SPSO decision report

Case: **201203387, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C attended a hospital emergency department, with a badly cut hand. He was assessed by an emergency nurse practitioner. Following an examination, the nurse noted that he had superficial cuts to the second, third and fourth knuckles which were treated with steri-strips (adhesive strips that can be used to close small wounds). Mr C was referred to a consultant orthopaedic surgeon three weeks later as he noticed that he had poor extension (straightening) of his middle finger. The consultant and a specialist orthopaedic registrar reviewed Mr C and said that the function of the finger was recovering. They did not arrange a further review, but some eight months later, Mr C was reviewed again at his request. The consultant suggested a night resting splint for six months, and discharged him back to the care of his GP. Mr C was only able to use the splinting for a month because he found it uncomfortable, and the GP referred him again for a further assessment. Mr C was reviewed some six months later, when again the consultant discharged him back to the GP saying that he was happy to see Mr C again if he wanted to talk things over further or reconsider the outcome of their discussion.

Mr C told us that he now has a bend in his finger, which is very sore. He complained that the nurse should have conducted a more thorough assessment or asked a doctor for advice. He was also concerned about the follow-up treatment he received.

After taking independent advice from a surgical adviser and a nursing adviser, we found that the record-keeping of the initial assessment was not of a reasonable standard. It did not show that the nurse carried out a full and extensive examination of the injury including, significantly, movement and wound base of the cuts. We also found that there were failures in discharge planning. Our nursing adviser said that it was difficult to know from the records if there was evidence of a further injury that would have meant he should have been referred to a specialist. However, as we have to reach a decision based on the evidence available, we upheld Mr C's complaint about his treatment after the injury occurred, given the failures in record-keeping in relation to the assessment and discharge plan.

In relation to the follow-up treatment the advice we were given, which we accepted, was that this was reasonable. We were satisfied that he was seen appropriately on three occasions, and our medical adviser explained that the treatment plans and discharge arrangements for these consultations were reasonable.

Recommendations

We recommended that the board:

- ensure that the findings of this complaint are discussed with the nurse and that it is used as a learning tool in terms of their professional development for carrying out examinations of this nature;
- bring the failures in record-keeping to the attention of the nurse; and
- apologise for the failures identified.