Scottish Parliament Region: Lothian

Case 200603030: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency

Overview

The complainant (Miss C) raised concerns that she received an inadequate medical examination at the Accident and Emergency Department of the Royal Infirmary of Edinburgh on 21 December 2005 when she presented with a foot injury.

Specific complaint and conclusion

The complaint which has been investigated is that the medical examination which Miss C received at the Accident and Emergency Department of the Royal Infirmary of Edinburgh on 21 December 2005 was inadequate (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 8 January 2007 the Ombudsman received a complaint from Miss C about the treatment which she received at the Accident and Emergency Department at the Royal Infirmary of Edinburgh (The Department), on 21 December 2005, for a foot injury. Miss C complained that the medical examination she received was inadequate. Miss C complained to Lothian NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Miss C which I have investigated is that the medical examination which Miss C received at the Accident and Emergency Department of the Royal Infirmary of Edinburgh on 21 December 2005 was inadequate.

Investigation

3. In writing this report I have had access to Miss C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional medical advisers (the Adviser) who is an Accident and Emergency Consultant, regarding the clinical aspects of the complaint.

4. 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 the report is contained in Annex 1. Miss C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The medical examination which Miss C received at the Accident and Emergency Department of the Royal Infirmary of Edinburgh on 21 December 2005 was inadequate

5. Miss C complained to the Board on 30 September 2006. She said that when she attended the Department she was suffering from severe cramps under the arches of both feet and sharp shooting pains over her ankles. She could hardly walk as the pain was so great. When she was seen by the Senior House Officer (the SHO), she was told after about three minutes that she had pulled a ligament and that she should rest up over the Christmas period. Miss C said she was discharged without a walking aid, despite the fact she could not stand and she felt as though she had been dismissed as unimportant. Miss C said that after a month of severe pain she approached her GP, who referred her to an Orthopaedic Consultant (the Consultant). The Consultant

arranged for Miss C to undergo a MRI scan (Magnetic Resonance Imaging: scan showing body organ images without use of radiation or x-rays) and concluded that Miss C had suffered Thrombophlebitis (thrombosed vein). Miss C was told the problem was initially caused by wearing walking boots where the tongue of the boot was pressing against a vein which caused it to be inflamed. The Consultant arranged for Miss C to receive new orthotics (appliances used to support weakened joints or limbs) which were fitted in July 2006. Although Miss C noted an improvement after this, she complained she was still not back to normal health. Miss C felt that if the SHO had been more thorough on 21 December 2005 she may have established the problem at that time and saved her prolonged pain and worry. Miss C could not understand how the SHO could say the problem was from a ligament rather than the vein. Miss C later complained that the SHO did not see her walk as she was seated during the consultation but she had told the SHO that her walking was extremely slow.

6. The Board's Chief Operating Officer (the Chief Officer) responded to the complaint on 7 November 2006. He explained that it was documented that, following the examination by the SHO, Miss C was able to put weight on her foot and walk normally and that there was no deformity, bruising or swelling of either ankle and no bony tenderness was found. The SHO also found the blood supply and nerves to be normal in both feet. The SHO recorded a diagnosis of soft tissue injury caused by wearing new boots and also recorded that Miss C was asked to use ice, compression and elevation to reduce the discomfort in her foot and to walk about as able. Staff also made sure that Miss C had pain relief at home and gave advice that she should contact her GP if the symptoms continued. It was felt that the SHO had carried out an appropriate and well-documented assessment.

7. The Adviser reviewed Miss C's clinical records. She said it was recorded that Miss C presented to the Department with pain in her feet after 'breaking in' some walking boots. A history of ankle tenderness after wearing new walking boots around the house was documented. There was no history of trauma. The tenderness was stated to be across the front of the ankles. No bruising, swelling, deformity, bony tenderness, calf tenderness or damage to veins or nerves was evident. Miss C was also found to be able to weight bear and her gait was normal. A diagnosis of soft tissue injury was made and treatment with rest, ice, compression bandage, elevation and Ibuprofen (analgesia) was advised, along with advice to contact her GP if the pain persisted. A typed

discharge letter was sent to the GP, which stated the problem was in the soft tissues and related to the new boots.

8. The Adviser also noted that Miss C was subsequently referred by her GP to the Consultant, who arranged for an ultrasound scan to be carried out. The scan took place on 7 September 2006, with the result that there was no abnormality or evidence of mass or a thrombosed vein. On 6 December 2006 the Consultant referred Miss C to the pain clinic. The referral letter stated that Miss C had been fully investigated with MRI and ultrasound, which had shown no abnormality.

9. The Adviser said that Miss C presented with a clear history of pain due to irritation by new boots. Examination by the SHO revealed no 'accident or emergency' requiring acute treatment or investigation and Miss C was correctly diagnosed as having some soft tissue problem secondary to the boots. The Adviser told me the advice given by the SHO was correct and that follow-up by the GP, if required, was appropriate. The Adviser could find no indication that the examination or advice offered by the SHO was deficient in any way.

Conclusion

10. Miss C felt that the treatment she received at the Department was inadequate and that, had a thorough examination taken place, it would have saved her from suffering from prolonged severe pain. I accept that it is not clear whether the SHO actually saw Miss C walking, however, the advice which I have received and accept is that the records indicate that the SHO obtained an appropriate history from Miss C and reached an appropriate diagnosis, based on the symptoms with which Miss C presented. The advice which the SHO gave to Miss C regarding rest, ice, compression bandage and to contact her GP if the symptoms persisted was also entirely appropriate. I also note from the results of subsequent scans that there was no evidence of a thrombosed vein, although this formed part of the Consultant's initial diagnosis. Accordingly, I do not uphold this complaint.

Recommendation

11. The Ombudsman has no recommendations to make.

21 November 2007

Annex 1

Explanation of abbreviations used

Miss C	The complainant
The Department	Accident and Emergency Department at the Royal Infirmary of Edinburgh
The Board	Lothian NHS Board
The Adviser	Ombudsman's professional medical adviser
SHO	Senior House Officer
The Consultant	The Orthopaedic Consultant who treated Miss C
The Chief Officer	The Board's Chief Operating Officer