Scottish Parliament Region: Glasgow

Case 200500877: Argyll and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital; Clinical treatment

Overview

The complainant was concerned that, on several occasions in October 2004, a hospital failed to admit him as an in-patient or to give him appropriate medical treatment.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) lack of appropriate medical treatment (*not upheld*); and

(b) poor record keeping (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations.

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[1] Argyll and Clyde Health Board (the former Board) was constituted under the National Health Service (Constitution of Health Boards) (Scotland) Order 1974. The former Board was dissolved under the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006 which came into force on 1 April 2006. On the same date the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by the former Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of the former Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to the former Board or Greater Glasgow and Clyde Health Board as its successor.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mr C. On 28 June 2005 the Ombudsman received his complaint about the hospital's lack of appropriate medical treatment.

2. The complaint from Mr C which I have investigated is that::

(a) Mr C received a lack of appropriate medical treatment.

3. As the investigation progressed, I identified issues concerning the standard of record keeping. Therefore, I informed the Board and Mr C that the investigation would additionally consider:

(b) the nursing and medical record keeping.

4. The advisers who assisted me had some initial concerns about some aspects of the nursing in the hospital's Accident and Emergency (A&E) Department, for example, whether appropriate nursing and discharge assessments had been carried out. The Board explained these (for example, why no discharge assessments had been required) to the satisfaction of the advisers and myself. I did not, therefore, pursue these aspects further.

Investigation

5. I was assisted in the investigation by three of the Ombudsman's clinical advisers, one of whom is an A&E consultant. Their roles were to explain, and give an opinion on, the clinical background to the complaint. We examined Mr C's hospital clinical records for the period in question, the Board's file of Mr C's complaint and the Board's response to my enquiries. To identify any gaps and discrepancies in the evidence, the content of some of these papers was checked against information elsewhere on the file and also considered against my own and the advisers' knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. I have also checked that the advisers' advice was clear, that (where appropriate) it was based on the evidence and that their conclusions followed logically from their views. Finally, in line with the practice of this office, the standard by which the complaint was judged was whether the events were reasonable, in the circumstances, at the time in question.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board have had the chance to comment on a draft of this report.

(a) Lack of appropriate medical treatment

7. In October 2004, Mr C was aged 49 and had suffered a great deal from back, leg and neck pain at various times over many years. He had inter-vertebral disc disease, which causes irritation to the nerves and which had been worsening over the years.

8. The events of the complaint start with 7 October 2004. Mr C's general practitioner (GP) referred Mr C to the hospital for an opinion about a nine-day history of leg pain. A doctor saw Mr C promptly and diagnosed sciatica, which he thought might be caused by a possible prolapsed disc in his back, pressing on a nerve root. He referred him back to the GP with advice to seek referral to a back specialist if the symptoms did not settle. The advisers consider the examination and advice to have been appropriate and well reasoned. Mr C himself had no complaint about this consultation.

9. On 10 October 2004 Mr C went to A&E as a self-referral because of pain in the leg and pain from leg muscle spasms. The A&E doctor who examined him found him difficult to assess because of the tension and spasm in the muscles. As he had not taken his analgesia (pain relieving drugs) that day, her plan was to give him some so that she could re-examine him and also assess the analgesia's effect, then refer Mr C back to the GP for appropriate pain control, based on that assessment. (The GP had already been prescribing pain relief but Mr C reported that it was not helping enough during this particular period of pain.) The A&E doctor reported that Mr C was unhappy with this plan and left before it could be carried out. In his complaint to the Board, Mr C implied that he left because the doctor left the room during the consultation and simply never came back. The Board implied that the doctor did return, having left temporarily to deal with other emergencies. I have not been able to establish the facts here. However, the advisers consider that the doctor's plan was very reasonable and that, although Mr C had been asking to be admitted as an in-patient, this would not have been appropriate.

10. On 11 October 2004 the GP sent Mr C back to the hospital with another referral letter, saying that the pain had worsened and that one leg would not bear his weight. He requested an in-patient admission. The A&E doctor who examined Mr C that day recorded reduced hip movement but normal back movement and, through questioning Mr C, ascertained that he did not have serious nerve compression. The doctor noted in the records his understanding that the GP was preparing a referral to a specialist. The advisers consider, again, that in-patient admission would not have been appropriate and that appropriate advice was given about sciatica and about a particular complication in patients with back pain, which would need urgent hospital attention if Mr C developed it. Mr C complained that the doctor was accompanied by a bodyguard. I have not investigated this as I am satisfied with the Board's explanation to Mr C about their chaperone policies in relation to potential intimate examinations.

11. On 13 October 2004 the GP sent Mr C to the hospital with another referral letter, suggesting in-patient admission for fuller assessment as he himself had x-rayed the area (lower leg) that day, could find nothing new and was unsure about the problem. A hospital doctor noted the previous visits and the severe pain and examined the area of pain around the knee and lower leg but found no obvious, likely, cause of the pain. A diagnosis of muscle cramps was made. Mr C was then reviewed, on the same day, by an orthopaedic consultant, who wondered whether there was nerve root irritation. He prescribed the drug amitriptyline as a possibility worth trying and asked to see Mr C again in one month in his own out-patient clinic. The advisers consider that these two doctors' assessments and conclusions were reasonable and that it was appropriate to decide to manage Mr C as an out-patient. They also consider it commendable that the first doctor on 13 October arranged for an orthopaedic review by the consultant.

12. On 15 October 2004 Mr C was taken to the hospital by ambulance, which he had called because of a collapse and feelings of faintness. He also had severe leg and back pain. A history was taken by an A&E doctor and a heart tracing was done, the result of which was within normal limits. It was felt that Mr C's symptoms were caused by his having taken a high dose (more than prescribed) of the amitriptyline. He was, therefore, discharged to the GP for advice about correct dosage. I note here that Mr C disputes firmly that he had taken any amitriptyline. It is not possible to establish whether he had or had not done so. The advisers

consider that it could have been helpful for the doctor to have considered the ongoing chronic leg pain, but they accept that the examination focused on the collapse and faintness because these were what had prompted the visit. In that respect the doctor acted appropriately in assessing the reasons for this and taking action to exclude causes which could require an in-patient admission, such as a heart attack.

13. Although not part of Mr C's complaint, I note that he made a self-referral to A&E on 20 October, following a fall. Examination revealed tender areas. X-rays were done, which showed no fractures (apart from old ones). A diagnosis of soft tissue injury was made, Mr C was discharged with pain relief and an orthopaedic follow-up appointment was recommended. The advisers consider that this was reasonable.

(a) Conclusion

14. Paragraphs 7 to 12 show that the advisers consider that Mr C's medical treatment during October 2004 was reasonable and appropriate. The advisers have added that Mr C's condition was a very difficult one to manage clinically and that in such a situation, decisions as to whether or when surgery may help are not straightforward, needing continuing assessment of scan results and analysis of the patient in relation to a range of options for conservative management, including physiotherapy, drug treatment and other aids to control pain. Over the years, Mr C had had these. The adviser considers that in cases like Mr C's during October 2004, orthopaedic out-patient care was an appropriate decision and that his case was not something which would be amenable to management by an A&E department. Referral to A&E for A&E or orthopaedic assessment would be relevant only to assess whether emergency treatment or admission was required, for example if there was a new fracture or injury or a new neurological impairment which required an urgent surgical procedure. These indications for in-patient admission were not proved to apply in Mr C's case in October 2004. The advisers also point out that the hospital were communicating appropriately with Mr C's GP and that Mr C was under appropriate orthopaedic follow-up arrangements. And they have explained that the failure to control Mr C's pain in October 2004 was a reflection of the complex nature of his medical problems, rather than any lack of care or inappropriate failure to act. Therefore, I do not uphold complaint (a).

(b) Poor record keeping

15. The advisers were concerned about the standard of the nursing and medical records, in particular that, despite several visits to the hospital, one could not see clearly Mr C's changing pain picture.

(b) Conclusion

16. I shall not go into detail as Mr C has seen a copy of the Board's reply to my enquiries. In short, the Board fully acknowledged record keeping shortcomings and detailed the many changes that they had put in place to address these, following the Ombudsman's investigation of an earlier complaint. Our practice is not to uphold a complaint where the authority which is the subject of the complaint has already taken satisfactory action before our involvement. Therefore, whilst I criticise the record keeping in this case, I do not uphold complaint (b).

31 October 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
A&E	The hospital's Accident and Emergency Department
The GP	Mr C's general practitioner