The investigation of a complaint by Mrs A against Betsi Cadwaladr University Health Board

A report by the Public Services Ombudsman for Wales

Case: 201101271

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs A and her late father as Mr Y.

Summary

Mrs A complained about the care given to her late father, Mr Y, when a patient at Glan Clwyd hospital in 2009. She said that there were delays in his diagnosis and treatment. Sadly Mr Y died on 7 November 2009 following extensive surgery to drain a perianal abscess and treat the quickly progressing and very serious infection which developed.

The Ombudsman upheld Mrs A's complaint. He found that delay in diagnosis and in carrying out surgery were significant factors in Mr Y's death. His main findings were:

- lack of review by a consultant urologist
- failure by doctors to record consistently and act upon significant test results to review the initial diagnosis
- poor communication between medical staff and with the family. There were missed opportunities to obtain information from the family, given that Mr Y had Alzheimer's disease and communication difficulties
- no overall plan of nursing care for Mr Y and a failure to reassess as his condition deteriorated
- a criticism of the decision not to carry out surgery late at night and the lack of direct dialogue between the consultant anaesthetist and consultant surgeon.

The Health Board agreed to make a payment of £3,000 for the trauma caused to the family for the distressing way in which Mr Y died and the knowledge that the delays contributed to the sad outcome. The Ombudsman made a range of recommendations for the review of procedures, audit and training His recommendations were accepted by the University Health Board.

The complaint

1. Mrs A complained to me about poor clinical and nursing care given to her late father, Mr Y, following his admission to Glan Clwyd hospital. Mr Y was elderly, suffered with COPD[1] and Alzheimer's disease[2] and had difficulties communicating. He was admitted on 22 October 2009 with urinary retention[3] and sadly died on 7 November 2009, following surgery to drain a perianal abscess.[4] The main issues she raised were:

- delay in diagnosing her father's abscess and in referring to a surgeon following the abscess being spotted. (She said that there was poor nursing and medical care, lack of access to a consultant and not enough communication with the family.)
- delay and no sense of urgency in carrying out surgery following a possible diagnosis of necrotising fasciitis[5]. (She said that there was poor decision- making relating to the timing of the surgery and an over reliance on junior anaesthetists and surgeons.)
- the Health Board's delayed response following the Independent Review Panel and report.

Investigation

2. I obtained copies of relevant documents from Betsi Cadwaladr University Health Board ('the UHB') and considered those together with the evidence provided by Mrs A. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked. Independent professional advice was also obtained from clinical advisers: my nursing adviser, Jane Young, who is an experienced ward sister, with many years

[1] Chronic obstructive pulmonary disease – a disease of the lungs in which the airway becomes narrowed.
[2] A form of dementia.
[3] The inability to pass water.
[4] Infection of the soft tissues surrounding the anal canal.
[5] Quickly progressing and extremely serious type of spreading infection, commonly known as the 'flesh eating' disease.

experience in a large teaching hospital and Patricia Durning a Consultant General Surgeon with many years experience of the management of the conditions referred to in this report.

3. Both Mrs A and the UHB were given an opportunity to comment on a draft of this report. Their comments have been taken into account in completing the report and finalising the conclusions.

The background events

4. Mr Y visited his GP on 21 October 2009 complaining of a sore bottom. (Mrs A said that her father was well enough to travel to the surgery by bus.) During the examination her mother noted a red lump on his left buttock. He was unable to provide a urine sample. He returned to the surgery the following day and was admitted to Glan Clwyd hospital because he was still unable to pass water. The referral from the GP said that Mr Y had not passed water since the day before and had an 'enlarged urinary bladder'. He queried 'recurrence of bladder growth causing obstruction'. (Mr Y had a past history of prostatectomy[6] and bladder cancer. He was attending annual checkups). My surgical adviser says that the hospital admission notes were extremely poor and there was no recording of Mr Y's basic vital signs or that a rectal examination[7] was performed. There was however a good action plan following admission for various tests and investigations to be done, including stool samples and a bladder scan. The medical notes following admission to the urology ward said that the bladder seemed full, with tenderness in the groins and that Mr Y had had loose stools for the last few days. Mr Y was catheterised.

[6] Surgery to remove all or part of the prostate gland.

[7] Examination of the back passage which is carried out where there are changes in bowel habit or to check changes in the prostate.

5. The nursing assessment for that day recorded that Mr Y had pain in his bottom/rectum and retention, but did not document the reason for the pain. There is no evidence that further investigations were carried out by nursing staff, to establish the source of Mr Y's pain.

6. The nursing notes for later the following day - 23 October 2009 – said that Mr Y was not feeling well and was sweating. A raised temperature was recorded and antibiotics were started. Another nursing note said that Mr Y was seen that evening by the consultant but there is no reference to this in the medical notes. Test results were normal except the white blood cell count was raised at 17.8 and a raised CRP[8] was underlined in the laboratory report on Mr Y's blood tests.

7. On 24 October 2009 Mr Y was seen by the registrar and a note was made that his temperature was settling slowly but was still not back to normal. An additional antibiotic was prescribed if needed. A nursing note said that the left side of Mr Y's sacrum (his buttock) was red and he was nursed on a special bed, to reduce the risk of pressure sores.

8. Another note, added to the original medical notes for that day, said that a digital rectal examination had been carried out on 24 October 2009 and a small benign feeling prostate was felt. A further explanatory note said that this had not been entered onto the record until 6 November 2009.

9. My surgical adviser pointed out that no reason was recorded in the medical notes as to why Mr Y was prescribed antibiotics nor was there any record of the urine test result or microbiology report

[8] A protein in the blood which indicates inflammation.

requested or further white cell count. Test results dated 24 October 2009 from a urine sample taken on admission showed no evidence of infection.

10. Early morning on 25 October 2009, Mr Y was reviewed following a fall. He was noted as not complaining of pain but there was superficial abrasion of the skin. His temperature was still elevated and another antibiotic was to be started if it persisted.

11. Mr Y had a second fall early on 26 October 2009. He was complaining of back pain and was seen by a doctor. His white cell count was still raised at 17.8. A referral was made to the Care of the Elderly specialist. Mrs A said that she had been on holidays until then and visited her father that evening. She said that he was unshaven and she was upset about his dishevelled appearance and overall deterioration. She asked nurses if her father could be shaved and washed. She offered to be present during the medical round because of her father's inability to answer questions fully but was told by nursing staff that it was not necessary.

12. The following day Mr Y was noted as not feeling well but unable to specify his complaint. The notes also indicated that he had been very aggressive during the night. Plans to discharge him had started and a bed in another hospital had been requested.

13. On 28 October 2009 Mr Y was seen by the Care of the Elderly consultant. He noted that Mr Y was uncomfortable when sitting and requested that the pressure areas should be checked. But there is no record that any physical examination was carried out. Test results showed a raised white blood cell count of 32.1 but this was not addressed in the medical notes.

14. When Mrs A visited that day, she said that her father was lying exposed on the bed. He was complaining that his bottom and legs

were hurting. Because of his rapid deterioration she asked to see a consultant. After telephoning the consultant's secretary she was referred back to the ward staff.

15. On 29 October 2009, Mr Y was said to be comfortable and waiting for transfer to another hospital. Bloods and urine were to be checked. The nursing note early that morning said that Mr Y had spent a very disturbed night and had been calling out. Cream had been applied to Mr Y's bottom – the gluteal cleft[9], which was reddened. A nursing note later that day said that Mr Y had a very sore buttock on the left side. Cream had been re-applied, but it needed to be looked at by medics.

16. Mrs A said that she saw a doctor that day who said that her father had an enlarged prostate and his bladder was not functioning normally. There is no note of this meeting. Mrs A said that she was given the impression she was speaking to the consultant but later discovered this was not the case. Mr Y's white cell count was still elevated at 29.6 but there was no entry in the records to suggest this was seen or acted upon.

17. A brief note in the medical records for 30 October 2009 said that Mr Y was comfortable. Results for blood tests and urinary culture were to be chased. A nursing note at 11:30am said that an abscess had burst on Mr Y's buttock and there was a 'tracking area' to his left thigh. The medical team was to review Mr Y later. Mr Y was started on antibiotics by mouth.

18. On the morning of 31 October 2009 Mr Y was seen by a doctor who noted a "perianal abscess discharging pus". This was confirmed by the General Surgical Registrar at 10 am. He did a rectal

[9] The groove between the buttocks.

examination and found a tender area of induration[10] around the anus and the left groin. Mr Y was treated with antibiotics. The plan was for surgery. The nursing notes show that Mr Y was 'check listed and prepared for theatre.' When the family visited that night Mrs A said that a red rash was spreading up the left side of her father's back.

19. The next note in the record is just after midnight on 1 November 2009 when Mr Y was reviewed for theatre by the on-call junior anaesthetist. His view was that because of Mr Y's condition and his high anaesthetic risk, he was not an appropriate case for surgery at that time. He noted that if the surgical team felt Mr Y needed to go to surgery the surgical consultant should contact the anaesthetics consultant. Mr Y's white cell count was 26.5.

20. The next note is out of order in the record and was for 9pm on 31 October 2009 when Mr Y had been seen by a second surgical registrar. He noted and underlined as important that there was perianal sepsis extending into the left groin, involving the scrotum and lower left quadrant of the abdomen. There was possibly necrotising infection.[11] The plan was still to surgically remove the infected tissue. Antibiotics were to be continued. There is no evidence that this note was seen by the on-call junior anaesthetist when he made the above decision, but in a later note at 30 minutes past midnight the second surgical registrar noted that he had explained the severe nature of the sepsis to the junior anaesthetist and that there was a need for surgery at whatever time of night. The surgical registrar noted that he told the surgical consultant at 1am that he was unable to do the surgery because of the view of the anaesthetics team. The team wanted the consultant surgeon to speak to the consultant anaesthetist. The consultant surgeon advised the surgical registrar that he should operate in the morning as a first case.

[10] The hardening of tissue which can occur when tissue is infected.
[11] Quickly progressing and extremely serious type of spreading infection.

21. The nursing notes for early hours on 1 November 2009 record a foul smelling discharge from Mr Y's sacral area[12]. Mr Y's surgery started at 1:12 pm on 1 November and he was transferred to the Intensive Care Unit immediately following his operation. The notes say that Mr Y had been treated for Fournier's gangrene[13] : an abscess leading to necrotising fasciitis had been found and more extensive surgery was required than originally thought. Infected tissue had been removed from the scrotum, left groin, abdominal wall, thigh and buttock. Mrs A said that the family were told that Mr Y was not expected to survive because of the extent of the wound and the risk of further infection.

22. Sadly Mr Y did not recover and he passed away on 7 November 2009.

23. Mrs A wrote to the UHB on 18 February 2010. The UHB in its response on 21 April 2010 acknowledged that with the benefit of hindsight Mr Y's urinary retention was caused by the development of the abscess. It said that opportunities were missed to diagnose Mr Y's condition and apologised for the delay in making the right diagnosis. It also said there were shortcomings in dealing with Mr Y's hygiene and personal needs and recognised the need to raise awareness among nursing staff when dealing with the needs of patients with dementia.

24. Mrs A remained dissatisfied and asked for a review of her complaint. An Independent Review Panel was held on 22 November 2010. The Panel's report, dated 12 January 2011, said that there were fundamental organisational and clinical management weaknesses between the urologists, the general surgeons and the

[12] Lower part of the back below the spine.
[13] A specific form of necrotising faciitis which affects the male genital area and perineum.

anaesthetists. It recommended that the UHB carry out an urgent review. The serious shortcomings highlighted were that:

- the initial clinical assessment was inadequate;
- there were missed opportunities to review the original diagnosis of urinary retention and infection and the raised white blood cell count was not acted upon;
- there was a lack of consultant urologist review of emergency admissions;
- nurses had not adequately expressed their concerns, noted from 30 October, to medical staff;
- the case was not referred to surgeons until the morning of Saturday 31 October and not drawn to the anaesthetist's attention until later that day
- the surgical registrar on call did not discuss the case with the consultant general surgeon
- the nine day delay in diagnosing the perianal abscess meant that the opportunity to treat Mr Y was lost and
- there were missed opportunities by clinicians to learn lessons by discussing the case at clinical meetings following Mr Y's death.

25. Mrs A said they were told to expect a response to the Panel's report within 20 days but there was a delay before the UHB replied, which made matters worse.

26. The Complaints Manager wrote apologising on 22 March 2010 that the report had not been acknowledged and enclosed an action plan. Clinical staff met and carried out a Clinical Incident Review. They agreed that there were significant failings and accepted the Panel's report. The family met with staff on 17 June 2011 to discuss the action taken in response to the report. There is no note of this meeting. Mrs A remained dissatisfied and complained to me.

27. The UHB drew up a robust supplementary action plan following the Clinical Incident Review. This included random checks of the standard of documentation in case notes, monitoring of the management of blood results by junior doctors and audits of rectal examinations. I have seen no evidence that these were carried out.

Related Ombudsman's Investigations and the UHB's response

28. I have previously raised my concerns about care at Glan Clwyd hospital. I issued a number of reports including one in February 2011 (Case Reference 2260/200900780) relating to a patient's care in 2008. The UHB responded to this by carrying out its own investigation and initiated a number of improvements. It also invited an external review of the standard of care at Glan Clwyd hospital. I am aware that a number of measures have been introduced since the time of the events mentioned in this report (2009), including the introduction of matrons on the wards and I welcome the progress which has been made.

Professional Advice

What the nursing adviser had to say

29. My nursing adviser says that record keeping was inadequate. She has stressed the importance of good record keeping for safe and effective care as quoted in relevant national guidance.[14] She said that on admission several appropriate risk assessments and evaluations had been performed for nutrition, pressure ulcer risk, bed rails risk and patient handling but there is no evidence that these were reassessed as Mr Y's clinical condition changed. Specifically about nutrition and hydration, she said that food charts were started on 27 October 2009, without any explanation but were not helpful because they were not completed. Also, overall she said fluid balance charts were poorly recorded with large gaps in time or no recording for parts of the day.

[14] Nursing and Midwifery Council guidelines on Record Keeping 2009.

30. In relation to Mr Y's specific needs she said that the initial nursing assessment had identified that he had pain in his "bottom/rectum". But there was no evidence that any further investigation was done by nurses or that this was reported to medical staff. Mr Y suffered from dementia, with communication difficulties and would have relied on nursing staff to investigate the cause of the pain, if no diagnosis was available. He was in a high risk group for the development of pressure ulcers and although an initial assessment was done, when he was found to be at low risk, there was no further assessment or reassessment undertaken during his ward admission. This was despite reference in the nursing notes to concerns about the skin integrity of his sacrum on two occasions. In particular she said there was no evidence that medical staff were informed of the concern about Mr Y's sacrum on 29 October 2009 and even after the abscess burst the following day, there was still no evidence of pressure area management.

31. She concluded that the documentary evidence did not show that Mr Y had been given a level of nursing care that met his specific needs. While the initial assessments were of an average standard there were no further reassessments undertaken and the evaluation did not identify that the nursing care needs of Mr Y had been met. Also, there was no plan of care to meet his needs in line with national guidance[15] and the documentation that was available was of poor quality and incomplete.

What the surgical adviser had to say.

Delay in diagnosis

32. The surgical adviser said that she broadly agrees with the findings at Independent Review. Specifically she said that Mr Y's admission notes were poor and there was no recording of basic vital

[15] Welsh Assembly Government 2003. Fundamentals of Care: Guidance to improve the quality of fundamental aspects of health and social care for adults.

signs or that a rectal examination was carried out. She said that it should have been recognised that perianal pain and perianal abscess can cause difficulties in passing water and should have been considered as possible causes. Instead she said the GP's suggestion that Mr Y's bladder cancer may have recurred was accepted without question and hospital doctors did not look beyond this. There were shortcomings in record keeping, for example records of temperature or blood test results (showing an elevated white cell count) were not consistently recorded in the medical notes. There was no note of a provisional diagnosis and no record as to why Mr Y was being treated with antibiotics. Also, a record (for 24 October 2009) that a rectal examination was carried out was not entered in the medical notes until 6 November 2009, the day before Mr Y died. She said that this was not good medical practice and raised the issue of probity. She has stressed that medical records are legal documents which should not be changed.

33. She stressed the importance of good communication with the family, especially because Mr Y had Alzheimer's disease. But she said there was little communication with the family. She said that there was little evidence that Mr Y was seen by a consultant urologist and the absence of consultant cover for emergency cases was highlighted at Independent Review. She has commented that doctors who initiate investigations have a responsibility to recover the results and sign them off or record them in some way, which should be incorporated in the training for junior doctors. There is little evidence she said, from either medical or nursing notes, that Mr Y's perineum or buttocks were examined at all (except for the one record in the nursing notes for 24 October 2009). All efforts she said were towards discharge and care of the elderly. Mr Y had been seen by the consultant for Care of the Elderly, who noted his distress but still no examination was carried out.

34. She said that Mr Y died following treatment for Fournier's Gangrene which is an extremely serious type of spreading infection. In her view the failure to diagnose perineal sepsis from 22 October 2009 to 30 October 2009 was highly significant.

Delay in carrying out surgery

35. The surgical adviser said that there was subsequent delay in surgical treatment which was highly significant because of the nature of the infection which is a particularly virulent spreading gangrene. The treatment was for the surgical removal of all affected tissues back to healthy tissue, with appropriate antibiotics, fluid and treatment for shock. In her view the delay from 10am on 31 October 2009 until 1:12pm on 1 November 2009 (when the operation started) i.e. twenty six and a half hours, was inappropriate and responsible for the extent of the surgery and ongoing septic complications.

36. She referred to guidelines in place that non life threatening surgery should not take place after midnight. Drainage of an abscess would not normally qualify as life threatening surgery. She has also referred to the debate between junior staff about when the operation should have been carried out. The first surgical registrar had not recognised the abscess as potentially necrotising fasciitis. At 11pm the junior anaesthetist was not informed that necrotising fasciitis was the suspected diagnosis and felt that it was not appropriate to carry out the operation late at night because of Mr Y's condition.

37. She said that the advice by the consultant surgeon to defer the operation and do it the following morning was not appropriate and in her view the case should have proceeded. She said that the overall responsibility was with the consultant surgeon and consultant anaesthetist and at the very least consultant to consultant contact should have taken place. She said that she has not seen any record that Mr Y was seen by a consultant before he went to theatre, except the Care of the Elderly physician.

38. Overall, she said that the misdiagnosis and subsequent delays were a significant factor in Mr Y's death. Mr Y's other illnesses and age were also significant and meant that he was less able to deal with the final stress of such a severe infection and extensive surgery. She has referred to a relevant case report[16] which concluded that the overall mortality for Fournier's Gangrene (normally 40%) is increased significantly to 75% where the infection has spread to a lower limb or anterior abdominal wall, as in Mr Y's case.

39. In her opinion from her personal experience the extent of the surgery is directly proportional to the area that the necrotising fasciitis has spread to, and therefore the virulence of the organism and delay in carrying out the surgery were all relevant.

Analysis and conclusions

40. Mrs A complained about the series of delays in diagnosing and treating her late father which she and the family believe resulted in his death. They remain distressed by the way in which he died following extensive surgery, which they feel could have been avoided had his abscess been treated promptly.

41. My investigation of Mrs A's complaint has confirmed significant shortcomings in both Mr Y's medical and nursing care. As with so many of the complaints I see there was poor communication between doctors, and between doctors and nurses, within the same team when Mr Y was on the urology ward. There was also poor communication with the family. It is of particular concern that Mrs A's offer to speak to doctors, because of her father's condition, was turned down. Had the family been more closely involved it is possible that Mr Y's abscess would have been diagnosed sooner. Overall the failings in communication hindered a prompt diagnosis. Also clinical

[16] 'Usefulness of Fournier's Gangrene severity index – a comparative study' by Gutierrez – Ochoa, Jet al.

judgement was not helped by poor recording in both the medical and nursing notes. Following diagnosis, the dialogue between the surgeons and anaesthetists when debating whether surgery should be carried out in the early hours of the morning was also inadequate. I set out below my reasons for reaching my findings and the implication that the failings had for Mr Y and the family.

42. My surgical adviser has highlighted that doctors seemed to accept without question the diagnosis suggested by the GP relating to Mr Y's history of prostate and bladder cancer. The inability to pass water can be caused by a number of conditions including the type of abscess which Mr Y had but there is no reliable evidence that a rectal examination, which should have been prompted by his symptoms, was carried out either on admission or on the ward, until it was done by the surgical registrar on 31 October 2009. I do not regard the retrospective note squeezed into the record for 24 October (but not entered until 6 November, the day before Mr Y's death) as reliable. I accept that it may not always be possible to write up notes immediately when on a busy ward. But notes should be written up as soon as possible after the examination carried out. While it was clearly stated that the entry was late the delay (almost two weeks) in making this recording was unacceptable and throws doubt on whether the examination was carried out at all and the findings.

43. Based on what my surgical adviser said there were further shortcomings in that test results were not recorded consistently throughout the medical notes. Significant results such as blood test results (the raised white cell count), raised temperature and raised CRP- all indicators of inflammation - were not always documented in the notes. There was no evidence that test results were reviewed on handover between shifts on the ward or at the end of the day, as they should have been, or that the appropriate action was taken. My adviser has highlighted that there was no recorded explanation for Mr Y's treatment with antibiotics. In fact there was no clear picture of a

working diagnosis from the case notes, other than a suggestion of a general assumption that Mr Y's bladder cancer had recurred and/or a urine infection. A negative urine test result and the test results mentioned above did not prompt a review.

44. I agree with my adviser that there is little evidence to suggest that Mr Y was seen by a consultant urologist. The opportunity for review by a senior clinician was therefore missed. I agree with both her and the clinicians at Independent Review that there was a lack of consultant urologist review of Mr Y, as an emergency admission, which is something that the UHB should address.

45. I am also concerned that Mr Y had communication difficulties because of his dementia and it is evident that he had problems expressing the source of his discomfort. The medical note for 27 October 2009 confirmed this. But there was poor communication with the family, both in order to obtain information from them and in keeping them up to date with Mr Y's treatment. Mrs A recalls meeting with someone, who she believed at the time, was the consultant but there is no record in the medical notes of this meeting, who it was with or what was said.

46. I am concerned also by the failings identified in nursing care. My nursing adviser has highlighted that fundamentally there was no overall plan of care to meet Mr Y's needs. I agree with her view that while a number of adequate assessments were carried out, these were not reviewed as Mr Y's condition deteriorated. It is of particular concern that the assessment relating to his skin integrity was not upgraded following concerns about the skin integrity of his bottom on 24 and 29 October 2009. The initial nursing assessment had recorded that Mr Y had pain in his bottom/rectum but this was not followed through and just as importantly does not appear to have been communicated to medical staff. Neither was there any evidence that concerns about the redness of Mr Y's sacrum and buttocks were

relayed to doctors with any sense of urgency on 29 and 30 October 2009.

47. There were further failings once the abscess was spotted. My surgical adviser has said that the 26 hour delay from 10am on 31 October 2009 until the operation was carried out the following day was inappropriate and was responsible for the extent of the surgery and the ongoing septic complications. I accept that the overall responsibility for this case was with the consultant surgeon and the consultant anaesthetist and that, at the very least, there should have been consultant to consultant contact. In my surgical adviser's view the decision not to proceed, although late at night was inappropriate, given the virulence of the disease.

48. Overall I agree with the advice I received that both the missed diagnosis and the delay in carrying out the surgery were significant factors in Mr Y's death. Proper investigation, a thorough review of the initial diagnosis and prompt treatment may well have led to Mr Y's survival. Also aspects of his nursing care fell below a reasonable standard and meant that the overall quality of his care was compromised.

49. The consequences were devastating for Mr Y, whose age and existing conditions made him vulnerable and less likely to survive such extensive surgery. It was also extremely distressing for the family to see him die in such circumstances.

50. Although the UHB acknowledged in response to the report at Independent Review that there had been serious shortcomings it was unfortunate that it then took some months to respond following the issue of the report, which added to the family's distress.

51. To the UHB's credit it has introduced a number of general measures to improve the standard of care in the hospital since the

events mentioned in this report. I welcome these changes. However I need to be satisfied that the specific failings in clinical care in this case have been addressed. The UHB should be able to show me that the measures identified in the action plan have been put in place and that lessons have been learnt from the serious shortcomings identified. I therefore make the following recommendations:

Recommendations

52. Within one month of the date of this report the UHB should give a meaningful apology to Mrs A, on behalf of the family, for the failings identified above. It should make a payment of £3,000 for the trauma caused to the family for the distressing way in which Mr Y died and the knowledge that the delays contributed to the sad outcome.

53. Within four months of the date of this report the UHB should satisfy me that:

- Case notes are reviewed randomly at Clinical Governance meetings.
- Junior doctors are reminded in their induction training of the importance of recording test results in case notes and that these are reviewed at the end of the day. Appropriate audits should be carried out.
- Consultant review of emergency urology admissions is carried out and some explanation of how this has been achieved.
- Audits of rectal examinations are carried out if not already completed. The results produced and any follow up advice to staff given.
- A protocol should be in place, if it has not already been introduced, to improve communication between anaesthetists and surgeons on call. There should be consultant to consultant contact when there are complicated clinical management issues as in this case to decide whether a condition is

sufficiently serious to over- ride the usual considerations for carrying out surgery after midnight.

It should also ensure within four months of the date of this report that:

- A Fundamentals of Care audit is undertaken by senior nurses and the results reported. Any areas of weakness to be addressed and improved.
- Nursing staff receive training on the assessment, particularly risk assessment, and management of, or prevention and treatment of pressure ulcers in line with published guidelines.
- Nursing staff to be reminded of the responsibilities of record keeping in line with NMC Record Keeping Guidelines 2009.

54. The UHB has accepted these recommendations.

Peter Tyndall
Ombudsman 8 August 2012