

Care provided to woman with Crohn's disease
16HDC01642, 17 June 2019

District health board ~ Colonoscopy ~ Embolisation ~ Delays ~ Right 4(1)

An 83-year-old woman was admitted to a general medical ward for a relapse of Crohn's disease. An inpatient colonoscopy was planned, but her condition improved over the next couple of days and it was thought that an outpatient colonoscopy within two weeks would be appropriate. However, the woman developed further gastrointestinal symptoms, so an inpatient colonoscopy was rebooked. Owing to a miscommunication about an intolerance to the standard bowel preparation, the colonoscopy did not occur until several days later.

Four days later the woman had an episode of per rectum bleeding. She later collapsed and was unconscious for approximately 30 seconds. The collapse was attributed to a vasovagal episode. Over the course of the day she had nine episodes of per rectum bleeding, and lost approximately 50–100ml on each occasion. Attempts to transfuse red blood cells were made, but anaphylactic reactions prevented adequate replacement of her blood loss.

A house officer and surgical registrar spoke with an interventional radiologist from another district health board to query the possibility of embolisation. Both the house officer and surgical registrar understood from their discussion with the interventional radiologist that the woman was not a suitable candidate for embolisation in view of her Crohn's disease. The interventional radiologist stated that she did not exclude embolisation, but suggested that the surgical registrar assess the woman, and for there to be a discussion with the relevant medical and surgical consultants about all possible treatment strategies.

It was decided to continue with conservative measures and to proceed with surgery if the woman became more unwell. She became increasingly drowsy, and an emergency bell was activated at 3.20am. Following involvement of the consultant intensivist and consultant surgeon at approximately 4am, the woman underwent emergency surgery to control her bleeding. Following the operation, the woman was transferred to the Intensive Care Unit (ICU). However, after consultation with the woman and her family, she was given palliative treatment only, and died a few days later.

Findings

The Commissioner was critical of the care provided by a number of staff. There was a preventable 48-hour delay in carrying out a colonoscopy, and an inadequate response to ongoing bleeding and transfusion reactions. Junior staff failed to escalate her condition to a consultant level, she was not admitted to ICU following the first emergency call, and poor decision-making led to delayed surgical intervention. For these reasons, it was held that the DHB did not provide services with reasonable care and skill and, accordingly, breached Right 4(1).

It was considered that the discussion with the interventional radiologist regarding the possibility of embolisation should have occurred at a consultant level, given the complexity of the case. No finding was made on the advice imparted by the interventional radiologist.

Recommendations

It was recommended that the DHB (a) report back to HDC on its consideration of the expert advisor's suggestion that there should be a policy whereby all patients with gastrointestinal bleeding are made known to the surgical services; (b) conduct a random audit of documentation within the general medicine ward to ensure that treatment plans and

discussions with other specialties are documented adequately; (c) provide a further update on the progress of the recommendations arising from its serious adverse event review, and in particular, its escalation pathways for deteriorating patients; and (d) provide the family with a formal apology for the deficiencies in the woman's care.