SPSO decision report

Case: **201701591, Scottish Ambulance Service**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained on behalf of her late husband (Mr A) that the ambulance service failed to transfer Mr A to hospital in an appropriately safe manner. Mr A had recently been diagnosed with a cancerous tumour on his femur (thigh bone) and was at risk of fracture. While being admitted to hospital for pain management, Mr A sustained a fractured femur while he transferred himself from a trolley cot to a hospital trolley. Mrs C was also concerned that the ambulance crew did not stay with Mr A in the accident and emergency department until he was attended to by hospital staff and did not complete an incident report regarding the fracture.

We took independent advice from a paramedic clinical team leader. We found that good practice should have dictated the use of transfer equipment or, as a minimum, the supporting of Mr A's leg during his efforts to self-mobilise. We also considered that the ambulcance crew should not have left Mr A in hospital without ensuring treatment had commenced and should have completed an incident report regarding the fracture. Therefore, we upheld Mrs C's complaint.

Mrs C also complained about how the ambulance service handled her complaint. We found that there was an unreasonable delay in responding to the complaint and a failure to keep her updated. We also noted that Mrs C only received a copy of the internal investigation report document. No formal, personalised complaint response letter was issued and she was not informed of her right to appproach us with her complaint. We upheld Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to adhere to best practice when transferring Mr A to the hospital trolley; failing to stay with Mr A until active treatment commenced; and failing to complete an incident report in line with protocol.
- Apologise to Mrs C for failing to respond to her complaint within 20 working days; failing to proactively inform her of the delay and keep her updated; and failing to issue a formal, personalised written response (including details of her right to approach the SPSO). The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- The ambulance service should demonstrate organisational learning to try to prevent similar future failings – they should complete and share with staff an anonymised case study highlighting the identified failings in this case.

In relation to complaints handling, we recommended:

- The ambulance service should ensure their complaints investigations comply with the requirements of the NHS Scotland model Complaints Handling Procedure – they should highlight these requirements to complaints handling staff.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.