Maidstone and Tunbridge Wells NHS
NHS Trust

Complaint case study for publication on Trust website July 2014:

Mr W contacted us to highlight concerns about the post-operative management of his catheter following a biopsy procedure at Tunbridge Wells Hospital

Mr W was admitted to Tunbridge Wells Hospital for a day case procedure. On admission, the nurse had another patient's notes and Mr W was issued with the wrong patient's wristband. This was picked up by a doctor. Following his procedure, he experienced problems passing urine and a 2-way catheter was fitted. Mr W formed the impression that the staff were anxious to send him home as it is a day case facility. His catheter was flushed and he was discharged with advice to attended Maidstone Hospital A&E should he experience any problem with his catheter. Mr W highlighted that Tunbridge Wells Hospital was more convenient for him, but staff advised him to attend Maidstone as the urology service is based there.

Mr W did experience problems a few hours after discharge, so attended Maidstone A&E where he was advised that the A&E team at Tunbridge Wells could have managed his catheter. Mr W had further problems the following day so attended Tunbridge Wells A&E where his catheter was attended to and he was discharged home.

Unfortunately, Mr W again had problems over the next few days. He returned to Tunbridge Wells A&E and was admitted. The decision was made to remove the 2-way catheter to be replaced with a 3-way catheter. A doctor made a number of painful attempts to site the new catheter before it was successfully inserted. This catheter later blocked so needed to be removed, cleaned and reinserted. Mr W requested some pain relief for this process, but none was provided. Following another blockage, medication (heparin) was administered and this resolved the problem.

Prior to being discharged, Mr W developed chest pain and had an ECG (measurement of the electrical activity of the heart) which revealed no cardiac problems. The pain passed, but Mr W developed a dry cough. He reported pain in his left leg to a nurse and asked if he could remove his surgical stockings. The nurse explained that he needed to keep them on.

The day after his discharge, Mr W attended his GP with leg pain and shortage of breath. The GP suspected a blood clot and sent him to Maidstone A&E where he underwent investigations. These showed phlebitis in his leg and blood clots in each lung. Mr W was commenced on appropriate treatment for these.

Mr W made 5 specific comments in his letter to the Trust:

1. The mix-up with his medical notes on his initial admission could have had severe consequences
2. He should not have been discharged on the day of his initial procedure
3. Why was he subjected to replacement of the catheter if effective treatment with heparin was possible?

4. The nursing staff did not encourage him to move around to reduce the risk of clots developing
5. Further investigation of his leg and chest pain should have been undertaken before his final discharge from the hospital.

Our findings

The complaint was investigated by a Matron with a Consultant Urologist and the complaint was partially upheld.

Apologies were offered for the poor experience on the day unit. The unit has reviewed its admission process and now notes and indentification bands are not taken to the patient bedside until their identification has been verified.

Urinary retention and haematuria (blood in the urine) are a known complication of the procedure Mr W underwent and the risk of this was discussed with him as part of the consent process. It is not always necessary for patients who experience this to remain in hospital. Flushing of the catheter is the correct treatment for this and the records support that Mr W was appropriately made ready for discharge with his catheter. With regard to advice given on discharge, Maidstone was recommended in case specialist input was reuqired, should Mr W experience problems with his catheter. Apologies were offered for any lack of clarity in this respect.

Catheter insertion is known to be uncomfortable despite the use of local anaesthetic. In view of Mr W's distress, the Ward Manager has raised awareness with the nursing team of the need to ensure that they advocate for patients at all times.

The administration of heparin was carried out by a urology specialist registrar base don his previous experience of using this technique at another Trust. This is not a treatment method routinely used at Maidstone and Tunbridge Wells NHS Trust, but we were glad Mr W found it beneficial.

The results of the ECG were reviewed by a doctor and revealed no evidence of an acute cardiac event. Unfortunately, there is nothing documented in the records about complaints of leg pain or a dry cough. The nursing notes indicate that Mr W was mobile and self-caring and therefore the nursing staff may not have felt it necessary to actively encourage him to mobilise.

At the time of Mr W's final review, there was no indication that he was suffering with a pulmonary embolism. It is very unusual for a patient who was largely mobile and self-caring to develop a pulmonary embolism following a two day admission. Nonetheless, apologies were offered for the concern and distress this caused Mr W.