AAR Delayed diagnosis of small bowel obstruction and delayed inter-hospital transfer

Facilitated by: ABC

Attendees:
- Medical SHO
- Stroke Consultant and Medicine Quality Lead
- Acute Medicine Consultant
- Trust Mortality Reviewer

Level of harm: Low harm- based on patient experience

Duty of Candour status: n/a

1. What happened?

Datix: Delayed diagnosis of SB obstruction. No CT or surgical review.

Summary:
Sixty nine year old with multiple medical comorbidities. Background of CABG and HTN, recent CVA. Referred from EM to SDEC as pyelonephritis. Presented for ten days before with chronic abdominal pain – ongoing for three months.
Also had about three stones weight loss.
Has CT in ED on – aneurysm seen and was referred to vascular team.
Represented to ED on with abdominal pain and diarrhoea (not new).
Referred to SDEC on Friday,
Seen by medics on the – symptoms of abdominal pain persisted.
Blood tests showed high CRP and WCC and raised Lactate.
The patient was opening bowels and had been drinking water.
Started on antibiotics and plan for Abdo X-ray as he had recent CT which did not show any obstruction.
Clinician also contacted Gastro who saw patient the same day.
Abdo X-ray performed after 5 pm on the showed nonspecific dilatation of the bowels.
On call SHO on AMU Site A –
Saturday, - Late Saturday morning:
Ongoing abdominal pain. Had Morphine which helped. Anti-emetic administered for vomiting. Noted CT report for .
Continued antibiotic. Noted seen by gasto team and waiting for endoscopy.
- Sunday morning:
Still having abdominal pain. Noted no bowel actions in a few days.
Bowels issues were not a problem before but appear to have developed in the initial few days of admission.

Reviewed abdominal X-ray report and decided to repeat X-ray. The X-ray was performed as a matter of urgency.
The SHO discussed repeat X-ray results with radiology - Radiology advised that since bowels were still dilated to proceed with a CT abdomen - this was performed the same afternoon - diagnosed SB obstruction. Patient was kept NBM, ryles tube inserted, referred to and accepted by surgery.
Plans made to transfer to STH urgently -there was a slight delay.

2. What did we intend to happen?

Based on presenting symptoms of abdominal pain, vomiting and raised CRP - obstruction to be considered as a possible differential diagnosis.
The first X-ray performed the Friday night to be escalated for further review and might have prompted an earlier CT abdomen, rather than a few days later when the patient still continued to have pain.
For patients in ED or SDEC who are acutely unwell and require urgent surgical intervention, transfer to be made to the site where the surgeons are even if there is not a surgical bed available - take to ED in the interim.

3. Why was there a difference?

No known systematic way to ensure that X-ray results are properly escalated for further review.
X-rays were reviewed but it appears that the findings were nil significant because the patient had a CT abdomen performed a few weeks before.
Surgery advised to send the patient to Site B ED if bed on ward not available.
No bed on ward was available, but the patient was not sent to ED, was instead transferred to Site B the following morning. However, there was no certainty that surgery would be performed that very night if the patient was transferred earlier.

It is not a certainty at what time the patient actually perforated. Lactate remained normal up to point of surgery. No evidence to suggest that perforation happened before surgery. It appears that this was an evolving pathology.
There are ongoing issues with transfer between sites. There is ongoing work being discussed with executives re acute surgical patients who need transfer between
Resources are limited to have surgeons to c o v e r

4. What are we learning?

Patient was post-taked in a timely manner.
Referred to and seen by specialty in a timely manner.
Had medical w e e k e n d review.
Appropriate investigations were ordered and performed.
Appropriate treatment was prescribed and administered.
Delay in transferring from
I but there is no certainty that
this affected t h e o u t c o m e for t h e patient.
There is no certainty that an earlier CT would have made a difference
as we cannot determine at what point the patient perforated.
Symptoms not specific for SB obstruction.

5. Immediate safety actions

SHO discussed case with registrar.
Repeat X-rays showed bowel dilatation, discussion had radiology, CT abdomen performed - SB noted - NBM and ryles tube - referred to and accepted by surgery.

6. Key learning points

For patients in | TED or SDEC who are acutely unwell and require urgent surgical intervention, transfer to be made to the site where the surgeons are even if there is not a surgical bed available -
The patient can be taken to ED in the interim - this will expedite
specialist intervention.

7. Improvement action plan

i. Share case within the acute
medical community at
Discuss in AMU M&M – AMU Consultant October 2024 – Completed.
ii. Link case to stream of work
which is currently being done
regarding the acutely surgical ill
patients and endoscopy transfers
between Site A and B.
Liaise with QM to arrange. – Medicine Quality Lead October 2024
iii. SHO can use case for personal
reflection/appraisal.
Discuss and share experience
with educational supervisor.
J – SHO. n/a