Scottish Parliament Region: Glasgow

Case 200502730: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Orthopaedics

Overview

The complainant raised a number of concerns about the care and treatment of his late sister (Miss C) by Greater Glasgow and Clyde NHS Board (the Board). In particular he complained that Miss C had an operation to fuse her ankle joint which left her in considerable pain when it would have been clinically more appropriate to have amputated the foot; and also that on her final admission on 25 July 2005 to hospital she had been inappropriately admitted to orthopaedics which delayed diagnosis of the septicaemia which caused her death on 6 August 2005.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) doctors did not take the clinically appropriate step to remove Miss C's foot from the ankle *(not upheld*); and

(b) Miss C was inappropriately admitted to an orthopaedic ward rather than a medical ward (*partially upheld*).

Redress and recommendations

The Ombudsman recommends that the Board review their procedures for ensuring an overall treatment plan with ongoing input from all the relevant specialisms where a patient has a number of underlying medical problems.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 5 January 2006 the Ombudsman received a complaint from the complainant (Mr C) about the care and treatment of his late sister (Miss C) by Greater Glasgow and Clyde NHS Board (the Board) between 2 June 2005 and her death on 6 August 2005. Mr C stated that Miss C had an operation to fuse her left ankle at the Southern General Hospital, Glasgow (the Hospital) which left her in considerable pain and that she needed to be readmitted shortly thereafter to have a protruding screw removed. Mr C complained that his sister should not have had to endure this process and should have had her foot amputated instead. Mr C also complained that the wound left by the protruding screw became infected and Miss C contracted septicaemia and died of multi organ failure due to sepsis. Mr C was concerned that a delay in admitting Miss C to a medical ward prevented timely treatment for the septicaemia.

2. Mr C complained to the Board on 26 September 2005 about a number of nursing and medical issues and received a written response from the Board on 20 January 2006 (having already raised a complaint with the Ombudsman's office because of the time taken by the Board to respond to his concerns). Mr C remained dissatisfied with aspects of the overall response and complained to the Ombudsman's office.

3. The complaints from Mr C which I have investigated are that:

(a) doctors did not take the clinically appropriate step to remove Miss C's foot from the ankle; and

(b) Miss C was inappropriately admitted to an orthopaedic ward rather than a medical ward.

Medical Background

4. Miss C suffered from a rheumatoid disease first diagnosed in her teenage years and had successfully undergone a number of orthopaedic procedures. On 2 June 2005 (aged 70) Miss C had ankle arthrodesis (fusion of the bones of her left ankle) performed at the Hospital using three screws. On 18 July 2005 Miss C was readmitted to the Hospital suffering from severe pain and apparent blood staining to her plaster cast. The plaster was removed and a screw was found to be protruding from the fused joint and was removed in Accident and Emergency (A&E) by an orthopaedic doctor. Miss C was discharged on 20 July 2005 but readmitted via A&E on 25 July 2005 to the orthopaedic ward.

Following a diagnosis of sepsis on 27 July 2005 she was transferred to the care of rheumatology where she died on 6 August 2005 from multiple organ failure.

Investigation

Investigation of this complaint involved reviewing Miss C's clinical records and the Board's complaint file. I have sought the views of a general medical and an orthopaedic adviser to the Ombudsman (Advisers 1 and 2 respectively).

5. 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 were given an opportunity to comment on a draft of this report.

(a) Doctors did not take the clinically appropriate step to remove Miss C's foot from the ankle

6. Mr C was concerned that his sister had had to undergo a painful procedure to fuse her ankle joint which resulted in further pain and a number of complications and gave rise to the infection which caused her death. Mr C considered that it may have been more appropriate to amputate the foot and avoid further pain altogether.

7. Adviser 2 told me that it was understandable that Mr C expressed concern about the value of the operation but that arthrodesis of a joint in rheumatoid arthritis is usually a very satisfactory operation which produces a high level of success and pain relief. Adviser 2 considered that a surgeon would only consider amputation in extreme circumstances and in an attempt to get rid of a serious infection.

(a) Conclusion

8. While the complications which arose in Miss C's case had severe consequences which with hind-sight may suggest it was not an appropriate decision, I consider that the plan to perform ankle arthrodesis was not unreasonable and was in line with good practice. Such operations are considered the most reliable way of achieving the hoped for benefits of relieving pain and stabilising the joint. I, therefore, do not uphold this aspect of the complaint.

(b) Miss C was inappropriately admitted to an orthopaedic ward rather than a medical ward

9. Mr C complained that when his sister was readmitted to the Hospital on 25 July 2005 her sepsis should have been diagnosed and she should have been transferred from A&E directly to a medical ward rather than being inappropriately placed in an orthopaedic ward where staff were not sufficiently experienced to deal with her medical rather than orthopaedic problems. Mr C believed that this was a crucial as the delay prevented his sister receiving the treatment she required as soon as possible. Miss C was transferred to a medical ward (rheumatology) on 27 July 2005.

10. In response to Mr C's complaint the Board noted that there was no suggestion of severe infection at the outset of Miss C's final admission only a local infection. The Board also stated that the care in orthopaedic wards was no different to that on the medical ward and staff in both were experienced in dealing with infections.

11. Adviser 1 reviewed Miss C's medical records from June 2005 onwards. The Adviser noted that Miss C had multiple medical problems with a long history of input from orthopaedics and rheumatology. Adviser 1 expressed concern that he could not find evidence in the records of an overall plan of management for Miss C's multiple on-going problems and in particular that there was no day-to-day review of this patient by the rheumatology department following her ankle operation.

12. Adviser 1 reviewed the records for the days immediately following Miss C's readmission on 25 July 2005. He noted that Miss C had the plaster removed and the wound inspected on the day following her admission but that she only received her first antibiotics at 09:45 on the morning of 27 July 2005 prior to her transfer to rheumatology as 12:30. A haemoglobin result on 26 July 2007 was low and the doctor on the ward round noted that the medical problems outweighed the orthopaedic issues. Adviser 1 noted that a rheumatology review didn't happen until after the ward round the following day (27 July 2005) but that the time between the rheumatology review and transfer was very prompt at only 30 minutes. Adviser 1 considered that the decision by A&E staff to admit Miss C to the orthopaedic team in the first instance was appropriate but that the orthopaedic team should have consulted with the rheumatologists much more promptly when Miss C was first referred by the A&E doctors on 25 July 2005 and in general more frequently throughout all her admissions.

Adviser 1 did note that even if she had had earlier or more co-ordinated treatment this may not have saved Miss C's life as she suffered a considerable number of illnesses.

(b) Conclusion

13. Based on the medical advice I have received I conclude that it was appropriate to transfer Miss C from A&E to orthopaedics in the first instance. However, I also conclude that there was both a general and specific failure by orthopaedics to involve other disciplines in Miss C's care planning and transfer her promptly on 26 July 2005 when it was recognised that her problems were more medical in nature. I, therefore, partially uphold this aspect of the complaint.

(b) Recommendation

14. In light of the above conclusion the Ombudsman recommends that where a patient has a number of underlying medical problems the Board review their procedures for ensuring an overall treatment plan with ongoing input from all the relevant specialisms.

15. The Board have accepted the recommendation and will act on it accordingly.

19 September 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Miss C	The complainant's sister
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	The Southern General Hospital, Glasgow
A&E	Accident and Emergency Department
Adviser 1 and	Medical adviser to the Ombudsman
Adviser 2	Orthopaedic adviser to the Ombudsman

Annex 2

Glossary of terms

Arthrodesis	Fusion of the bones in a joint
Septicaemia	An infection of the blood
Sepsis	An overwhelming infection of the blood-stream caused by bacteria