Scottish Parliament Region: Glasgow

Case 200503048: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category
Health: Hospital; Orthopaedics

Overview
The complainant (Ms C) raised a number of concerns about the care and treatment, which she had received from Greater Glasgow and Clyde NHS Board (the Board) during the period April 2003 to October 2005.

Specific complaint and conclusion
The complaint which has been investigated is that the Board failed to provide reasonable care following Ms C's operation on 18 April 2003 (*upheld*).

Redress and recommendation
The Ombudsman has no recommendations to make on these issues because he is satisfied that the Board have made changes that address the concerns raised in this report.

Main Investigation Report

Introduction

1. On 2 May 2006 the Ombudsman received a complaint from the complainant (Ms C) about the care and treatment she had received from Greater Glasgow and Clyde NHS Board (the Board) during the period April 2003 to October 2005 and that the Board failed to address her complaints. Ms C complained that following an operation on her fractured right ring finger on 18 April 2003, she failed to receive appropriate and reasonable post-operative care including delays in treatment. This led to a second operation, levels of pain and restricted use of her finger, all of which were avoidable. Ms C complained to the Board but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Ms C which I have investigated is that the Board failed to provide reasonable care following her operation on 18 April 2003.

Investigation

3. In writing this report I have had access to Ms C's clinical records and complaint correspondence with the Board. I obtained advice from the Ombudsman's professional adviser (the Adviser) on the orthopaedic and physiotherapy aspects of this 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 this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Ms C and the Board were given an opportunity to comment on the draft of this report.

Clinical background

5. Ms C sustained an injury to her right ring finger whilst trying to hold onto the collar of a horse which had bolted. She attended the accident and emergency department of Inverclyde Royal Hospital on 3 April 2003. An x-ray showed that she had fractured the proximal phalanx bone. The injured finger was strapped to the normal middle finger and Ms C was provided with a sling. At the Fracture Clinic the following day, a specialist registrar noted from the x-ray that the fracture was oblique and undisplaced, and there was bruising, swelling and tenderness at the base of the right ring finger. On 18 April, Ms C was admitted for an operation to correct the clinical rotation.

Complaint: The Board failed to provide reasonable care following Ms C's operation on 18 April 2003

6. Ms C complained that she had not been satisfied with the treatment which the Board had provided since April 2003. Ms C said her main concerns related to delays in treatment and that inadequate care and splinting had been provided after her first operation. Ms C's second post-operative appointment had been postponed for nearly three months with no explanation. At this appointment (8 August 2003), she requested a second opinion. An appointment was made with another consultant (the Consultant) in September but this also was cancelled and with no explanation. On 5 September, Ms C saw a private consultant and was advised that she required a specialised splint (joint jack), which she purchased herself. Ms C saw the Consultant on 17 October, who recommended continued use of the splint. On 21 January 2004, the Consultant said a second operation was required urgently, but Ms C did not receive it until five months later (June 2004) which she had secured by her own efforts. Ms C also complained that she had been discharged improperly from physiotherapy and had appropriate physiotherapy treatment continued there would have been further improvement to her finger. The delays and inadequate care had resulted in avoidable permanent damage to her finger and she could no longer ride horses.

7. In their response to the complaint, the Board said the records indicated that following her referral to the Consultant, Ms C had been given an appointment for 26 September 2003 which had been moved to 17 October. They could not explain the change in appointment date. On 17 October, the Consultant judged that continued use of the splint for three months was appropriate. At the end of the three months, he decided that little progress had been made and that a second operation was required. He was unable to operate as quickly as he would have liked because of emergency admissions, but believed the delay did not influence the final outcome as he had achieved a good clinical result in June 2004. The contracture in Ms C's finger had reoccurred, but the Board said Ms C had been aware there was a possibility this might happen following the operation and assured her the standard of care provided was of the highest calibre.

8. In response to Ms C's complaint about the standard of physiotherapy she had received, the Board said she had been seen 11 times during the period 14 July to 26 September 2004 and the range of movement in her finger had

improved. On her discharge, Ms C had indicated she was happy to continue with self-management exercises at home (a normal desired outcome), which suggested she had been satisfied with the outcome of her treatment. Physiotherapists had also increased her sessions to twice-weekly to address Ms C's concerns. Finally, there was no evidence to suggest the standard of rehabilitation provided had been inadequate.

9. In his review of Ms C's clinical records, the Adviser said Ms C had had a very unpleasant fracture with very possibly soft tissue damage to the central slip of the extensor tendon in the right ring finger. The fracture configuration was unstable and there may have been other soft tissue elements damaged at the time of the injury. The outcome of fractures in the fingers with soft tissue injury can be difficult to predict. If just a bone is broken, the outcome should be excellent, but the outcome was less certain when soft tissue was also involved as the injury was more serious. In this context, the treatment Ms C had received had been largely reasonable. The clinicians involved seemed to have diagnosed quickly the rotational deformity Ms C developed during conservative treatment and the decision to operate was the right one. It was difficult to know whether surgery had caused the central slip damage or whether it was damaged at the time of the injury. However, the Adviser was concerned about the six-month delay in Ms C's second operation.

10. Referring to the delays in treatment and whether this had any effect on the eventual outcome, the Adviser said the only significant delay was that between the decision to operate in January 2004 and when it was carried out in June 2004. This second major surgical operation should have been carried out as soon as possible. He also said that not putting Ms C on an emergency list was appropriate given the delicacy and intricacy of the hand surgery required.

11. After the Adviser gave this advice, it emerged that Ms C’s operation was originally scheduled for early April 2004. Ms C was seen at a Pre-Admission Clinic on 6 April 2004. I have not seen any note of this clinic. However, I have seen a nursing note of 1 June 2004 which says ‘surgery cancelled in April 2004 due to mouth abscess’. When I asked her about this, Ms C checked with her dentist and she has confirmed to me that she did have an abscess which was being treated with antibiotics in April 2004. I have been advised that in these circumstances it was reasonable to postpone the operation.

12. In terms of the physiotherapy treatment Ms C received, the Adviser said it was difficult to assess the overall management of Ms C including the standard of treatment provided because of difficulties in reading the notes and the format of the notes. The notes should make clear all aspects of management of the patient by the physiotherapy department including assessment and treatment provided, and all communication with the patient and the orthopaedic surgical team. Given the complexity of Ms C’s injury, the physiotherapist providing treatment to Ms C should have been a specialised hand physiotherapist and, although well qualified, Ms C's physiotherapist was not a specialised hand therapist.

13. The Board have told me that they did not employ a specialist hand physiotherapist at that time. The Board subsequently told me, however, that they do employ extended scope practitioners who are trained to higher level but do not solely cover one part of the body.

14. The Chartered Society of Physiotherapy Core Standards of Physiotherapy Practice (2005) guidance states that record-keeping should provide written evidence of, amongst other things, a compilation of data consisting of details relating to the patient including their perception of their needs and their expectations, a physical examination in which the result of the outcome measurement is recorded, identified needs/problems and subjective and objective markers together with the physiotherapist’s clinical diagnosis. It should also contain a treatment plan including timescales, goals and outcome measures, which should be evaluated and reviewed at each session. The records should also be concise, legible and in a logical sequence, and should clearly record appropriate consent to medical procedure.

15. The General Medical Council Good Medical Practice guidance states that, in providing care, clinicians 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 clinician'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.

Conclusion

16. Ms C complained that the Board had failed to provide reasonable care following her operation on 18 April 2003, which Ms C believed resulted in avoidable permanent damage to her finger. In particular, she had concerns about the delays in treatment and the physiotherapy treatment that had been provided. It is clear from the clinical advice I have received that the complex nature of the injury Ms C sustained meant a successful outcome would be difficult to achieve. I accept the Adviser's view that overall, the surgical treatment Ms C had received was reasonable.

17. There was a delay in carrying out the second operation, and it is not clear if the outcome for Ms C would have been better had she received a second operation sooner. However, the postponement of the operation in April 2004 was not within the control of the Board.

18. Not being treated by a specialised hand physiotherapist may also have contributed to the eventual outcome. I criticise the Board for appearing to fail to provide Ms C with appropriate specialist physiotherapy treatment.

19. Shortcomings have been identified in the Board's record-keeping, particularly in relation to obtaining consent for both operations and the physiotherapy treatment provided. It is not clear from the records that Ms C had been made aware fully of the risks of the operations (whether these had been discussed is impossible to determine in the absence of any written record given the passage of time since the event and the difficulty in corroborating an oral account). If Ms C had not been made aware of the risks, then she did not give informed consent to the procedures. Communication with patients and the recording of it in medical records is vital to good record-keeping, which should provide a clear narrative of the patient's treatment and should conform to guidelines. This is particularly pertinent to issues of consent, but the inadequacy of the physiotherapy records has also meant the Adviser has been unable to reach a firm conclusion on the quality of the physiotherapy treatment provided. I criticise the Board for their record-keeping.

20. Taking all of these circumstances into account, I uphold the complaint as there was poor record-keeping, particularly in relation to physiotherapy treatment provided. The Board had also failed to record if fully informed consent had been sought, and given, particularly in relation to possible complications of the first and second operations. These failures in record-

keeping make it difficult to understand the management of Ms C including the decision making which determined treatment and whether all aspects of treatment were reasonable.

Recommendations

21. This investigation highlighted the inadequacy of the Board's record-keeping at the time. In a draft report the Ombudsman recommended that the Board:

(i) provide evidence that the problems identified in this complaint have been addressed and that their record-keeping meet relevant standards; and

(ii) ensures their health professionals are aware of and follow the guidance issued by the then Scottish Executive Health Department on good practice on obtaining consent.

In response to the draft report, the Board provided me with evidence that their practice and procedures have been reviewed and changed. I have reviewed these changes, and they have also been reviewed by one of the Ombudsman's advisers. We are satisfied that the changes address the concerns raised in this report, and, therefore, the Ombudsman has no recommendations to make on these issues.

22. The Board have also told me that the Surgery and Anaesthetics Directorate will work through the issues identified in the report to identify if further actions are required, and this review will include the level of extended scope practitioner coverage and support.

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	Ombudsman's medical adviser
The Consultant	Consultant Orthopaedic at Inverclyde Royal Hospital

Annex 2

Glossary of terms

Contracture	Permanent physical defect that does not allow passive correction of a joint or other deformity
Central slip	Integral part of the extensor tendon mechanism on the back of the finger which allows the proximal interphalangeal joint to become straight when the extensor tendon is working
Extensor tendon	Located on the back of the hand and fingers, allow you to straighten your fingers and thumb
Fracture configuration	The pattern of the breaks in a bone
Proximal interphalangeal joint	Joint between the first (proximal) and second (middle) phalanges
Proximal phalanx	Small bone of a finger, closest to the palm of the hand
Rotational deformity	Poor result of fracture management which means one bit of the bone has rotated on another as the fracture has healed

Annex 3

List of legislation and policies considered

General Medical Council Good Medical Practice guidance

Chartered Society of Physiotherapy Core Standards of Physiotherapy Practice (2005)

Annex 4

Pictorial description of terms