Scottish Parliament Region: Lothian

Case 200500714: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Orthopaedic

Overview

The complainant (Mrs C) raised a number of issues regarding her treatment and care following an ankle fracture.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) failure by the Consultant to align properly Mrs C's broken ankle (*upheld*);

(b) Mrs C's concerns about the alignment had been dismissed by medical staff at the time (*upheld*); and

(c) failure by medical staff to provide appropriate advice to Mrs C on managing her injury (*upheld*).

Redress and recommendations

The Ombudsman recommends that:

(i) the case be discussed at the Consultant's next annual appraisal;

(ii) the Board provide evidence that their records have been submitted to scrutiny, via audit, and address the problems identified in this report in record-keeping; and

(iii) the Board introduce a protocol on providing advice to patients on managing plaster cast injuries.

Main Investigation Report

Introduction

1. On 10 June 2005 the Ombudsman received a complaint from a woman referred to this report as Mrs C that the failures in the treatment and care she received in St Johns Hospital, Livingston (the Hospital) in 2004 led to an avoidable operation on her ankle.

2. Mrs C complained she continued to experience problems following the alignment of her ankle at the Hospital when it had been set in plaster. She said she had expressed her concerns to medical staff but these had been dismissed. Nor did she receive appropriate advice on managing her injury. Mrs C complained the failures in the care and treatment she had received led to the need for reconstructive surgery on her ankle. Mrs C brought her complaint to the attention of Lothian NHS Board (the Board) in December 2004. She then met with the Consultant but remained dissatisfied. Mrs C applied for an independent review of her complaint but came to the Ombudsman when the Board were unable to secure a Convener and Lay Chairman after the NHS Complaints Procedure had been revised from 1 April 2005.

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

(a) failure by the Consultant to align properly Mrs C's broken ankle;

(b) Mrs C's concerns about the alignment had been dismissed by medical staff at the time; and

(c) failure by medical staff to provide appropriate advice to Mrs C on managing her injury.

Investigation

4. In writing this report I have had access to the documents provided by Mrs C, Mrs C's clinical records covering the period of the complaint and correspondence relating to the complaint from the Board. I have obtained advice from an independent professional adviser on the orthopaedic aspects of this complaint (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

5. The Nursing and Midwifery Council Guidelines for Records and Record Keeping (2005) (the guidelines) and the General Medical Council (GMC) Good Medical Practice (2006) guidance were also reviewed. Both indicate the importance of record-keeping and the GMC guidance provides guidance on the duties of a doctor, including their relationship with their patient.

Clinical background

6. Mrs C stumbled down a step injuring her right ankle and was brought into the Hospital on 17 March 2004. The Casualty Officer found on examination that the ankle was very tender on the inner side near the medial malleolus. There was also some tenderness up the leg and the notes record there was minimal instability. An x-ray revealed a 'Weber C' ankle fracture and Mrs C was placed in a below knee plaster.

(a) Failure by the Consultant to align properly Mrs C's broken ankle

7. Mrs C complained that her foot had been set in plaster at a strange angle on 17 March 2004.

8. The Board responded that the fracture was in alignment and went on to heal in an acceptable position. A radiograph taken on 22 April 2004 showed no gap between the margin of the talus and tibia and the medial malleolus appeared to have united. Following this response, Mrs C met with the Consultant. In his note of that meeting, the Consultant said it was possible the position that Mrs C's foot had been held in the plaster cast was not ideal but that this was unlikely to have altered the end result.

9. The Adviser said that, from the medical records, at first the intention was for Mrs C to starve in preparation for going to theatre, presumably to internally fix the fracture of the right ankle. However, it was decided by the Consultant that an operation was presumably not in the best interest of Mrs C. The diagnosis was of a 'virtually undisplaced fracture of the fibular neck and medial malleolus' which was to be treated in a below the knee plaster cast. The Adviser said the medical records do not easily provide a narrative of exactly how Mrs C's treatment had been decided. However, it was clear from the x-rays that Mrs C's ankle fracture was not benign.

10. The Adviser examined the x-rays relating to Mrs C's injury, which had been taken on 17 March - 20 March 2004, 1 April 2004, 22 April 2004 and 24 March 2005. There appeared to have been damage to the right leg below the

knee in the following areas: a proximal fibula fracture, 'Maisonneuve', and disruption of the inferior tibio fibular ligament and fracture of the medial malleolus, tear of the deltoid ligament or anteromedial joint capsule. The latter injury can lead to a wide diastasis, that is, opening of this distal tibio fibular articulation. It is important to restore fibula length, which in Mrs C's case had been shortened only a little but probably sufficiently to give the talus the chance to angulate into valgus as it had done. He advised that there were signs on the first x-ray that this was potentially a serious ankle injury and more than a little chance it was unstable. As such, serious consideration should have been given to investigating further with a CT scan to get more information on the configuration of the fragments in and around the right ankle joint. With this further information, it would have been most reasonable for the case to have been discussed at a trauma meeting between consultants and registrars so that a combined decision could be made. This is because, in the Adviser's opinion, a lot of pointers suggested that surgery, despite Mrs C's age and rheumatoid arthritis, would have been a reasonable option to try to obtain the best possible outcome.

11. The Adviser went on to state that if conservative treatment is recommended, as in Mrs C's case, then treatment with an above knee plaster would be preferable to a below knee plaster and that the utmost diligence would have been required to change plasters on a regular basis as the swelling of the leg went down. As the swelling goes down, so any form of splintage becomes almost useless unless it is replaced regularly in the early stages. The Adviser did not see any evidence of this and was concerned that the clinical management in Mrs C's case was not reasonable.

12. In terms of alternative treatment, surgery, the Adviser pointed out that there can never be an absolute guarantee that surgical procedures such as an open reduction of the complex ankle fracture will result in a massively improved situation. Moreover, surgery in Mrs C's case would be less predictable because she already was suffering from rheumatoid arthritis which might have affected any number of joints in the foot, as well as the ankle, before she had this particular accident. Nonetheless, he advised that surgery in Mrs C's case at least gives a more than 60% chance of restoring some normality to the ankle joint (or any other joint damaged by trauma).

13. The Adviser said there were two opportunities where consideration of surgery might have led to a better outcome. This was clearly an option that had

been considered in the first instance and was a reasonable line of action which was unfortunately cancelled (see paragraph 9). The second opportunity arose on 1 April 2004 when the displacement of the talus laterally is more obvious on the x-ray. The Adviser said that, even if signs of the seriousness of the injury on previous x-rays had been missed, this x-ray should have rung alarm bells for most surgeons and might have led to open reduction and internal fixation to restore normal congruity as near as possible in the ankle joint.

14. The Adviser commented that the outcome for Mrs C following her treatment was poor. Mrs C's fracture had healed in a poor position leading to some deformity of the ankle. The Adviser said that it was a very difficult series of fractures and joint damage in the affected ankle which may have mitigated against a good result whatever form of treatment had been recommended. However, he was concerned the severity of the fracture at the first two assessments had not been realised and, when an opportunity to correct matters could have been taken, nothing happened.

15. In reviewing the medical records, the Adviser commented that he had found them far from complete and, in particular, he found there were very brief in-patient notes (see paragraphs 17 and 23).

(a) Conclusion

16. Mrs C complained that the Consultant had failed to align properly her broken ankle, which had led to a poor outcome. The advice which I have received, and accept, is that there were problems with the clinical management of Mrs C's fracture, which had healed in a poor position. However, it is not clear if the outcome for Mrs C would have been better had she received surgical treatment rather than conservative treatment. What is clear is that, given the nature and severity of Mrs C's injury, surgery should have been considered as a serious option. While it appears that surgery was the initial intention, this was not then considered as an option. I criticise the Consultant for failing to recognise the severity of the injury. A CT scan should have been carried out and the results discussed between consultants and trainees at a trauma meeting, to decide best management of the injury when it had first been presented. Furthermore, the advice I have received is that an above knee plaster would have been preferable to a below knee plaster and there is no evidence that Mrs C's plaster had been changed on a regular basis, which is likely to have impacted on the outcome. Given these failings in the

management of Mrs C's care, and that the ankle had healed in a poor position, I uphold the complaint.

(a) Recommendation

17. The Ombudsman recommends that this case be discussed at the Consultant's next annual appraisal. In particular, that the Consultant considers the advice in this report that, in cases such as this, a CT scan should have been carried out and the results discussed between consultants and trainees at a trauma meeting. The Adviser also raised concerns about the record-keeping in this case and the Ombudsman recommends that the quality of record keeping should be audited and the results also discussed at the Consultant's next annual appraisal.

(b) Mrs C's concerns about the alignment had been dismissed by medical staff at the time

18. Mrs C complained that she had raised her concerns about the alignment of her foot to the medical staff she had seen during her out-patient appointments in 2004, particularly on 1 and 22 April, but felt she had been ignored. In her meeting with the Consultant on 24 March 2005 she said her concerns about the alignment had been dismissed.

19. [1]In a letter to me, the Consultant said he had been attentive to Mrs C's complaint that her foot was out of alignment. He had been satisfied that, following the application of a well fitted plaster, the fracture was in an acceptable alignment and went on to heal in an acceptable position. The radiograph (of 22 April 2004) revealed no widening of the ankle mortise and so he was happy to discharge Mrs C from further clinical review. He had had to examine the radiographs on a computer, which takes time and attention, which may have given Mrs C the impression he was not paying attention to her.

20. Mrs C has provided notes of her conversations with medical staff which indicate that she raised her concerns with staff on a number of occasions. However, the clinical records do not document what information had been

[1] Mrs C had met the Consultant as part of the local resolution process and so there was no written response from the Board about two aspects of her complaint (complaints b and c). I asked for the Consultant's written response to these aspects of Mrs C's complaint but recognised the difficulties in commenting on an oral exchange that had taken place some years previous.

provided by medical staff to Mrs C to address her concerns. The Adviser has said communication with patients and the recording of it in medical notes is vital to good record-keeping, which should provide a clear narrative of the patient's treatment and should conform to guidelines.

21. The GMC Good Medical Practice guidance states that, in providing care, doctors must keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, any drugs prescribed and other investigation and treatment. It goes on to state that records must be made at the same time as the events being recorded or as soon as possible afterwards. Reference is also made to the doctor's relationship with the patient, including working in partnership with patients by listening and responding to their concerns and preferences and giving patients the information they want and need in a way they can understand.

(b) Conclusion

22. Assessing the communication between Mrs C and medical staff is problematic, given the passage of time since the event and the difficulty in corroborating an oral account by either Mrs C or the staff. The medical records do not document any communication with Mrs C about her concerns, which should have been recorded together with any advice given. Mrs C has provided evidence which indicates she had raised her concerns with staff. However, the clinical records do not document how her concerns were addressed. It is also clear from the advice I have received that the Consultant failed to recognise the severity or the injury (see paragraph 17). Taking all this into account, and taking into consideration the GMC guidance, on balance, I have decided to uphold this complaint.

(b) Recommendation

23. This investigation has highlighted the inadequacy of the Board's record-keeping. There was a failure to record communication with Mrs C and complaint (a) revealed they did not provide a narrative of how Mrs C's treatment had been decided. The Ombudsman, therefore, recommends that the Board should provide evidence that their records have been submitted to scrutiny via audit and that the problems identified in this complaint have been addressed, so that assurances can be given to the Ombudsman that they adhere to the minimum standards required by the Nursing and Midwifery Council Guidelines for Records and Record Keeping (2005) and GMC guidelines.

(c) Failure by medical staff to provide appropriate advice to Mrs C on managing her injury

24. Mrs C complained she was not given appropriate advice on managing her injury. For example, she should have been given a rocker for the plaster, had appropriate footwear and instructions on how to partially weight-bear.

25. The Consultant said patients are provided with advice by him, the nursing staff and plaster technicians on ongoing management. He could not remember the exact details about the advice given to Mrs C but said had they expected any likely problem of mobilisation, it would have been addressed. However, he apologised if Mrs C had not understood that it is normal practice for patients to start to weight-bear through the foot towards the end of the healing process. He also said Mrs C should not have been discharged without any form of shoe and he had not been aware that she had not brought appropriate footwear with her. He apologised to her for not ascertaining this but said the nurses are there to assist and had she alerted them they would have taken appropriate action at an earlier time.

26. The Adviser said a rocker to take weight through on a below the knee plaster is only one way that orthopaedic surgeons allow weight-bearing to take place. A weight-bearing plaster to allow weight-bearing may also be used. Physiotherapists should be available to help patients to learn how to partially weight-bear and give patients instruction sheets routinely. In terms of footwear, Mrs C should have been informed that coming out of plaster she would need some form of footwear to go home in. Sometimes a patient's foot is too swollen to wear their own shoe and they should be given a temporary canvas boot and padding or some other form of temporary footwear from the hospital. The clinical records do not indicate what information and/or advice had been given by medical staff to Mrs C on managing her injury at any point during her treatment or on discharge.

(c) Conclusion

27. Similar issues arise in this complaint as in complaint (b): the difficulty in assessing communication some time after the event and corroborating an oral account; and the lack of information in the medical records about advice given by medical staff to Mrs C on managing her injury. It is impossible to determine conclusively what advice had been provided to Mrs C. However, the Consultant has accepted there were shortcomings in the advice provided and it is clear that Mrs C left the Hospital without a full and complete understanding on how to

manage her injury. It is the responsibility of the medical staff involved to ensure that patients are fully aware of how to manage their injury properly and the consequences of not doing so before they are discharged from their care. I, therefore, uphold the complaint.

(c) Recommendation

28. The Ombudsman recommends that the Board introduce a protocol to be followed on advising patients how to manage their plaster cast injury properly which is clear to all medical staff and is recorded in patients' notes when it has been carried out.

29. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

21 November 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Hospital	St John's Hospital, Livingston
The Board	Lothian NHS Board
The Consultant	Consultant Trauma and Orthopaedic Surgeon at St John’s Hospital
The Adviser	Adviser to the Ombudsman
GMC	General Medical Council

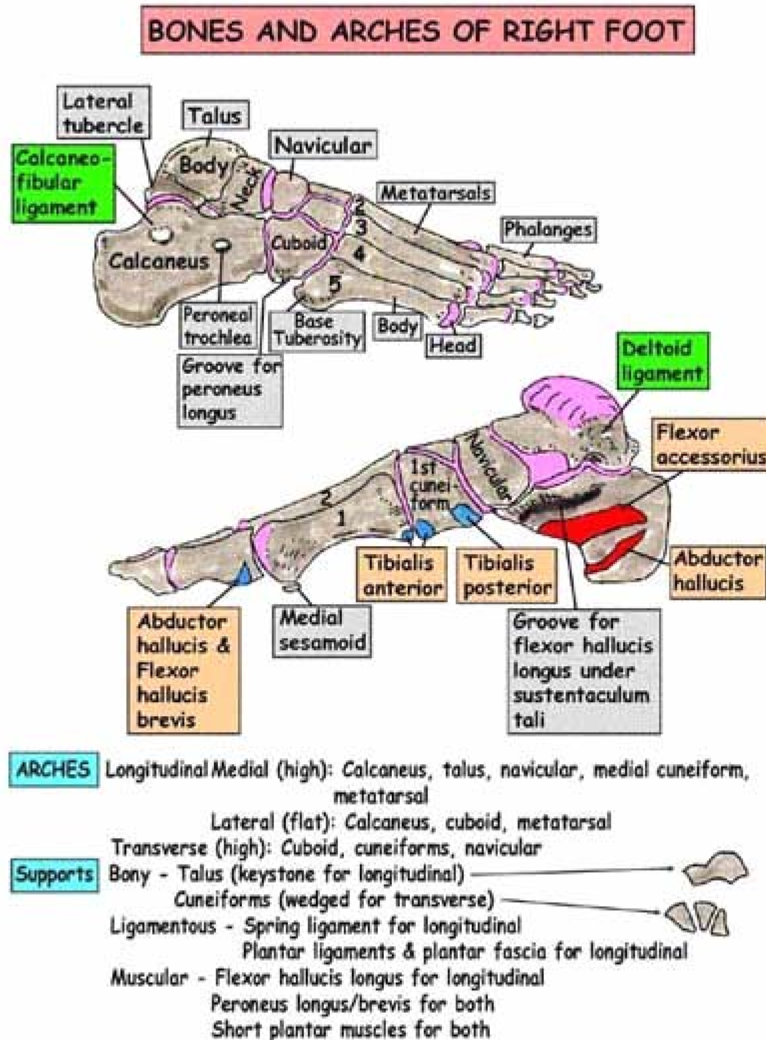
Annex 2

Glossary of terms

Term	Definition
Deltoid ligament	Ligament consisting of four parts which pass downwards from the medial malleolus of the tibia to bones in the foot
Diastasis	Dislocation or separation of two normally attached bones between which there is no true joint
Fibula	A small bone that parallels the lower leg which makes up the outside of the anklebone
Malleoli (malleolus, singular)	The far end of the tibia and fibula which form an arch that sits on top of the talus
Talus	A bone in the foot which, together with the tibia and fibula, make up the bony elements of the ankle joint
Tibia	The main bone of the lower leg which makes up the inside of the anklebone
Valgus	An abnormal outward or inward turning of a bone

Annex 3

Pictorial description of terms



Annex 4

List of legislation and policies considered

Nursing and Midwifery Council Guidelines for Records and Record Keeping (2005)

General Medical Council (GMC) Good Medical Practice Guidance (2006)