SPSO decision report

Case: **201304880, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C's wife (Mrs C) had an operation at Gartnavel General Hospital to treat a bunion on her foot, which involved inserting metalwork. Afterwards, she was in pain and could only mobilise with difficulty. The wound was slow to heal and six weeks after the operation she was admitted to a hospital in another board area with a severe infection, which was treated with intravenous antibiotics. At her next review, Mrs C's foot was still swollen and she had pain over her ankle and tenderness in her shin. The metalwork was removed the following month. However, at a subsequent review, she had pain in her heel and a magnetic resonance imaging scan (MRI: a scan used to diagnose health conditions that affect organs, tissue and bone) then showed that she had a tendon condition. Mrs C was reviewed again 14 weeks later, but decided not to have a further operation in light of the terminology the consultant used at that review.

Mr C complained about the care and treatment provided to his wife. He said that her tendon was damaged during the operation, causing pain in her ankle outside the site of injury and that she should not have been discharged so quickly. He also said that her infection was not treated reasonably and that the metalwork should have been removed sooner. Finally, Mr C complained that the injured tendon was not investigated appropriately or within a reasonable time and that there was an unreasonable delay between the scan and the subsequent consultation.

We took independent advice from one of our medical advisers, who said there was no evidence that Mrs C's tendon was injured during surgery. She had a wound that was slow to heal and was complicated by infection, but this was treated appropriately and effectively and the metalwork was removed within a reasonable time. In relation to Mrs C's final consultation, we were unable to reconcile the differing accounts about communication. However, we found that the advice given about the condition and treatment options was reasonable. Having said that, the delay between the MRI and subsequent consultation was unreasonable. Although this had no impact on the outcome for Mrs C, we found that the delay caused her additional uncertainty while she was dealing with a painful condition.

Recommendations

We recommended that the board:

- bring the failings in record-keeping to the attention of the relevant healthcare professional; and
- inform us of the steps taken to ensure there is no recurrence of the delay between the MRI scan and follow-up consultation.