Scottish Parliament Region: Lothian

Case 200800148: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; medical care and treatment

Overview

The complainant (Mr C) complained on behalf of himself and his family that Lothian NHS Board (the Board) failed to provide reasonable care and treatment to his wife (Mrs C) from 28 September 2007 to 15 January 2008. Mrs C was admitted to the Royal Infirmary of Edinburgh (Hospital 1) following a fall in September 2007. Mrs C suffered a fracture of her left ankle and a plaster cast was applied to her left leg. Mrs C subsequently had an above knee amputation of her left leg. Mr C did not consider this treatment was reasonable given Mrs C's other medical conditions. Mr C further complained that Mrs C contracted a Methicillin-resistant staphylococcus aureus (MRSA) infection while in Hospital 1 and about the overall standard of nursing care that Mrs C received. During the course of my investigation, I also included, as part of the investigation, the standard of record-keeping in respect of Mrs C's medical records.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the plaster cast that was applied to Mrs C's left leg was not appropriate treatment given Mrs C's other medical conditions (*not upheld*);

(b) Mrs C contracted a MRSA infection whilst a patient in Hospital 1 (*not upheld*);

(c) the standard of nursing care which Mrs C received was inadequate (*not upheld*); and

(d) the standard of record-keeping in respect of Mrs C's medical notes was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) undertake a review of the policy for reviewing plaster casts and in particular referral to senior medical staff;

(ii) encourage the doctor concerned to reflect on the case at their next appraisal;
(iii) apologise to Mrs C and her family for the failing to review Mrs C's plaster cast which has been identified in head of complaint (a) of this report;
(iv) provide the Ombudsman with copies of the next Scottish Patient Safety Programme audit documentation in relation to all patient records within the orthopaedics department of Hospital 1; and
(v) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in head of complaint (d) of this report.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. The complainant (Mr C) raised concerns about his wife (Mrs C)'s care and treatment in a formal written complaint to Lothian NHS Board (the Board) on 14 January 2008. The central aspect of his complaint concerned the treatment of the fracture of Mrs C's left ankle and the resultant outcome for Mrs C. He further raised concerns that Mrs C had contracted Methicillin-resistant staphylococcus aureus (MRSA) and about her standard of nursing care.

2. The Board investigated the concerns raised by Mr C and his family and how they could be resolved. They were unable to do so to Mr C and his family's satisfaction. Therefore, Mr C brought his complaint to the Ombudsman's office in April 2008.

3. As the investigation progressed, I identified an issue concerning the standard of record-keeping in respect of Mrs C's medical records. Therefore, this issue was included in my investigation. I, therefore, informed the Board and Mr C that the investigation would additionally consider this issue.

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

(a) the plaster cast that was applied to Mrs C's left leg was not appropriate treatment given Mrs C's other medical conditions;
(b) Mrs C contracted a MRSA infection whilst a patient in Hospital 1;
(c) the standard of nursing care which Mrs C received was inadequate; and
(d) the standard of record-keeping in respect of Mrs C's medical notes was inadequate.

Investigation

5. In order to investigate this complaint, I reviewed all of the complaint correspondence between Mr C and the Board. I have also corresponded with the Board, reviewed their records for Mrs C and sought professional medical advice from two of the Ombudsman's independent professional advisers, a consultant orthopaedic surgeon (Adviser 1) and a nursing adviser (Adviser 2). I also met with Mr C and his daughter (Mrs D) who was my main point of contact during my investigation.

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, Mrs D and the Board were given an opportunity to comment on a draft of this report.

(a) The plaster cast that was applied to Mrs C's left leg was not appropriate treatment given Mrs C's other medical conditions

7. On 28 September 2007, Mrs C, who was then 72-years-old, while getting into a car, lost her balance which caused her to fall. She attended the Accident and Emergency department of the Royal Infirmary of Edinburgh (Hospital 1) where she was found to have sustained an undisplaced fracture of the outer bone of her left ankle, known as a Weber C fracture. It was decided that admission was necessary as Mrs C was suffering from a number of other ongoing health problems including type 2 diabetes mellitus, morbid obesity, osteoporosis, asthma, chronic obstructive airways disease, hiatus hernia and psoriasis. Mrs C's left leg was subsequently placed in a below knee non-weight bearing plaster cast.

8. On 9 October 2007 Mrs C was transferred to the Astley Ainslie Hospital (Hospital 2) for rehabilitation and discharged home on 26 November 2007. Following complications, Mrs C was re-admitted to Hospital 1 on 4 December 2007. A below knee amputation of Mrs C's left leg was performed on 19 December 2007 and a subsequent above knee amputation was performed on 15 January 2008.

9. Mr C and his family questioned why a plaster cast had been applied and not a moon boot given Mrs C's other medical conditions. Mr C said that he felt that medical staff had failed to 'react, listen or take action' when Mrs C and her family complained that the plaster cast was too tight and that she was in severe pain. Mr C believed this had been caused by Mrs C developing a pressure sore on her left foot, as a result of the plaster cast being fitted too tightly on her leg. Mr C felt that the amputation of Mrs C's lower left leg had come about through 'negligence, poor care and the inattentive attitude of both nursing and medical staff'.

10. The Board responded to Mr C's complaint on 5 March 2008. In order to address Mr C's complaint, the Board stated they had approached the consultant orthopaedic surgeon (Consultant 1) who had treated Mrs C.

11. In his response, Consultant 1 said that Mrs C had been under his care since her admission to the orthopaedic trauma unit on 28 September 2007 after a fall. The fall had caused Mrs C to sustain a Weber C fracture to her left ankle. This type of fracture is usually unstable and often requires an operation, but on occasion can be conservatively managed in a plaster cast. His opinion was that Mrs C required the firmness of a plaster cast to provide the extra support needed to allow the bone to knit together.

12. Thereafter, he had reviewed Mrs C over the following days and noted that she was doing well. He would normally expect a patient to go home once their fracture was immobilised. However, because of Mrs C's limited ability to mobilise, she stayed in Hospital 1 as an in-patient until it was deemed safe, by the physiotherapists, for her to go home. When he reviewed Mrs C's ankle on 16 October 2007 the fracture showed signs of healing which meant that the ankle fracture was behaving stably. The decision was made at that time to change her cast due to skin care problems and because the cast felt tight on an intermittent basis. When the cast was removed it was discovered that there was a necrotic sore over the anterior part of Mrs C's ankle. He had examined this and felt it would heal satisfactorily with conservative treatment. As there were signs of the bone healing on the x-ray it was felt that Mrs C's ankle could now be placed in a moon boot, to facilitate her comfort and to allow her ankle to be dressed.

13. Mrs C was next reviewed at his clinic on 14 December 2007. He admitted Mrs C for intravenous antibiotics for a presumed infection in the ulcer, wound care and pain relief. At the same time he also arranged a review at the diabetic foot clinic and also a dermatological and plastic surgery review. It was noted that the ulcer was not behaving typically, according to a pressure type ulcer. He, therefore, felt there was infection on the background of the psoriasis on Mrs C's leg. Mrs C had complained of pain, but as she had been in pain in both legs equally this made it difficult to assess the cause of the pain.

14. Consultant 1 said that advice was obtained from a consultant plastic surgeon (Consultant 2), who assessed the ulcer on Mrs C's leg. Although plastic surgery options were available, Consultant 2 felt that because of Mrs C's pre-existing circulation problems there may have been a problem in getting successful reconstruction using plastic surgery. A vascular opinion was, therefore, sought. The vascular team carried out a duplex vascular assessment because Mrs C was unable to tolerate a magnetic resonance imaging (MRI)

based vascular assessment because she was claustrophobic. This showed very poor circulation in both of Mrs C's legs from the femoral artery down. This meant that no reconstructive procedures were suitable. Therefore, the vascular surgeon recommended a below knee amputation, at the same time advising that this might proceed to an above knee amputation in view of the extremely poor blood supply in the limb.

15. Following the below knee amputation, Mrs C was treated with an antibiotic, Vancomycin, to prevent further infection. However, the wound began to break down. A second orthopaedic opinion was requested from another consultant orthopaedic surgeon (Consultant 3) as to whether an above knee amputation was necessary. He reviewed Mrs C on 9 January 2008 and was due to review her on 14 January 2008 but could not attend. Mrs C remained in pain and Consultant 1, therefore, performed an above knee amputation on 15 January 2008.

16. The Board also asked Consultant 3 to comment on Mrs C's treatment. He said that he agreed with Consultant 1 that the above knee amputation should be carried out where the wound healing had been unsuccessful.

17. I asked Adviser 1 to review Mrs C's medical notes. Adviser 1 stated that prior to the accident in September 2007 Mrs C appears to have been a grossly disabled lady. She was suffering from pain in her feet as well as pustular psoriasis, some degree of ischaemic heart disease and chronic obstructive airways disease. As a consequence of Mrs C's immobility and the steroids used in her treatment, Mrs C had developed osteoporosis and had suffered a previous fracture in her left shoulder. Prior to the accident, she had suffered what appears to have been severe pain in her legs and feet, which was under investigation, and had been started on Gabapentin. She was also known to have maturity onset diabetes mellitus, which was under good control with a mixture of diet and an anti-diabetic medication by mouth.

18. Adviser 1 told me that when Mrs C was seen in the Accident and Emergency department of Hospital 1 on 28 September 2007 she was appropriately assessed and wisely admitted in view of the problems she suffered generally and the likely difficulty the ankle fracture would produce in Mrs C maintaining her mobility. The fracture of an ankle such as was sustained by Mrs C is potentially unstable and in ideal circumstances is fixed using plates and screws to avoid the risks of the fracture moving and the later development

of arthritis of the ankle. However, any such treatment of Mrs C would have been at high risk of infection because of her psoriasis; her evident impaired blood supply to the legs; her diabetes mellitus; and her obesity.

19. According to Adviser 1, Mrs C appears to have been fully assessed by Consultant 1 who noted the absence of any tenderness, swelling or pain on the inner side of the ankle suggesting this fracture was likely to be reasonably stable and, therefore, could be treated conservatively without the risks of surgery. Therefore, he can see no fault in such decision making. He noted that Consultant 1 recommended that a cast be applied from Mrs C's left toes to knee and this appears to have been done on the day after her admission.

20. Adviser 1 said that there is evidence that Mrs C had increasing pain thereafter. The ward nurses appear to have asked for advice about Mrs C's pain from the duty junior doctor. That doctor does not appear to have seen the patient, but merely advised that the plaster should remain in position.

21. Adviser 1 has told me that when a plaster is applied to a limb there is always the danger that it may be applied in too tight a fashion or that swelling may occur underneath it causing it to tighten. The earliest indications of such a condition are increasing pain and later the development of evident impairment of circulation, if this be severe. When a doctor is warned of such an event the correct action is to see the patient, split the cast or divide it down the sides in a process known as bivalving, if the pain appears severe and generalised or, if localised, to window the cast to make sure there is no local pressure on the skin. In the absence of such action, pressure on the skin can impair the blood supply to the skin either by blocking the outflowing veins or by blocking the inflow through arteries or smaller arterial vessels. If the blood supply to the limb is poor before the fracture, the potential for such damage is greater. False reassurance may arise when pain disappears, but this may simply be due to death of tissues.

22. Adviser 1 said that, unfortunately, he is forced to conclude that the failure of the junior doctor to attend Mrs C and deal with the plaster cast after it was applied probably led to the development of a pressure sore over the front of the ankle. In his view, it should be mandatory practice in any department where patients are treated by the application of a cast that the subsequent development of severe pain under the cast be appropriately dealt with by a doctor if the nursing staff are unable to deal with it themselves. It should be

mandatory that any junior doctor or, indeed, senior doctor advised of pain in a limb immobilised in a plaster cast at least assess the patient, note their findings and either deal with the problem by release of the cast or by the making of a window, or gain advice from a more senior party.

23. Adviser 1's belief is that Mrs C suffered a pressure sore over the front of her ankle following the application of a tight plaster cast and that she was predisposed to the development of such a condition by the longstanding poor blood supply to her legs, which had started to cause symptoms prior to her injury in September 2007. He has told me that the decision not to fix Mrs C's fracture was wise because he suspects the wounds would not have healed. Once the ulcer appeared on her left leg secondary infection took place, ultimately with MRSA. Because of the poor blood supply to Mrs C's leg and the subsequent development of another zone of ulceration unrelated to the pressure sore amputation became inevitable. The fact that a below knee amputation was not sufficient to gain healing suggests that the blood supply was parlous and would have given rise to problems within a short time even had this event not occurred.

24. Adviser 1 also addressed the question of whether this fracture could have been initially treated with a moon boot rather than a plaster cast. The view of Adviser 1 is that as long as the fracture was stable treatment with a moon boot would have been reasonable, although difficult. He has advised me that such orthoses depend upon pressure being applied to the skin and the same dangers exist as with a plaster cast. The advantage of a moon boot is that the apparatus can be removed quickly for treatment of the underlying skin. However, the use of such a moon boot could have caused a pressure sore, albeit in all likelihood in a different zone.

(a) Conclusion

25. Adviser 1 has told me that even had Mrs C not suffered the fracture to her left ankle she would have ended up with amputation of her left leg at a high level unless reconstructive vascular surgery was successful. I note from the Board's response to the complaint, however, that no reconstructive procedures were suitable because of the very poor circulation in Mrs C's leg. Adviser 1 concluded that, in his opinion, vascular problems in the left leg rather than an infection led to Mrs C having to undergo the amputation. Therefore, based on the advice I have received from Adviser 1, which I accept, I do not uphold Mr C's complaint. I recognise that Mr C and his family will be disappointed by

the decision I have reached. It is clear, from my discussions with Mr C and Mrs D, the profound and devastating effects that the amputation has had on Mrs C and her family. However, I have to be guided by the advice I have received from an independent consultant orthopaedic surgeon who has fully reviewed the medical notes of Mrs C.

(a) Recommendations

26. Nevertheless, I do acknowledge, as identified by Adviser 1, the failure of the junior doctor to attend to Mrs C's plaster cast. Therefore, the specific recommendations which the Ombudsman is making arising from this failing is that the Board:

(i) undertake a review of the policy for reviewing plaster casts and in particular referral to senior medical staff;

(ii) encourage the doctor concerned to reflect on the case at their next appraisal; and

(iii) apologise to Mrs C and her family for the failing to review Mrs C's plaster cast.

(b) Mrs C contracted a MRSA infection whilst a patient in Hospital 1

27. Mr C said that when Mrs C was transferred to Hospital 2 on 9 October 2007 he learned that she had contracted MRSA. He believed Mrs C had contracted MRSA whilst a patient in Hospital 1 between 28 September 2007 and 15 January 2008 and that had she not contracted MRSA she could have received vascular treatment for her left leg and it would not have been amputated.

28. The Board asked Consultant 3 to comment on this. Consultant 3 said at the time he had reviewed Mrs C, her daughters were present. He had discussed the implications of MRSA with them explaining that MRSA is not acquired solely in hospital and is widespread throughout the community.

29. Advice was obtained from Adviser 1. Adviser 1 told me that MRSA is a staphylococcus aureus resistant to Methicillin and similar antibiotics and is common in the community outside hospitals, particularly in the aged. Its danger is when it gets into a person's body because then only a few very powerful antibiotics with quite marked toxicity can be used in treatment. When patients are transferred from one hospital to another, MRSA screening is performed to make sure they do not harbour the organism. Those who are colonised by MRSA, ie having MRSA strains of bacteria living on their skin and/or in their

nose, throat or mouth, are more likely to give it to other people or indeed spread it into their body should they have an operation.

30. The view of Adviser 1 is that it would be wise for all hospitals admitting patients who are unscreened for MRSA to swab all patients who are admitted to assess whether they have been colonised before their entry into hospital. However, this is not as yet a universal requirement.

31. Adviser 1 has concluded, however, that the problems with Mrs C's left leg occurred for reasons other than the MRSA infection, namely because of vascular problems in the leg. Adviser 1 has stated that ulcers are a culture medium for any other infection that is around, but the ulcer does not have a direct relationship to MRSA, it is a concurrent rather than a consequential process.

32. In response to the advice I received from Adviser 1, the Board told me that they have a policy for screening patients for MRSA on admission to hospital. Mrs C was an emergency admission from home and was admitted to an emergency admission unit where patients were assumed to be MRSA positive, but not specifically treated. Emergency admissions are not routinely screened unless they are admitted from another hospital care environment or have chronic ulcerations. Mrs C's MRSA status was checked when she was later re-admitted with a leg ulcer.

33. The Board said that had Mrs C been admitted as an elective procedure, she would have been MRSA screened because she had chronic ulceration and multiple previous admissions to hospital with medical problems, admission would have been deferred and the MRSA treated prior to admission. Mrs C's bacteriology results show that in February 2007, months prior to her admission in September 2007, she had MRSA in her sputum suggesting that because of her multiple medications, co-morbidites and psoriasis, she was a chronic carrier. It is likely given her chronic chest and skin conditions that an eradication policy would be unlikely to be successful.

(b) Conclusion

34. From the evidence I have seen, and the clinical advice I have received I am unable to conclude that Mrs C contracted MRSA while a patient in Hospital 1 between 28 September 2007 and 15 January 2008. Furthermore, based on the clinical advice I have received, I am unable to conclude that an

MRSA infection caused or contributed to the amputations to Mrs C's left leg. Therefore, I do not uphold this complaint.

(b) Recommendation

35. In view of the conclusion I have reached on this complaint, the Ombudsman has no recommendation to make.

(c) The standard of nursing care which Mrs C received was inadequate

36. Mr C raised a number of concerns about Mrs C's nursing care. This included that Mrs C's pain was not managed well; there was a lack of continuity of care; and her general welfare and dietary needs were also not managed well. Further, that although Mrs C was known to suffer from diabetes and psoriasis staff failed to treat the sores on her feet despite creams being supplied by the family.

37. In their response to Mr C's complaint, the Board asked the charge nurse (the Charge Nurse) on the ward where Mrs C was a patient to comment.

38. The Charge Nurse said that the vast majority of the patients in the ward where Mrs C was a patient are elderly and vulnerable. Therefore, indifference by staff towards patients, such as Mrs C, would not be tolerated. He considered that Mrs C's problems were taken very seriously. Mrs C was seen by a consultant orthopaedic surgeon and his team, a consultant pain specialist, a vascular surgeon, an ortho-geriatrician staff grade and various consultants, nurses, physiotherapists and the hospital at night team. Referrals and advice were also sought from the tissue viability nurses and dermatology team.

39. The Charge Nurse said that Mrs C's skin creams were prescribed on her medicine chart but as a 'required' option and not regularly. He accepted that this could and should have been better prescribed and for this he apologised.

40. Advice was obtained from Adviser 2 who told me that Mrs C's medical notes show that a multi-disciplinary ankle and foot injury care pathway was implemented following Mrs C's admission to Hospital 1. Adviser 2 stated that Mrs C's care pathway ended on 2 October 2007 which surprised her given the complexity of Mrs C's pain, and that an individualised and specific plan of care was not developed for Mrs C after that date. This, in Adviser 2's view, would have been good practice.

41. Adviser 2 noted that there are only three formal recordings of Mrs C's pain score on her observation chart. She suggested that the maintenance of an appropriate pain assessment chart would have been essential for the monitoring and management of Mrs C's pain, particularly, as there was no way of measuring the increase or decrease of pain other than the recording of staff's opinion on each shift. There is, however, evidence that analgesia was given as prescribed to Mrs C and that efforts were made to ensure that stronger analgesia was given to her when pain was not relieved by regular analgesia.

42. Adviser 2 was of the opinion that the cause of Mrs C's pain may have been difficult to assess because she did have pre-existing pain in both legs. In Adviser 2's opinion, differentiating between the types and the site of the pain may have been difficult. She also cannot state unequivocally that staff did not act quickly enough to investigate Mrs C's concerns about the discomfort she was experiencing underneath the plaster cast. Adviser 2 said that although she had identified some shortcomings in the documentation of pain scores and the lack of escalation of concerns, she did, however, consider that overall there is evidence that Mrs C's pain was taken seriously, that referrals were made to appropriate teams and Mrs C was reviewed by them in a timely manner.

43. Adviser 2 also considered Mr C and his family's complaint that the nurses always appeared to be different each time they visited and there was a lack of continuity of care. Adviser 2 said that it is important to recognise that in order to cover the 24 hour period there is always a nursing shift system in place and in addition to a core team of ward nursing staff on occasions it is often necessary to have agency staff on a ward due to staff sickness and or vacancies. From Adviser 2's review of Mrs C's medical records it is clear that there are regular entries in the nursing records by the same nurse on a number of nights. Again, on day duty there do appear to be a number of entries regularly made by the same staff members.

44. Mr C raised concerns that a swab which was taken from Mrs C's right foot was lost. Adviser 2 has been unable to locate the result from this swab in the clinical records. Having reviewed the records, Adviser 2 can advise that on 9 October 2007 an entry in Mrs C's medical notes records that a right heel swab was taken on 5 October 2007. This had grown staph aureus sensitive to varying antibiotics, and not MRSA. It is clear from this entry that the swab was reviewed.

45. Adviser 2 also considered whether Mrs C's general welfare and dietary needs were managed well including her diabetes. Adviser 2 has told me that there is evidence in the nursing notes that Mrs C's personal hygiene needs were attended to. Mrs C also had an assessment of her malnutrition risk on admission. An appropriate and well validated screening tool was utilised. According to the assessment Mrs C was identified as being in the low risk category. However, the view of Adviser 2 is that a further assessment should have been undertaken a week later. There is no evidence that this was done.

46. Adviser 2 has drawn to my attention the assessment of and the care planning for Mrs C. Adviser 2 has told me that assessment is the cornerstone to establishing the needs of older persons admitted to hospital and it should be an on-going and dynamic process. It is the view of Adviser 2 that specific care plans should have been generated for Mrs C in relation to pain management, her diabetic status and her foot and leg care, in view of her psoriasis.

47. Adviser 2 has noted that a core care plan developed for Mrs C focused primarily on her orthopaedic management. The use of core care plans is an acceptable practice. However, these require regular review and additional, specific and person centred care plans do need to be added as an integral part of on going assessment.

48. Adviser 2 has told me there is no evidence of a specific care plan regarding Mrs C's psoriasis and the need to have creams applied. However, in Mrs C's medical records there is an entry that Mr and Mrs C complained about this on 8 October 2007. From the evidence available it does appear that the appropriate creams were not applied on a daily basis although it is clear from the entry made in Mrs C's notes on that day that attempts were made to apply the cream but this was declined by Mrs C. However, immediate and appropriate action was taken by a member of the nursing staff who issued an apology to Mr and Mrs C, contacted the dermatology department and an out-patient appointment was made for 12 October 2007. Adviser 2 is satisfied that appropriate apologies and action were taken on this issue by nursing staff.

49. Following the advice received from Adviser 2, I asked the Board to comment on the issues which Adviser 2 has raised in her advice to me concerning care planning.

50. In their response, the Board told me a malnutrition Universal Screening Tool 2005 (MUST) assessment was made of Mrs C on 28 September 2007 and was recorded as '0' low risk. The Board have told me that this should have been repeated on a weekly basis. The Board have accepted that there is no evidence that this was undertaken. The Board have told me that a system has now been put in place in the ward where Mrs C was a patient whereby all patients are re-screened over weekends, thereby ensuring that patients are screened on admission and weekly thereafter.

51. The Board have told me that Mrs C's diabetes is noted in her initial assessment and in the Integrated Care Pathway (ICP) which would lead nurses to use her 'Diabetic Treatment Chart' as part of her care planning. Copies of these have been supplied to me. The Board have also supplied me with what they say is evidence of assessment and monitoring of Mrs C's diabetes, which are in the admission document dated 28 September 2007 and the ICP dated 29 September 2007. The Board has told me that ICPs provide the basis of core care in planning and management within the orthopaedic department of Hospital 1. Therefore, the ICP will guide the nurse to use supplementary documents relating to the specific care requirements of that patient. In Mrs C's case, it was the 'Diabetic Treatment Chart' and the 'Wound Assessment Chart, copies of which have also been supplied to me.

52. With reference to the assessment of Mrs C's pain, the Board have also told me that throughout the time that Mrs C was a patient in the orthopaedic department she was reviewed both by an ortho-geriatrician and the pain team, both of who ensure that regular assessment of regimes are made. The pain team hold their own notes on patient management, which regrettably the Board are not able to supply.

53. The Board have told me that a working group meets regularly to re-evaluate, improve and adapt ICPs in the light of new evidence, need or legislation. This process has also included the ongoing production and evaluation of such supplementary pathways as 'Surgical patients with Diabetes Mellitus' 'Urinary Catherisation', 'Patients with Diarrhoea', 'Blood Transfusion' and 'Patients with MRSA' which are incorporated into the patients generic pathway as required.

54. During the course of my investigation, Mr C and his family raised a specific issue concerning a particular event on 15 January 2008, the day Mrs C had her

surgery for the above knee amputation. The family say that immediately after her surgery the syringe driver administering a pain relieving drug was not working and nurses did not notice this even though Mrs C was screaming in pain and was clearly uncomfortable. I asked the Board to comment on this.

55. In their response, the Board told me that it can be standard practice with subcutaneous infusion syringe drivers for an inaccurate reading within the first hour of commencing the infusion. Therefore, it would not be expected for nursing staff to act immediately when the infusion did not give the full dose. When checked the next hour and found not to be working staff acted promptly and had medical assistance within half an hour.

(c) Conclusion

56. Failings have been identified in the nursing care of Mrs C, specifically in relation to the treatment and application of creams to the sores on her feet and the follow-up to her initial malnutrition screening assessment. However, I am satisfied that appropriate action has been taken by the Board to address these failings. Although Adviser 2 identified some shortcomings in the documentation of pain scores and the lack of escalation of concerns, I have noted that she did, however, consider that overall there is evidence that Mrs C's pain was taken seriously, that referrals were made to appropriate teams and Mrs C was reviewed by them in a timely manner.

57. In relation to Mrs C's care planning, I am satisfied that the ICP and the supplementary documents relating to Mrs C's specific care requirements did address her specific care needs. I have also noted the ongoing action that the Board are taking to re-evaluate, improve and adapt ICPs in the light of new evidence, need or legislation. Therefore, I am satisfied that the Board have, where appropriate, taken action and made changes that address the concerns raised and failings identified in this complaint. In all the circumstances, I, therefore, do not uphold this complaint.

(c) Recommendation

58. As the Board have addressed the outstanding issues, the Ombudsman has no recommendation to make.

(d) The standard of record-keeping in respect of Mrs C's medical notes was inadequate

59. During the course of my investigation, Adviser 1 and Adviser 2 raised concerns and identified a number of shortcomings in the standard of record-keeping in Mrs C's medical notes. Therefore, although not part of the initial investigation, I have included this in my investigation and the Board were given an opportunity to comment.

60. Adviser 1 pointed out his concern that there is no note of the findings of Consultant 1 when the plaster cast was removed from Mrs C's ankle on the 16 October 2007. There appeared to be no direction given to the doctors at Hospital 2, where she was rehabilitating as an in-patient and such lack of documentation should be addressed.

61. Adviser 1 raised concerns about the consent forms which Mrs C signed prior to her amputation surgery. He noted that although the operation was described, neither consent form has been completed adequately; there was a singular failure to affix patient identifier labels or give the details in a written form; the name and status of the practitioner was not given; and the signature was indecipherable.

62. While Adviser 1 has told me that he can have no criticism of the care given to Mrs C in Hospital 2, he finds it disturbing that when Mrs C was seen in varying hospital departments there was either a lack of notes or the parties concerned did not write a handwritten letter or annotation in the available notes, which could be returned to Hospital 1. This should in his view be addressed.

63. Adviser 2 told me that she had identified a number of shortcomings in the standard of record-keeping. She said there are clear standards of record-keeping in nursing and the importance of documenting care cannot be over-emphasised. It is Adviser 2's opinion that the Board should be able to demonstrate that there are appropriate systems in place to monitor standards of all aspects of nursing documentation in line with professional standards.

64. The Board in their response told me that they asked Consultant 1 to comment on the fact that some of Mrs C's medical records appear incomplete and there did not appear to be a note of his findings when Mrs C's plaster cast was removed from her ankle on 16 October 2007. Consultant 1 confirmed there is an omission in Mrs C's case notes for this date. He said that Mrs C was

reviewed, her x-ray was satisfactory and the cast was changed for skincare. He was subsequently called to the plaster room later that visit to review a small ulcer which was discovered by the plaster technicians on removing the cast. It was thought that it would heal spontaneously and Mrs C was placed in a removable moon boot to allow skincare and mobilisation, as the fracture had sufficient stability. Mrs C was readmitted to Hospital 1 on 4 December 2007, an earlier appointment on 20 November 2007 being deferred for reasons unknown. It was at this visit that the ulcer was enlarging. Consultant 1 stated that consent forms were written by and signed and dated by him on the days when Mrs C had her amputation surgery.

65. The Board stated that the consent forms are incomplete in that there is no patient label attached, although Mrs C's name is written on the consent form, the date of birth is missing from one and entered in the wrong place on the other and the date is not entered where Mrs C had signed. The operation is correct, the consultant's signature is correct and the date of signing is correct.

66. The Board have also told me that within the remit of the Scottish Patient Safety Programme (SPSP), they have adopted a formal review process to monitor the standards of record-keeping. A multi-disciplinary group review a cross section of health records monthly to evaluate compliance to the standards of record-keeping. A copy of the pro-forma document used for this has been supplied by the Board.

(d) Conclusion

67. I acknowledge the action that the Board has taken to monitor and review the standards of record-keeping as detailed at paragraph 66 of this report. However, on the basis of the advice I have received from Adviser 1, I consider there is sufficient cause for me to uphold this complaint and to make recommendations to the Board.

(d) Recommendations

68. Therefore, the specific recommendations which the Ombudsman is making arising from the failings in record-keeping identified in this complaint is that the Board:

(i) provide the Ombudsman with copies of the next SPSP audit in relation to all patient records within the orthopaedics department of Hospital 1; and

(ii) remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified.

69. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	Mr C's wife and the subject of the complaint
The Board	Lothian NHS Board
MRSA	Methicillin-resistant staphylococcus aureus
Advisers 1	Professional medical adviser to the Ombudsman
Adviser 2	Professional medical adviser to the Ombudsman
Mrs D	Mr and Mrs C's daughter
Hospital 1	The Royal Infirmary of Edinburgh
Hospital 2	Astley Ainslie Hospital, Edinburgh
Consultant 1	A consultant orthopaedic surgeon at Hospital 1
Consultant 2	A consultant plastic surgeon who assessed the ulcer on Mrs C's leg on 14 December 2007 at Hospital 1
MRI	Magnetic Resonance Imaging
Consultant 3	A consultant orthopaedic surgeon who reviewed Mrs C on 9 January 2008
The Charge Nurse	The charge nurse on Mrs C 's ward
MUST	Malnutrition Universal Screening Tool

ICP	Integrated Care Pathway
SPSP	Scottish Patient Safety Programme

Annex 2

Glossary of terms

Anterior	The front of the ankle
Duplex vascular assessment	An assessment of the blood vessels in the leg using ultrasound
Femoral artery	A main artery in the leg
Gabapentin	A medicine used to relieve pain
Integrated Care Pathway	A plan of patient care
Methicillin	An antibiotic of the penicillin class
Methicillin-resistant Staphylococcus aureus (MRSA)	A bacterium that can cause serious infections
Necrotic sore	Dead/dying tissue in an open wound
Scottish Patient Safety Programme	A national programme to drive improvements and standardise approaches to care in hospitals
Vancomycin	An antibiotic medicine used in the treatment of infections