SPSO decision report

Case: **201004752, Greater Glasgow and Clyde NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: some upheld, recommendations

Summary

Miss C complained about the care and treatment her mother (Mrs A) received in hospital after she suffered severe burns to her body. Miss C said that her mother had made a good recovery from a skin graft. However she believed that an error inserting a needle into Mrs A's left arm caused her mother to suffer a life threatening flesh eating bug (necrotising fasciitis) requiring intensive care treatment and a longer stay in hospital. She said that Mrs A was left with a damaged arm and suffered unnecessary trauma.

The clinical advice that we received from our medical adviser is that necrotising fasciitis is a very uncommon condition and can be difficult to diagnose because it usually presents with oedema (swelling). Mrs A had oedema in her legs, groin and arms. Our adviser said that necrotising fascitis is even rarer as a consequence of inserting a needle, and that in Mrs A's case it would have been difficult to make the diagnosis earlier. The department of burns and plastic surgery acknowledged that there was a delay in diagnosing the condition, but had learnt from this. The board had also issued an apology. Accordingly, while we appreciated that Mrs A suffered trauma and distress, we considered the delay in diagnosis was not unreasonable given the symptoms that Mrs A had. We, therefore, did not uphold the complaint.

Miss C also complained there was unreasonable delay before a central line was inserted into her mother's left arm. Our adviser said that it is not appropriate for any junior doctor to have five attempts to insert a cannula, as happened with Mrs A before a central line was inserted. The board conceded that the number of attempts at cannulation was excessive but had learned from what happened to Mrs A. In particular, they had produced a policy to deal with this. While we welcomed the introduction of the policy, and acknowledged that lessons had been learned by clinical staff, we considered there was an unreasonable delay in inserting a central line and we upheld this complaint.

Finally, Miss C complained that there was unreasonable delay before a naso-gastric tube was inserted and that her mother should have been fed in this way much earlier. We did not uphold this complaint. The clinical advice we received from our adviser was that overall the nutritional care and treatment Mrs A received was appropriate and there was no unreasonable delay in inserting a tube.

Recommendations

We recommended that the department of burns and plastic surgery:

- should consider obtaining early advice from general physicians, nephrologists and of intensive care staff where there are problems with fluid balance in patients with complications.

We recommended that the board should:

- establish a policy, including indications, for central venous lines in complicated burns patients;
- provide an update on the review of the West of Scotland Regional Burns Unit Venous Access Policy;
- provide evidence that audits are undertaken regularly to monitor compliance with the board's guidelines for the prevention and management of adult in-patient falls and that results indicate a reasonable standard of care; and
- ensure that, where appropriate, a daily medical entry is included in the records of all in-patients.