SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Highlands and Islands

Case ref: 201304732, Highland NHS Board
Sector: Health
Subject: Hospitals; appointments; admissions (delay / cancellation / waiting lists)

Summary
Mr C was an older man with multiple health problems; in July 2013 he suffered a fall at home and fractured his hip. He was taken to his local hospital, with the intention being he should be transferred to Raigmore Hospital for surgery. Mr C was not transferred until two days after the fall, and surgery was performed three days after the fall. He spent time recovering in another hospital after the surgery, and was discharged in August 2013. Mr C died in May 2014.

Mr C's wife (Mrs C) complained to Highland NHS Board (the Board) about the length of time taken to transfer Mr C to Raigmore Hospital, particularly taking into account the amount of pain relief that he was being given at the local hospital. She felt he should have had surgery within one day, given his multiple health problems, and that the delay and use of pain relief had contributed to his poor recovery and subsequent decline in health. The Board apologised for the distress caused and said that due to bed pressures it had not been possible to transfer Mr C earlier, but that appropriate care was being given by the local hospital and that there had been no detrimental effect on Mr C. I obtained further information about the other hip operations being performed over the relevant period. The Board said those operated on earlier had been admitted to Raigmore Hospital directly, and that Mr C's transfer had been delayed further by a lack of available orthopaedic receiving beds.

My investigation found that whilst the standard of care provided at the local hospital was reasonable, the delayed transfer meant Mr C received a large quantity of morphine, which has potential side effects which Mr C went on to suffer. In addition, the local hospital did not have the facilities required to provide the type of care outlined within the relevant national guidelines for patients with hip fractures. I found that Mr C was an emergency trauma patient and that, despite the Board's position that such patients would be prioritised over routine and elective patients, he was not prioritised appropriately. The information provided about the other procedures performed over the relevant period indicated there were no issues with theatre or surgical team availability.

Mr C had to wait on the basis that he was admitted to a local hospital rather than Raigmore Hospital directly. The importance of the timing of such surgery, in terms of the outcome, is also highlighted in the relevant national guidelines. I was critical of the Board's actions, particularly given the adverse outcome for Mr C.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide evidence that they have procedures in place to ensure that when emergency trauma patients require transfer to an orthopaedic unit for treatment, they appropriately prioritise in accordance with their clinical need;	17 July 2015
(ii) carry out an audit of the last 50 patients admitted to Raigmore Hospital for hip fracture surgery and detailing those who presented at the emergency department (at Raigmore Hospital) and those who presented elsewhere and required transfer;	17 August 2015
(iii) bring the Medical Adviser's comments to the attention of the bed management team (at Raigmore Hospital) and the relevant medical director; and	17 July 2015
(iv) apologise to Mrs C for the failures this investigation identified.	17 July 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to the Ombudsman about the time it took to transfer her late husband (Mr C) from a hospital on Skye to Raigmore Hospital in Inverness for surgery for a fractured hip. The complaint from Mrs C I have investigated is that Highland NHS Board (the Board) unreasonably failed to operate on Mr C's fractured hip within a reasonable time (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer examined all information provided by Mrs C and discussed her complaint with her by telephone. They also reviewed a copy of Mr C's clinical records and the Board's complaint file. Finally, they obtained independent advice from an adviser who specialises in care of the elderly (the Medical Adviser) on the clinical aspects of the complaint. In this case, we have decided to issue a public report on Mrs C's complaint because the failings I found led to a significant personal injustice to Mr C, and to highlight the need to consider patients' clinical needs in relation to bed management criteria and disseminate the learning from this case to other health boards.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical background

4. On 10 July 2013, Mr C, suffered a fall at home (around 10:00) and fractured his hip. Soon after, he was admitted to MacKinnon Memorial Hospital (on Skye) and x-rayed. Clinical staff intended to transfer him to Raigmore Hospital (in Inverness) the next day for surgery and managed his pain with morphine in the meantime. However, Mr C was not transferred to Raigmore Hospital until 12 July 2013, and surgery was performed on 13 July 2013. He was transferred to Portree Hospital (on Skye) on 22 July 2013 and was discharged home on 9 August 2013. Mr C died on 1 May 2014.

Complaint: The Board unreasonably failed to operate on Mr C's fractured hip in a reasonable time

5. Mrs C said that when Mr C was admitted to MacKinnon Memorial Hospital, healthcare professionals told her that the only help they could give Mr C was pain management. She telephoned MacKinnon Memorial Hospital the following day (11 July 2013) and was told that there were no beds available at Raigmore

Hospital and that he would have to wait until one became available. Mrs C was concerned about the length of time it took Mr C to be transferred and the amount of pain relief that was required before surgery was performed (on 13 July 2013). Mrs C complained that given Mr C's previous health problems (he had cancer and suffered a stroke) and his age (76), he should have been operated on within 24 hours. Mrs C said that Mr C struggled to recover from what happened and she believed that the delay in surgery and increased need for morphine contributed to his poor post-operative recovery and subsequent decline in his health.

The Board's response

6. The Board said they were sorry to hear about the distress caused by the delay in Mr C's admission to Raigmore Hospital. Unfortunately, at the time of the admission there were bed pressures in the hospital. When this happened, staff on a bed management team considered each patient due to be admitted and decided whether or not the admission could proceed. The decision on whether to admit a patient was made following full discussion and involvement with the patient's consultant. When Mr C fell on 10 July 2013 sustaining a fracture of his left hip, it was agreed that he should transfer to Raigmore Hospital for further treatment. An orthopaedic consultant (at Raigmore Hospital) raised concerns about Mr C and the need to transfer him from MacKinnon Memorial Hospital to Raigmore Hospital at the earliest possible time without compromising clinical care. Given the bed pressures within Raigmore Hospital, patients were prioritised. As Mr C was an in-patient at MacKinnon Memorial Hospital and being provided with appropriate care with regular contact from the orthopaedic department of Raigmore Hospital, it was agreed his transfer could be delayed. The Board said the delay had no detrimental effect on Mr C. As soon as it was appropriate, arrangements were made to have Mr C transferred. The Board were sorry this added to the distress caused to Mr and Mrs C, but said the priority must be that all patients within the board area were treated safely and in a timely manner.

7. Mrs C also raised her complaint through her MP, and in the Board's response to the MP, they said that emergency patients were transferred immediately to a location where definitive care could be provided for their condition. However, there could be pressure on beds at Raigmore Hospital and so emergency trauma and cancer patients would be prioritised over routine and elective patients. Despite this, there could be occasional and unfortunate delays in transferring patients to Raigmore Hospital because of bed availability.

8. In response to further enquiries by my complaints reviewer, the Board provided details of hip fracture operations performed over the period 10 July to 13 July 2013. The Board said that the earliest date Mr C's surgery could have been performed was 11 July 2013 on the assumption that he could have been safely transferred from MacKinnon Memorial Hospital on 10 July 2013. However, given Mr C was admitted to MacKinnon Memorial Hospital around 15:00 on 10 July 2013, transfer to Raigmore Hospital would not be considered for a stable patient when the priorities would have been assessment and pain relief. The Board said that the earliest realistic date for transfer was 11 July 2013. No other patients with orthopaedic trauma were transferred from peripheral hospitals ahead of Mr C and the majority of orthopaedic trauma patients whose surgery was performed between 11 and 13 July 2013 had been admitted directly to Raigmore Hospital (with the exception of one patient who had been transferred from another hospital on 9 July 2013). The Board went on to say that the 24 hour delay before Mr C was transferred on 12 July 2013 was because of a lack of available orthopaedic receiving beds in Raigmore Hospital due to the number of acute orthopaedic patients admitted directly at that time. The availability of operating theatre time or orthopaedic surgeons was not a factor in determining the timing of Mr C's transfer and no other patient was actively prioritised for surgery ahead of him.

Relevant guidelines

9. Scottish Intercollegiate Guidelines Network (No. 111), management of hip fracture in older people states that services and resources should be organised to: maximise the proportion of medically fit patients receiving surgery as soon as possible after presenting to hospital with hip fracture; reduce the duration of pain and the dependency; and reduce hospital length of stay. The guideline cited the Scottish Hip Fracture Audit (National Waiting Times Unit) which states that 'patients will be operated on within 24 hours from admission to a specialist unit for hip surgery following fracture' subject to medical fitness and during safe operating hours.

Medical advice

10. My complaints reviewer asked the Medical Adviser if Mr C's fractured hip was operated on within a reasonable time given his clinical need, the geography and bed pressures at Raigmore Hospital. The Medical Adviser said that MacKinnon Memorial Hospital provided a reasonable standard of initial clinical care. Healthcare professionals assessed him in sufficient detail on admission,

made a diagnosis and provided care appropriate to the level required initially. There was a clear plan to transfer him to another hospital (Raigmore Hospital) for surgery on his broken hip. However, the transfer was delayed. As a result of this delay, Mr C was left with a broken hip which acquired analgesia in the form of morphine. He had received six doses of 10 milligram of morphine. This dose was often needed for an injury as significant and painful as Mr C's. However, it has potential side effects including confusion and constipation. Mr C suffered these symptoms and it was probable that this was caused by the amount of morphine he received. Better care for Mr C would have been a rapid transfer and operation. This would have reduced the amount of morphine he needed and the side effects he suffered (the Medical Adviser noted that he needed much less medication after his operation).

11. The Medical Adviser went on to say that the relevant guideline highlighted the timing of surgery and transfer as a key issue to improve the outcome of patients and referred to the Scottish hip fracture target of patients going to theatre within 24 hours of admission to an orthopaedic unit. Almost all of the elements of care described (in the guideline) needed to occur in a ward used to dealing with acute trauma. On the basis of the information available to the Medical Adviser, he said it was unlikely that these elements of care would have been managed as well in the MacKinnon Memorial Hospital as in a specialist unit. The Medical Adviser stressed that he was not critical of the care Mr C received in this hospital, but the treatment of a broken hip was emergency surgery, the sooner the better and this was something that the local hospital was not equipped to provide. The Medical Adviser said that the delay in transferring Mr C had an adverse effect on the outcome given that he suffered side effects from the extra morphine medication required and that one of his blood tests showed an abnormality at the time of transfer which may have been improved by an earlier transfer and operation. He also had a slow recovery from his surgery. The Medical Adviser noted that the Board cited 'bed pressures' at Raigmore Hospital in explaining the delay and said that even so, Mr C was an emergency trauma patient but failed to be transferred despite the Board's stated position that emergency trauma (and cancer) patients would be prioritised over routine and elective patients. Overall, the Medical Adviser found the level of care provided to Mr C fell below a level he could reasonably expect.

12. My complaints reviewer asked the Medical Adviser to comment specifically on the information provided by the Board about the reasons for the delay. The Medical Adviser said that the information showed the details of the hip fracture

operations performed during this period, which confirmed that there were no issues with theatre or surgical team availability and that the reason for the delay in Mr C's transfer and operation was a lack of bed availability. However, the Medical Adviser said that patients who were taken directly to Raigmore Hospital were admitted, unlike Mr C who had to 'wait' in another hospital. The Medical Adviser said that the Board should carry out an audit to help judge the magnitude of any discrepancy between those patients who presented at Raigmore Hospital's emergency department and those who presented at another hospital and required a transfer. In relation to those patients who required a transfer to Raigmore Hospital, the Medical Adviser said that a delay of 24 hours may be reasonable in the circumstances of some transfers, but that any more than this would be of concern.

Decision

13. Mrs C complained that the Board failed unreasonably to operate on Mr C's fractured hip within a reasonable time. In reaching my decision, I have taken into account the information Mrs C provided and Mr C's clinical records. The advice I have accepted is that Mr C was clearly an emergency trauma patient but the Board failed to transfer him within a reasonable time for the required surgery. The Medical Adviser said that this had an adverse effect on the outcome for Mr C because of the amount of medication he required to control his pain. The Scottish Hip Fracture Unit's target for patients to receive the required surgery (from admission to a specialist unit) also indicated the importance of the timing of surgery to improve the outcome for patients. Given the importance of the timing of surgery, I am concerned about the potential impact of the Board's bed management criteria. While I appreciate that there can be fluctuating pressures on resources, particularly bed availability, I am not satisfied by the evidence that the failure to prioritise Mr C was reasonable given his clinical need. In addition to the clinical effects the delay had on Mr C, it was also clear to me that the delay was extremely distressing for Mrs C who continues to be concerned about its impact on Mr C's post-operative recovery. Related to this, I am critical that the Board failed to properly explain the criteria to Mrs C so that she fully understood why they delayed Mr C's transfer. I uphold the complaint.

Recommendations

14. I recommend that the Board:	*Completion date*
(i) provide evidence that they have procedures in	17 July 2015

	place to ensure that when emergency trauma patients require transfer to an orthopaedic unit for treatment, they appropriately prioritise in accordance with their clinical need;	
(ii)	carry out an audit of the last 50 patients admitted to Raigmore Hospital for hip fracture surgery and detailing those who presented at the emergency department (at Raigmore Hospital) and those who presented elsewhere and required transfer;	17 August 2015
(iii)	bring the Medical Adviser's comments to the attention of the bed management team (at Raigmore Hospital) and the relevant medical director; and	17 July 2015
(iv)	apologise to Mrs C for the failures this investigation identified.	17 July 2015

15. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Mr C	the complainant's husband
the Board	Highland NHS Board
the Medical Adviser	one of the Ombudsman's advisers who specialises in care of the elderly

Annex 2

List of legislation and policies considered

Scottish Intercollegiate Guidelines Network (No. 111): Management of hip fracture in older people