appears to have been taken to clarify the position for Ms C who, therefore, remained anxious as she continued to have symptoms. I uphold this complaint.

(a) Recommendation

12. The Ombudsman recommends that the Board apologise to Ms C and consider offering her a further clinical assessment, including imaging of the biliary tract, under the care of a consultant not previously involved with her care, and that they liaise with the psychiatric team who provide support for Ms C. The Ombudsman also recommends that the Board share this report with Consultant 1 so that he is aware of the advice we have received.

(b) Ms C was not treated in a reasonable manner when she attended the Department on 4 June 2005

13. Ms C said that, despite presenting at the Department with a 'bleeding bowel' and asking to see a psychiatrist, she was forcibly removed from the Department by the police and taken into custody. She was later released on bail to appear at the Sheriff Court but the Procurator Fiscal declined to take further action and the case was dismissed.

14. In response to her complaint, the General Manager wrote to her on 7 July 2005. He said that he understood that Ms C was a 'regular attendee' to the Department and the majority of her attendances involved the abdominal symptoms she experienced in relation to her gallbladder. He said he realised that it was difficult for Ms C if she was nauseous and in discomfort to appreciate that the Department was for acute emergency situations and could not deal adequately with her symptoms. On 4 June 2005 she was assessed by a doctor within the Department and told she could go home. It was not possible to keep all patients within the Department who were considered fit for discharge. The General Manager said that Ms C refused to leave and became argumentative and, as her behaviour was upsetting other patients, the Charge Nurse had no option but to inform security and the police. In a further response on 30 August

2005, the General Manager said that there was no record of Ms C asking to see a psychiatrist.

15. Adviser 2 said that the only clinical record relating to this incident was a typed sheet, which stated that Ms C arrived at 02:12 on 4 June 2005 by emergency ambulance. It noted her previous medical and psychiatric history and frequent attendances at the Department. It also noted that there was a letter from Consultant 2 stating that she did not have any biliary colic (pain caused by gallstones) and did not need cholecysectomy. Adviser 2 said this implied that the Department doctor must have had access to Ms C's clinical notes. Ms C's presenting complaints were listed as abdominal pain, bleeding from the rectum, nausea, abdominal swelling, increased weight and decreased appetite, and that all have been present for a number of months. On examination, Ms C was found to be in a stable condition and bloods were tested, although it was not noted what for, and were reported to be largely normal except for an isolated liver enzyme. The management plan was to refer Ms C back to her GP for ongoing investigation and she was discharged. Adviser 2 said that he would have expected there to be a full nursing assessment and some observations, along with full notes on which investigations were done and doctor's notes. Adviser 2 would also have expected the communication and circumstances surrounding the summoning of the police and Ms C's removal to be documented. The document in the clinical notes appeared to be no more than a summary of the type that might be sent to the patient's GP.

16. I asked NHS Lothian if they had any other documents relating to this incident. The Chief Operating Officer replied that Ms C's patient notes regarding this attendance were missing but they would try to find them. He confirmed that the document Adviser 2 had was the GP summary. He enclosed copies of the haematology and biochemical results. The Chief Operating Officer agreed that these documents would not be an adequate record of Ms C's attendance if that was all there was. It was unfortunate the others were missing. It was only following the issue of the draft report that the missing records were found and the Board sent a copy to me along with a statement from the Charge Nurse on duty that night and the Incident Report by the Security Officer.

17. Adviser 2 said that the records disclosed that Ms C arrived at the hospital at 02:12. Her observations were normal and the nurse noted that there was 'no

sign of PR blood'. Further nursing notes record repeated observations at 03:00. Adviser 2 said that Ms C's history is noted briefly. Ms C was examined and blood results noted which show no cause for concern. The conclusion was that Ms C's problems had been present for a number of months. The plan was to refer Ms C back to her GP as she possibly needed an ultrasound scan and follow up for melanoma. Adviser 2 said that there is no mention in either the nursing or the medical notes of a request to see a psychiatrist. Adviser 2 said that the clinical records showed that Ms C's assessment in the Department was reasonable. Adviser 2 said that in the absence of any signs of shock, obvious signs of blood loss, severe pain or anaemia it was appropriate to refer Ms C back to her GP. Adviser 2 considered that the discharge letter to Ms C's GP was very helpful and complete. Adviser 2 said that there is no evidence in the notes that a psychiatrist was requested or felt to be necessary. Ms C's presentation throughout had been for clinical, not psychiatric, symptoms. Adviser 2 said that the records concluded with at 06:30 with a note that Ms C refused to leave the Department after she had been cleared for discharge by the doctor but did not say anything about the police being called.

18. The statement from the Charge Nurse said that Ms C was told that she need not come into hospital and could go home but she refused to leave the premises. Security had been called. The Security Officer reported that he was called to attend to a patient who was refusing to leave the Department. Ms C was pointed out to him and he had spoken to her but she was adamant that she was not going to leave. The Security Officer had, therefore, asked his control to call the police. The Security Officer waited with Ms C until the police arrived at 07:01. The police took Ms C from the site at 7:05.

19. Adviser 3 said that the Department is the busiest in Scotland and regularly sees more than 300 people in 24 hours. It does not have the capacity to accommodate patients who have been treated and discharged. In addition, security is an increasingly important issue in all Accident and Emergency departments with the emphasis on making sure that only those people who require to be in the building are present. It is, therefore, reasonable for the Department to take steps to have patients who have been discharged, but who refuse to leave, removed from the building.

(b) Conclusion

20. Having read the medical and nursing notes relating to Ms C's attendance at the Department Adviser 2 is satisfied that Ms C's condition was assessed in a

reasonable manner. Adviser 2 said that having established that Ms C's symptoms had been present for some time and did not amount to a medical emergency it was appropriate for Ms C to be discharged back to the care of her GP. Adviser 2 said that there is no evidence in the notes that Ms C asked for a psychiatrist or that the medical staff attending to Ms C considered that referral to a psychiatrist was necessary. When Ms C refused to leave following discharge Adviser 3 said that it was reasonable for steps to be taken to remove her. I require to be guided by the advice I have been given and having considered the matter I do not uphold this complaint. I am, however, very critical of the loss, albeit temporary, of Ms C's patient notes and that no explanation has been given for this. The Ombudsman, therefore, has the following recommendation to make.

(b) Recommendation

21. The Ombudsman recommends that the Board apologies to Mr C and ensure that there are appropriate procedures for safe storage, filing and tracking of clinical notes in the Department, to ensure they are available for retrieval and reference in future. She asks that the Board notify her of the action taken in this regard.

22. 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
The Board	Lothian NHS Board
The Department	The Accident and Emergency Department, Royal Infirmary of Edinburgh
Adviser 1	Adviser to the Ombudsman, who is a hospital consultant
Adviser 2	Adviser to the Ombudsman, who is a consultant in Emergency Medicine
Adviser 3	A Nursing Adviser to the Ombudsman
Consultant 1	The consultant general surgeon
Consultant 2	The consultant upper GI (gastrointestinal tract) surgeon
GGT	Gamma-glutamyl transferase

Annex 2

Glossary of terms

Biliary tract	Refers to the bile ducts within the liver
Cholecystomy	Removal of the gall bladder
Enzyme	Catalyst for a biochemical reaction
Gallstones	Deposits which occur when bile, which is normally fluid, forms stones
Intrahepatic duct dilation	Narrowing of the bile duct within the liver
Phenelzine	An anti-depressant
Gamma-glutamyl transferase (GGT)	Test which helps to detect liver disease and bile duct injury]