Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 27th April 2017** **Agenda Item: 2.1**
REPORT TITLE:	Patient Story: Missed appendicitis and loss of parental confidence
EXECUTIVE SPONSOR:	Dr Des Holden Medical Director
REPORT AUTHOR (s):	Des Holden Medical Director
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Discussed at Serious Incident Review Group (S.I.R.G) and with CCG quality group

Action Required:		
	Discussion (√)	

Purpose of Report:

To inform the Board of one patient's (and her parents') experience of unscheduled care in our hospital

Summary of key issues

Appendicitis can be a difficult diagnosis to make especially if the history is atypical. It is therefore necessary to ensure all abnormal physiological observations are noted, all investigations provide results, that where a wait and see management plan is being made it has hard stops, and that re-presentation affords the opportunity for a fresh and senior review of the differential diagnosis. In the context of failure to improve clinically, and repeated unscheduled presentation, lack of confidence in staff can quickly develop where perceived poor communication with the patient and parents, or between team members is observed.

Recommendation:

To discuss what learning and assurance we can take from this patient story (paediatric surgery at sash, the role of the surgical board in providing assurance that care and onward pathways are robust and of high quality)

Relationship to Trust Strategic Objectives & Assurance Framework:

SO1: Safe – Deliver safe, high quality care ***and improving*** services which pursue perfection and be in the top ***25% of*** our peers
SO2: Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy
SO3: Caring – Work ***with compassion*** in partnership with patients, staff, families, carers ***and community partners***

Corporate Impact Assessment:	
Legal and regulatory impact	Relevant to regulation
Financial impact	minor
Patient Experience/Engagement	Poor experience for patient and family

Risk & Performance Management	Joint care of children by paediatricians and surgeons adds a safety net and to the quality of the patient and carer experience.
NHS Constitution/Equality & Diversity/Communication	
Attachment:	

TRUST BOARD REPORT – 27TH April 2017
PATIENT STORY - : Missed appendicitis and loss of parental confidence

Background:

A 10 year old girl was brought to ED by her mother with lower abdominal pain and possible appendicitis. She was admitted to the paediatric ward under the surgeons but her EWS remained 0 and when reviewed by a consultant the next day her symptoms were improved though not settled. She was discharged with working diagnosis of ileitis. The patient was brought back two weeks later with continued pain, bowel upset, and weight loss. Urine dip was clear and some blood tests were not done for technical reasons, but a middle grade doctor diagnosed a urine infection and again discharged the patient after USS of the lower abdomen commented appendix was seen and at upper limit of normal.

Four days later the patient was re-referred by the GP and was seen by the paediatricians. She had a high temperature; blood tests indicated significant inflammatory morbidity and imaging showed a large mass in the lower abdomen. A malignant diagnosis was initially considered though MRI quickly suggested this was a ruptured appendix. Referral was made to SGHFT, but they had no capacity. The patient was taken to BSUH and had radiological drainage of the abscess with a plan for interval review. She developed bowel obstruction and was re-admitted there for laparotomy. She subsequently made a good recovery.

Given the additional morbidity suffered by this patient the case was declared an SI. 80 of 300 appendicectomies performed each year at SaSH are in children aged over 5 (under 5s are referred to tertiary care). It is well known that the diagnosis can be difficult to make. Nationally about 10% of cases are found to be normal at operation, reflecting a desire not to leave suspected appendix to complicate, particularly in female patients. For this patient it is possible that insufficient weight was given to a raised temperature that settled while on the paediatric ward. On the second admission a raised temperature was recorded but not timed and dated, some blood tests were sent but for technical reasons not processed and then not repeated (incomplete clinical information) and in hindsight the USS of the lower abdomen, with recurrent admission, was too readily reported as within normal limits. The diagnosis of urinary tract infection was not supported by the clinical information and probably represents a care pathway in line with the earlier diagnosis rather than a fresh look at the clinical picture.

Learning:

Appendicitis can be difficult to diagnose, especially with a changing clinical picture and in this the case the time course was unusually long. The SI investigation concluded that where a firm diagnosis can't be reached a more proactive follow up than wait and see should be instituted. The now established Paediatric surgical board has reviewed the case and worked with all departments to review pathways and investigations.

The parents in their being open meetings reported feelings of lack of confidence in the service they received. This came from difficulty in being heard, late review compared to other children on the ward, perceived negativity they and their GP received when talking to the SaSH surgical team and senior clinicians making contradictory statements about the care pathway and the staff involved in decision making. This has been discussed at the surgical governance board by the Chief of surgery, and within the department by the clinical lead for surgery, and with several individuals named by the parents.

Dr Des Holden
Medical Director
April 2017