Scottish Parliament Region: Glasgow

Case 200502299: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; General Surgical

Overview

The complainant (Miss C) raised a number of concerns about the treatment she received at the Victoria Infirmary, Glasgow (the Hospital) in July 2005 following an operation to remove her appendix. The complainant was concerned that the management of the wound was poor and that staff had not told her that her appendix had been gangrenous and the wound was at risk of infection. She also complained there was a failure to inform the thyroid clinic of the result of a blood test and that her antithyroid medication had been increased.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) there was poor wound management and communication *(not upheld);* and

(b) staff failed to advise the thyroid clinic of the result of a blood test and that antithyroid medication had been increased *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board gives consideration to providing telephone or electronic updates to out-patient clinics when discharge letters for in-patient stays will not be ready prior to the next out-patient appointment.

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

Main Investigation Report

Introduction

1. On 6 January 2006 the Ombudsman received a complaint from the complainant (Miss C) about the treatment she received from Greater Glasgow and Clyde NHS Board (the Board) at the Victoria Infirmary, Glasgow (the Hospital) in July 2005 following an operation to remove her appendix.

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

(a) there was poor wound management and communication; and

(b) staff failed to advise the thyroid clinic of the result of a blood test and that Miss C's thyroid medication had increased.

Investigation

3. In writing this report I have had access to Miss C's clinical records and correspondence relating to the complaint. I sought clinical advice from one of the Ombudsman's professional medical advisers (Adviser 1) and a nursing adviser (Adviser 2). 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 can be found at Annex 1 with a glossary of medical terms at Annex 2. Miss C and the Board have had the opportunity to comment on the draft of the report.

Medical background

4. Adviser 1 reviewed Miss C's clinical records and noted that Miss C was referred to the Hospital on 30 June 2005 with a history of abdominal pain associated with vomiting and had diarrhoea. She was 22 years old at the time and her only significant medical history was noted to be hyperthyroidism for which she was taking Carbimazole. The history and physical signs were suggestive of appendicitis and immediate admission for surgery was arranged. Intravenous antibiotic therapy in the form of Cefradine and Metronidazole intravenously was instituted. At 18:20 on 30 June 2005, an open appendicectomy operation was performed. At operation the appendix was described as 'acutely inflamed with gangrenous tip and early abscess and early mass formation'. On the operation notes – which Adviser 1 felt were clear and comprehensive - it was recorded that a routine appendicectomy was performed. The abdominal cavity was washed out with saline. The abdominal wound was closed in layers, using absorbable sutures, and the skin closed with staples. The post-operative instructions included the continuation of the intravenous

antibiotics which had been commenced preoperatively.

5. Post-operatively Miss C appeared to have made a smooth early recovery. Her pain settled quickly, but she was noted to have a rapid pulse rate which was thought to be possibly due to her overactive thyroid and instructions were given for her to be prescribed Propranolol intravenously if her tachycardia persisted; her thyroid management was also discussed with her consultant endocrinologist who suggested increasing her Carbimazole dosage, commencing Propranolol, and who also agreed to review her in his out-patient clinic at Glasgow Royal Infirmary. On 2 July 2005 the notes say 'Wound healed well, apyrexial, still on antibiotics – stop today – if well, home tomorrow'. On 3 July 2005, Miss C's condition is described as 'very well, apyrexial no issues, wound dry and clean'. She was reviewed by the registrar prior to discharge, an information leaflet was issued by the nursing staff, and arrangements were made for her to have her wound clips removed on 11 July 2005.

6. On 9 July 2005, Miss C attended the Accident and Emergency Department at the Hospital complaining of discharge from her wound. She was seen in the Accident and Emergency Department and subsequently by a member of the surgical team. The wound was found to be discharging and she was admitted under the care of Consultant 2. At this stage it was ten days since Miss C's operation and the admission notes recorded that she had had a fever 'for two days and that her wound had been discharging a yellowish exudate for one day'. The wound was found to be mildly erythematous with a yellowish discharge from which a swab was taken. Blood cultures were also sent, analgesia was prescribed and following discussion with the surgical Senior House Officer, a decision was made to remove the wound clips and not to prescribe antibiotics at that time. Adviser 1 noted from the records that Miss C was much more comfortable following the removal of the wound clips and that later in the day her temperature had returned to normal. Miss C was seen by Consultant 2 at 15:00 on the day of admission and he advised with regard to her wound management the use of a stoma bag to collect the discharge and thus reduce the likelihood of excoriation. A stoma bag was, therefore, attached to the wound which continued to drain copiously.

7. Miss C was reviewed on the ward round on 11 July 2005, and on that occasion a pelvic ultrasound was carried out which showed findings in keeping with a possible abscess in the pelvis. Digital rectal examination, however, revealed no abscess posteriorly and a possible 'boggy mass' palpable anteriorly

which could have been due to the wound abscess. Thereafter the wound continued to drain and Miss C's general state seemed to have improved. Adviser 1 noted that Miss C's white cell count and CRP had returned to normal on 15 July 2005. Miss C was allowed to go home on 'temporary leave' and when she returned on 18 July 2005, the drainage was continuing but she was feeling well in herself. Miss C was thereafter reviewed on the ward and in the out-patient clinic. Adviser 1 noted that when Miss C was seen in Consultant 2's out-patient clinic on 25 July 2005 the letter to Miss C's general practitioner stated 'the wound is now almost dry'. When Miss C was seen by Consultant 2 on 17 August 2005, a letter to Miss C's GP states 'the wound has almost now completely healed now. There is a little suture material protruding. We will trim this back today'. The continuing management of Miss C's wound appears to have been totally carried out by primary care staff.

(a) There was poor wound management and communication

8. Miss C complained to the Board that when she was discharged on 3 July 2005 there was no dressing on the wound and she was not told how to take care of it. The wound started to leak on 9 July 2005 and she was admitted back into hospital as she had developed an infection. During that week the stoma bag was only emptied when she asked the staff and she was not given antibiotics to treat the infection. Miss C said the wound management was poor; that staff never explained to her what caused the infection and when she asked she was told 'these things happen'. She was never told the appendix was gangrenous or that the probability that she would suffer a wound infection would be high.

9. The Board responded to the complaint in that Miss C had been admitted on 30 June 2005 with a diagnosis of acute appendicitis. An inflamed appendix was removed and the tip was found to be gangrenous with early abscess formation. Intravenous antibiotics were prescribed and discontinued 48 hours post-operatively. Post-operative recovery was satisfactory but rapid pulse rate was noticed. Miss C was seen by a consultant endocrinologist who recommended Propranolol and increased the prescription for her over active thyroid medication. Discharge was arranged on 3 July 2005 as Miss C had no high temperature or sign of infection. An information leaflet was provided with advice and a discharge form for District Nurses and appointment to see GP on 11 July 2005 for removal of skin clips. An apology was made that the copy discharge letter was not sent to the thyroid clinic regarding the operation and the prescribing of additional thyroid medication but this was complicated by the

fact that Miss C was readmitted on 9 July 2005 under Consultant 2's care. On readmission Miss C had a raised temperature and a wound abscess was diagnosed. It was decided to remove the clips to allow drainage and not prescribe antibiotics. A wound manager bag was fitted over the wound to collect the drainage fluid. An ultrasound was performed on 11 July 2005 and identified an abscess which was discharging spontaneously. Miss C was advised of the result.

10. On 13 July 2005 Miss C's temperature had returned to normal and 100mls of fluid had drained in the previous 24 hours. Digital rectal examination found no evidence of blood. Consultant 2 could not recall exactly what was said to Miss C but felt that he had clearly kept her informed as she asked questions on several occasions. On 15 July 2005 medical staff assessed Miss C as being fit for a weekend pass and the nurses explained how to manage and change the wound manager bag if required at home. The bag was checked prior to discharge on pass. Miss C was finally discharged on 19 July 2005 and it was agreed bloods would be checked and Miss C would make an alternative thyroid clinic appointment. The GP was advised that the wound had largely settled and was almost dry. At Consultant 2's clinic on 17 August 2005 it was noted Miss C continued to make good progress. Consultant 2 wrote to the GP on 28 September 2005 after reviewing her at his clinic and said the appendectomy wound was a little withdrawn but had dried up. It was at this appointment that Miss C raised concerns about her in-patient management. In summary staff felt that they had communicated with Miss C in a satisfactory manner and had not prescribed unnecessary antibiotics.

11. Adviser 1 said that he felt Miss C was correctly managed. The diagnosis of appendicitis was made promptly and her surgery was carried out expeditiously. The finding of a gangrenous appendix tip at the time of laparotomy confirmed the seriousness of the appendicitis but from the operative notes there does not appear to have been associated peritonitis. The use of prophylactic antibiotics for the first three days was totally in keeping with standard clinical practice and that to stop antibiotic therapy in a patient who was clinically well and apyrexial after three days was also totally appropriate. It was in Adviser 1's view, totally reasonable not to recommence antibiotic therapy when Miss C was readmitted for draining a wound abscess – the treatment for such a condition is drainage and this was occurring spontaneously. Adviser 1 said that unnecessary antibiotic use should be avoided especially if one wishes to minimise the risk of antibiotic resistance and troubles with diseases due to

overgrowth of bacteria such as clostridium difficili and MRSA.

12. Adviser 1 continued that the association of wound infection with a severely inflamed appendix is well documented and appropriate steps were taken to minimise its occurrence. Whether Miss C was told her appendix was 'messy' or gangrenous was not, in Adviser 1's opinion, particularly relevant – these descriptive terms are sometimes used to explain to a patient that the organ was indeed diseased as suspected but do not suggest any different form of management should have been instituted. Adviser 1 said it was obviously difficult to comment as to precisely what was said to Miss C in her post-operative period with regard to the risk of infection and he would not expect the details of every conversation to be recorded in the case records. He commented it was good surgical management to cover a discharging wound with a stoma bag of some sort used to reduce the likelihood of the discharging fluid damaging the surrounding skin and to make management of the wound more comfortable for the patient. In conclusion Adviser 1 felt that Miss C was managed reasonably in every respect. Appendicitis can be a very severe disease, wound infections in association with appendicitis do occur even with correct management – as had happened in Miss C's case.

13. Adviser 2 said that the nursing records were generally legible, signed and sequential and completed to a good standard. The Nursing Notes recorded clear progress of the patient. Evaluation of Miss C's care was documented by the Nursing Notes which were fully detailed. Adviser 2 did have a slight concern that the Patient Care Plan Sheet did not contain sufficient provision to communicate exactly how care was to be delivered. Adviser 2 suggested that the board might consider this need when the relevant nursing documentation next undergoes a design review. However, overall Adviser 2 was satisfied that the care Miss C received was of a reasonable standard.

(a) Conclusion

14. Miss C believed that she had not received adequate information from staff regarding the seriousness of her condition and that the wound was managed inappropriately. However, after accepting the advice of the Advisers, I am satisfied that Miss C was provided with reasonable explanations from staff regarding her operation. I also hope that Miss C will take some comfort from the comments from the Advisers which provide additional information regarding her management while in hospital. Accordingly I do not uphold this aspect of the complaint.

(a) Recommendation

15. The Ombudsman has no recommendations to make.

(b) Staff failed to advise the thyroid clinic of the result of a blood test and that Miss C's thyroid medication had increased

16. Miss C also complained to the Board that she was due to attend an appointment at the thyroid clinic at Glasgow Royal Infirmary on 19 July 2005 but she was still in Ward 9 about to be discharged. Although Miss C had previously alerted the staff, it appeared that nobody had told the ward sister. The ward sister arranged for Miss C to have a blood test to check her thyroid and said the result would be passed to the clinic. Miss C's next appointment at the thyroid clinic was on 23 August 2005 and when she attended the doctor was unaware that she had had her operation or that her thyroid medication had been altered. Miss C also complained about the failure of staff in Ward 9 to inform the thyroid clinic of the operation or results of blood tests and that she had been prescribed additional thyroid medication.

17. Adviser 2 said that the administration process for passing on information to the thyroid clinic and the readmission of the patient for wound management, had unfortunately conspired through the timing of each event, to create a poor communication link. She commented that there are often time delays from dictated letters to type format.

(b) Conclusion

18. Clearly there was a failure by staff to inform the thyroid clinic that Miss C had been an in-patient and that her thyroid medication had been increased. The result of a blood test had also not been passed on. Such information could have been relevant to clinicians at the thyroid clinic when Miss C attended her next appointment yet it was left to Miss C to provide this information. I accept that at times there will be a delay in typing discharge letters etc and usually this would not affect future treatment unless there was, as in this case, an out-patient appointment within a few weeks. I should point out that when Miss C was an in-patient, contact was made with her consultant endocrinologist who agreed to review her in the clinic. As stated above, there was a communications breakdown and accordingly I have decided to uphold this aspect of the complaint. The Board have already apologised to Miss C over this issue.

(b) Recommendation

19. The Ombudsman recommends that the Board gives consideration to providing telephone or electronic updates to out-patient clinics when discharge letters for in-patient stays will not be ready prior to the next out-patient appointment.

20. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her that the recommendations have been implemented.

27 March 2007

Annex 1

Explanation of abbreviations used

Miss C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
The Hospital	Victoria Infirmary Glasgow
Adviser 1	The Ombudsman's professional Medical Adviser
Adviser 2	The Ombudsman's professional Nursing Adviser
Consultant 2	Consultant who was responsible for Miss C's treatment following admission on 9 July 2005

Annex 2

Glossary of terms

Analgesia	Pain relief
Antibiotic	Medication effective against bacteria and infections
Appendicitis	Inflammation of the appendix
Apyrexial	Normal temperature
Carbimazole	Antithyroid Medication
Cefradine	Antibiotic medication
CRP	Tests for infection
Erythematous	Reddened
Excoriation	Loss of top layer of skin
Hyperthyroidism	Excess production of thyroid hormone
Metronidazole	Antibiotic medication
Peritonitis	Inflammation of the membrane which lines the abdomen and other organs
Propranolol	Hypertension medication
Stoma Bag	A receptacle worn over the stoma to collect faeces
Tachycardia	Rapid heart rate
Ultrasound	Imaging technique using soundwaves to examine internal organs