Scottish Parliament Region: Glasgow

Case 200603373: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Clinical treatment/Diagnosis

Overview

Mr C complained about the treatment he received when he was a patient in Glasgow Royal Infirmary. In particular, he said that his condition was misdiagnosed and, therefore, he did not receive appropriate, timely treatment.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C's condition was misdiagnosed, in that he had pleurisy rather than pneumonia; had he had a CT scan at the outset, his diagnosis would have been quite clear (*not upheld*);

(b) as a consequence of Mr C's condition being incorrectly diagnosed, he did not receive appropriate, timely treatment and an antibiotic was incorrectly administered *(partially upheld)*; and

(c) staff failed to listen to him and an x-ray was taken covertly (*not upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board emphasise to staff that extreme care should be taken when drugs are being administered and recorded.

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

Main Investigation Report

Introduction

1. On 1 February 2007 the Ombudsman received a complaint from Mr C. He said that on 17 May 2006 he was taken into the Emergency Department (ED) at Glasgow Royal Infirmary (the Hospital). He complained that he was misdiagnosed and, therefore, did not receive appropriate or timely treatment. Mr C maintained that he had pleurisy rather than pneumonia and that the evidence supported this. He asserted that if he had had a CT scan at the outset, his diagnosis would have been quite clear. Mr C also complained about his treatment while he was in the Hospital: in particular, that there was delay in administering an antibiotic; which was then incorrectly administered; staff failed to listen to him; an x-ray was taken covertly; and necessary medication was not provided to him.

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

(a) Mr C's condition was misdiagnosed, in that he had pleurisy rather than pneumonia; had he had a CT scan at the outset, his diagnosis would have been quite clear;

(b) as a consequence of Mr C's condition being incorrectly diagnosed, he did not receive appropriate, timely treatment and an antibiotic was incorrectly administered; and

(c) staff failed to listen to him and an x-ray was taken covertly.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the correspondence between Mr C and Greater Glasgow and Clyde NHS Board (the Board). I have also had sight of Mr C's medical records and the Board's complaint file. On 13 June 2007 I made a formal enquiry of the Board's Chief Executive and a response was received dated 9 July 2007. Advice on Mr C's diagnosis and the treatment he received has also been obtained from an independent medical adviser.

4. While I have not included in this report every detail investigated, 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) Mr C's condition was misdiagnosed, in that he had pleurisy rather than pneumonia; had he had a CT scan at the outset, his diagnosis would have been quite clear; and (b) as a consequence of Mr C's condition being incorrectly diagnosed, he did not receive appropriate, timely treatment and an antibiotic was incorrectly administered

5. Mr C said that, on admission to the Hospital on 17 May 2006, his diagnosis was that he had pneumonia. He disputed this and said that he had pleurisy but that all the treatment he received related to pneumonia. He said that he was continually asked to give a sputum sample even though he had a dry cough and could not, therefore, give one. He believed that, on admission, he should have been given a CT scan and then his diagnosis would have been quite clear. He contended that this would have avoided all the problems he subsequently had to face, including being given an undiluted antibiotic which, he said, caused a thrombosis in his arm.

6. Mr C said that, after being admitted, generally he suffered a great deal of discomfort and that this continued until 20 May 2006. He said that, eventually, a doctor 'appeared out of the blue' with a portable ultra sound machine and he was scanned, which showed fluid in the pleural cavity. A drain was inserted and he was moved to another ward. Mr C said that the fluid drained overnight and his temperature returned to normal, which greatly relieved his pain. However, he contended that in the meantime there were constant problems with drips not working properly. He maintained that he had five cannulae (a cannula is a tube inserted into a blood vessel through which fluids can be passed or drained) inserted in the short time he was in the Hospital.

7. After being transferred to the new ward (see paragraph 6), Mr C said that the staff could not get the drip to work. As a result, he did not get the medication he had been prescribed overnight. He said that he told the nurse this the next day (21 May 2006) and she told him that he would have to wait for the doctor to see him again. Mr C said that when the doctor saw him he was told he had 'normal pneumonia' and he was prescribed oral antibiotics. The doctor did not mention the antibiotics he was supposed to have received overnight. Later that evening, Mr C said that he was sent for an x-ray in the orthopaedic department. He said that this was taken clandestinely. As a result of the x-ray, he said that he was put back on intravenous antibiotics but that the same staff who could not get the drip to work the previous evening had difficulty again and, despite the antibiotics being available, they could not be given to him. Mr C said that when he told the doctor that he did not get the antibiotics

prescribed, he was told that was nonsense. In the circumstances, Mr C said that he would be better off at home and he said he, therefore, discharged himself.

8. On 11 July 2006 Mr C made a written complaint to the Board about his treatment and he received their reply on 5 October 2006. The Director who wrote said that Mr C had been admitted to ED at 18.32 and was assessed for treatment at 18.39. Mr C was then seen by the duty doctor at 19.00 who, after examination, diagnosed pneumonia. Mr C's admission was arranged and strong antibiotics were prescribed. The Board said that the doctor reviewed Mr C half an hour later, while he was waiting to be transferred to Ward 43 (an assessment unit), and noted that he had not been given the antibiotics prescribed because nursing staff were busy with other patients. The reply said:

> 'The medication had already been drawn up, but the nurse had not yet added the clarithromycin to the IV fluid bag. Unfortunately, the doctor thought that the clarithromycin was augementin and administered it by slow IV injection (whereas clarithromycin should have been in an IV infusion).'

9. The Board said that, when Mr C complained about the pain, the doctor stopped and immediately took remedial action and, with a senior doctor, explained the error to him. The Board said that the doctor concerned very much regretted Mr C's distressing experience and apologised to him. The doctor had commented that he thought that Mr C had been understanding and accepted his apology. The Board made unreserved apologies again.

10. The Board confirmed that, by chest x-ray and by clinical examination on admission, Mr C had been diagnosed with right-sided lower lobe pneumonia. They said that his notes recorded the fact that he had a dry cough but, because staff required a sputum sample for analysis, he was given humidified oxygen and chest physiotherapy in an attempt to encourage this. They commented that it was often the case that patients begin to produce sputum some days after treatment but apologised to Mr C if this had not been made clear to him. The Board also said that his records clearly documented Mr C's chest pain and that analgesia was prescribed in increasing doses to relieve this but that he continued to experience a degree of pain until an empyema (pus in the pleural cavity) was drained on 20 May 2006. The Board maintained that the consultant on call recalled his meeting with Mr C during his ward round and, as he noted the persistence of fever and pleurisy despite appropriate antibiotics, and the

complication of empyema, requested the Respiratory on-call team to investigate further – this despite Mr C's view that they arrived 'out of the blue' (see paragraph 6). The Board said that the consultant recalled speaking to Mr C about this and discussing the likely diagnosis and use of ultrasound.

11. The Board confirmed that Mr C was transferred to another ward on the evening of 20 May 2006 (Ward 30), where it was noted that Mr C's pain had reduced since the insertion of a chest drain to drain off the empyema. However, they said that there was no record that Mr C had expressed any concerns about the insertion of cannulae or administration of intravenous antibiotics. The Board added that the drug cardex clearly recorded that Mr C's medication had been administered as prescribed and that the staff nurse involved said that she would not have signed for drugs if she had not been confident that they were administered. The Board regretted that all this was at odds with Mr C's recollection.

12. Mr C was unhappy with the Board's response as he felt that it had not answered all his concerns and he, therefore, emailed the Board on 19 October 2006. He wanted clinical proof that he was suffering from pneumonia and an explanation why he was not given a CT scan until he attended his own GP (after he discharged himself from hospital). In their further reply, dated 1 December 2006, the Board provided their explanation for Mr C's diagnosis and rehearsed the situation concerning his treatment. They further said that, after he had had a chest drain inserted on 20 May 2006, in accordance with good clinical practice, a plan had been formulated to request a CT scan if he failed to improve on the basis of his next chest x-ray. The Board said that a further radiology investigation was performed that day (20 May 2006) and it was noted that 'mid and lower opacity had reduced when compared to the previous study' but that further observation was still required. They stated that it was then that the consultant learned, with some surprise, that Mr C had discharged himself, against medical advice, and before his treatment had been completed. Because of their concern for him, the Board said that a senior house officer contacted his GP. In concluding their letter to Mr C, the Board noted Mr C's unhappiness with his treatment at the Hospital but maintained that he had been provided with appropriate care and treatment in accordance with his clinical needs. The Board later offered Mr C a meeting as he continued to dispute his diagnosis and treatment and, a meeting between him and the Hospital's Clinical Director and a Consultant Respiratory Physician was

arranged on 24 January 2007. However, as he remained unhappy, Mr C complained to the Ombudsman on 1 February 2007.

13. I sought independent advice on the care and treatment Mr C received and, as part of this, received a glossary of the appropriate medical terms (see Annex 2). The adviser confirmed that he had fully and carefully reviewed all the available documentation, including the medical and nursing notes, charts, reports, investigations and blood tests. It was the adviser's view that Mr C had been correctly diagnosed as having right-sided pneumonia and that he also had pleurisy but that this was *as a consequence of the pneumonia* (his italics). The adviser confirmed that pleurisy (inflammation of the pleural membrane) could occur as a primary event and was not always a complication of pneumonia. He said that in this case there was no evidence of any other cause for pleurisy and clear evidence of bacterial pneumonia. He added that the medical notes confirmed that Mr C had had pleuritic pain for two weeks prior to his admission to hospital, indicating that the complication of pleurisy had occurred early on in Mr C's illness, and the adviser speculated that this could have been the reason for Mr C's belief that he had been incorrectly diagnosed. The adviser was also satisfied that at the time of his admission there was 'suggestive evidence' of the beginnings of a pleural effusion on physical examination and a CT scan would 'not normally be performed under such circumstances since it is unlikely to provide any more information than is available on chest x-ray'. He added that, regardless, the treatment would have been the same at this stage of the disease.

14. Specifically, with regard to Mr C's treatment, the adviser said that it was his view that there had been no significant delay and that the appropriate treatment had been promptly prescribed. He confirmed that there had been a minor delay in administering the first dose of intravenous antibiotics but he took the view that this was as a result of the competing pressures of a busy ED. However, he noted that a serious consequence of this 'delay' was that a junior doctor administered a partially prepared dose of antibiotic in an undiluted form causing Mr C pain and inflammation in his vein. He confirmed that this was a clear and potentially dangerous error but that the doctor concerned and the Board had made unreserved apologies.

15. The adviser said that the prescription charts in Mr C's notes clearly recorded that he had received the subsequent doses of intravenous antibiotics on each occasion, in accordance with the prescribed times; although he noted

Mr C's equally clear recollection that one antibiotic had not been given to him completely and that another had not been given to him at all. However, he felt that there was no other hard information to allow him to form an objective opinion on what were diametrically opposed views. He did comment that his experience showed that it was common practice for the prescribed drug to be 'signed for' at the time when the nurse *started* the infusion to which the drug had been added. If the administration was perhaps interrupted by poor flow, the time at which the infusion was discontinued, often by a different nurse on duty, was not always reliably recorded. Similarly, he said it was not clear to him whether the same nurse who had signed for the drugs actually administered them (see paragraph 11).

16. With regard to Mr C's comments about repeated requests for sputum samples (see paragraph 5) and that he could not produce one because he did not have pneumonia, the adviser took the view that Mr C's belief was incorrect and that good practice required reasonable attempts to be made to identify the infecting organism, in order to prepare the most appropriate antibiotic treatment. He said that this was particularly important in situations where previous antibiotic treatment had failed (as in Mr C's case). In pneumonia, the infecting organism could usually be identified by a simple culture of the sputum. The adviser said that, consequently, persistent attempts to obtain sputum were consistent with good practice as a 'dry' cough would often become productive with time and manipulations such as high humidity inhalation or physiotherapy. The adviser said that, while he could understand Mr C's exasperation, he did not take the view that the requests made of him were unreasonable.

17. In all the circumstances, the adviser concluded that Mr C's illness had been correctly diagnosed as pneumonia and that he had been treated accordingly. He took the view that it had not been appropriate to use a CT scan and to have done so would not have provided any more information than was already available. The adviser identified a slight delay in administering the first antibiotic and noted the serious consequences that stemmed from this. However, he felt that he was unable to make a comment about whether or not Mr C had received all the antibiotic infusions he had been prescribed (see paragraphs 13 to 15). When Mr C's pleural effusion reached an appropriate volume, it was drained under ultrasound control and he said that the records indicated that the development of empyema was suspected and an appropriate management had been put in place (but pre-empted by Mr C's discharge). However, the adviser commented that, in general, communications with Mr C

may not have been good and this, together with the initial and serious error in administering the first antibiotic, may well have coloured his perception of the standard of care he was given. The adviser confirmed in his comments that the problems relating to intravenous administration of antibiotics were less than satisfactory (see paragraph 14).

(a) Conclusion

18. In reaching a conclusion about Mr C's diagnosis and treatment, I have to be guided by the medical advice I am given; the independent adviser has taken the view that Mr C was correctly diagnosed and treated. The diagnosis would not have been different, nor would the treatment, if a CT scan had taken place on Mr C's admission. He concluded that it had not been necessary to do this. In all the circumstances, I do not uphold this part of the complaint.

(b) Conclusion

19. Given the information above, while I am satisfied that Mr C received appropriate care, there were problems with intravenous drug administration but I have been unable, for reasons given in paragraph 17, to determine whether Mr C received all the antibiotics at the time they were prescribed to him but it was clear that oral treatment was initiated to overcome the immediate difficulties (see paragraph 7). However, on balance, I partially uphold this complaint, as I have to record my serious concerns at the error that occurred with the first antibiotic (although I note the doctor concerned's and the Board's sincere apologies). I have been unable to reach a view about the level of communication, given the diametrically opposed recollections of those involved.

(b) Recommendation

20. In the light of the above, the Ombudsman recommends that the Board emphasise to staff that extreme care should be taken when drugs are being administered and recorded.

(c) Staff failed to listen to him and an x-ray was taken covertly

21. Mr C said that after he was moved from the ED to a ward, he informed staff about the injection of the undiluted antibiotic (see paragraph 7) but he said that the nurse dismissed what he said and that he had to insist that she check the position with the ED. He also said that he kept telling staff he had a dry cough when he was repeatedly asked for a sputum sample but that, again, they ignored him. Further, Mr C complained that he was sent, covertly, to the

orthopaedic department for an x-ray (see paragraph 7) and he was concerned that he had not been sent to the main x-ray department.

22. In responding to Mr C's concerns on 5 October 2006, the Board apologised that Mr C felt that staff had been dismissive and disrespectful, although they said that the staff nurse who had been directly involved with Mr C thought that she had been sympathetic towards him and regretted that he thought otherwise. She said that this had not been her intention. The Board also commented on the situation with regard to Mr C's frustration at being asked for sputum requests, which I have dealt with above (see paragraph 16).

23. With regard to the x-ray that was performed in the orthopaedic department; the Board said (in their letter of 5 October 2006) that while they had been unable to determine the exact reasons for this, they assumed that it was arranged to 'facilitate and accommodate' his care and comfort. In the Board's letter to me (of 9 July 2007), they further made the point that there was nothing clandestine about the x-ray and that, while the general radiology department was some 10 to 15 minutes away from the ward where Mr C was, the orthopaedic x-ray was only two minutes away. They said that any comment from staff about being owed a favour for carrying out the x-ray, as Mr C had complained, was meant merely to be light hearted.

(c) Conclusion

24. While Mr C was left feeling ignored and his views dismissed, on balance I do not uphold this aspect of his complaint. Similarly, I am satisfied with the Board's explanation concerning the x-ray.

25. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

19 December 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
ED	Emergency Department
The Hospital	Glasgow Royal Infirmary
The Board	Greater Glasgow and Clyde NHS Board

Annex 2

Glossary of terms

Empyema	When the fluid of a pleural effusion becomes infected by bacteria, pus is formed from the effusion and the condition is then known as an 'empyema'. The bacteria usually infect the effusion from an adjacent infected lung, ie, from an area of pneumonia adjacent to the pleura but infection from the blood stream also occurs
Pleura	The shiny, smooth, moist membrane that lines the inside of the chest wall and covers the lungs: it lubricates and allows smooth motion of the lungs against the chest wall on respiration
Pleural effusion	The accumulation of fluid between two layers of pleura (ie, between the lung and the chest wall): there are a number of different causes of fluid accumulation; infection of the underlying lung (pneumonia) is one common cause
Pleurisy	Inflammation of the pleura: there are a number of causes of the inflammation but the condition is known as pleurisy irrespective of the cause
Pleuritic	The technical adjective that describes a specific type of chest pain that occurs as a result of inflammation of the pleura: this pain is typically sharp, stabbing, well localised and occurs or is made worse by inhalation
Pneumonia	Infection in the small air spaces of the lungs, typically caused by certain bacteria and some viruses: the infection causes inflammation of the air spaces (the alveoli) with the exudation of fluid that fills the air spaces causing the lung to appear solid or 'consolidated'