Surrey and Sussex NHS Healthcare NHS Trust

TRUST BOARD IN PUBLIC	Date: 28.3.13 Agenda Item: 2.2
REPORT TITLE:	**A Patient Story**
EXECUTIVE SPONSOR:	Dr Des Holden, Medical Director
REPORT AUTHOR:	Dr Des Holden, Medical Director
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	

Purpose of the Report and Action Required:		**(√)**
	Approval	
	Discussion	√
	Information/Assurance	

Summary: (Key Issues)

Requesting and agreeing investigations with a patient requires good communication - explaining what will be done and why and listening to and addressing any concerns that arise. Where planned care pathways are changed there is the potential for unintended consequences and such changes should not be made lightly, and where made should be communicated to an equally high or if possible higher standard.

Relationship to Trust Corporate Objectives & Assurance Framework:

To deliver a safe, high quality service.
Duty of candor

Corporate Impact Assessment:	
Legal and regulatory implications	Risk of litigation
Financial implications	
Patient Experience/Engagement	A poor patient experience
Risk & Performance Management	As discussed at relevant divisional and management boards, and reported externally
NHS Constitution/Equality & Diversity/Communication	

Attachments:

Appendix ….

Surrey and Sussex NHS
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A PATIENT STORY

A male patient was admitted to the Acute Medical Unit (AMU) with a gastro-intestinal bleed. He had a variety of other chronic medical problems. Initial assessment suggested upper GI pathology and an upper GI endoscopy was requested. The patient was appropriately consented for this. The consultant in the endoscopy suite saw the referral and felt that the source of bleeding was more likely to be from the lower GI tract and communicated with the ward that a flexible sigmoidoscopy would be done. He asked for the patient to have an enema to prepare the bowel for inspection. The following day a young female nurse attended the patient to administer the enema but the patient refused (stating that it was not necessary for a gastroscopy). The patient was re-attended by a male nurse who explained the change of procedure and administered the enema.

During the investigation the descriptions provided by staff and by the patient of this interaction are very similar. The nurses believed he refused to let the first administer it but did not object to the second nurse; the patient reports that he never gave consent for an enema but felt powerless to refuse a second time.

It is reported that the patient experienced significant acute pain at this time, although there was no evidence of any local pathology. The patient then attended endoscopy where the consultant decided that the original endoscopy was in fact the best investigation to perform and this went ahead without complication. The patient appeared to stop bleeding and was subsequently discharged three days later complaining of anal pain. A further three days later he was re-admitted with severe peri-anal sepsis and required debridement of the perineum and a laparotomy and de-functioning colostomy. The patient then had a long and difficult recovery finally being discharged from care10 months later.

<u>Contributing factors</u>
Complex decision making process. The investigation suggested that communication between the original medical review and the endoscopy department and then with the ward and the patient allowed presumption and a lack of challenge to occur. It is unclear whether the ward staff knew that the procedure planned had been changed.

Written consent for an enema is not explicitly required in either the Trust consent policy or the Trust's intimate care policy – with the standard being to offer full verbal description and taking verbal consent.

Despite administration of the enema being experienced as unusually painful, and the patient complaining of perianal pain on the day of discharge, a review which demonstrated new bruising around the anus did not prompt a request for a senior review prior to discharge.

<u>Lessons learned and changes made</u>
The trust under records the discussion and consent of enema administration, even if the discussion or administration are unusual. This case has been used on non-GI wards as a case study for this element of care.

Communication issues between the ward and the endoscopy unit teams allowed the former to tolerate uncertainty in the procedure a patient was to experience. There are potential parallels for some other services (including for instance imaging and cardiology).

This case has been used to high-light how uncertainty and changes in pathway can undermine communication. To relevant departments and at clinical leads meetings.

The trust has traditionally under-reported minor incidents (eg pain on administering an enema). It is hoped that the new web based reporting system will enhance the alerting of minor incidents.

Conclusion

With significant changes to the planned diagnostic procedure the patient received an enema which was ultimately not needed. These changes were remote from the bed side and others not involved in the changes were left to communicate them. This practice is at risk of resulting in poor patient experience of our services even if the procedures are successful. This patient's experience was compounded by suffering an extremely rare complication of enema administration, not previously seen in SASH.

Des Holden Medical Director
18.3.2013

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