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: South of Scotland**

**Case ref: 201508020, Dumfries and Galloway NHS Board**
**Sector:** Health
**Subject:** Hospitals / Clinical treatment / Diagnosis

**Summary**
Miss C complained about how the board had treated her finger injury, and how they dealt with her complaint. Miss C was employed on a dairy farm, where she suffered a crush injury to her left ring finger. Miss C was taken to the Dumfries and Galloway Royal Infirmary where she underwent surgery. Miss C said she had been told that her finger would undergo a partial amputation, which she had consented to. This procedure would have allowed her to return to work in the shortest possible time period.

Miss C said that she had asked to speak to the board's complaints team to make a formal complaint whilst still on the ward, but that no action had been taken by the board. She had subsequently submitted a formal complaint, but the board had maintained the surgery she underwent was the surgery she had consented to.

We took medical advice on Miss C's treatment and the consent process undertaken by the board. The advice said that Miss C had not had her consent properly recorded. The procedure that was undertaken was not that listed on the form. Additionally no record had been made of any discussions with her, despite the form containing clearly marked sections for this. The advice said no treatment plan was recorded, nor was the rationale for performing surgery other than a partial amputation recorded. The advice stated the failure to perform a partial amputation on Miss C's finger had significantly prolonged the healing process and it was clear from her submissions that her primary motivation was to return to work as soon as possible.

We found the board's records of the consent process were inadequate and that the operation performed on Miss C was not the procedure she had consented to. The board were unable to explain this, instead maintaining that Miss C had undergone the appropriate surgery. We also found the board's investigation into Miss C's complaint had been inadequate. It had failed to identify the lack of records supporting her consent as a concern and had failed to obtain a statement from the doctor responsible for documenting this and performing the

surgery for his actions. Additionally the board's complaint response misrepresented the records of Miss C's interactions with medical staff and failed to address Miss C's concerns about the financial impact of the surgery on her.

**Redress and recommendations**

| The Ombudsman recommends that the board: | *Completion date* |
|---|---|
| (i) review their process for obtaining informed consent, taking account of the failings this investigation has identified and relevant guidance in this area; | 21 December 2016 |
| (ii) provide evidence Doctor 1 has undergone training and suitable continuing professional development courses to improve their communication skills and understanding of the consent process; | 21 December 2016 |
| (iii) carry out a significant event analysis ensuring that Doctor 2 reviews his understanding of the consent process and the definition of a finger terminalisation procedure; | 21 December 2016 |
| (iv) provide evidence that both Doctor 1 and Doctor 2 have reflected on the failings identified in this report as part of their appraisal process; | 26 April 2017 |
| (v) review their complaints investigation in light of the comments from the adviser; | 21 December 2016 |
| (vi) review their handling of Miss C's complaint in order to identify areas for improvement and ensure compliance with their statutory responsibilities as set out in the 'Can I Help You' guidance; and | 21 December 2016 |
| (vii) apologise for the failings identified in the report, acknowledging that the procedure performed on Miss C was not the one that she wished to have carried out. | 7 December 2016 |

**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 Miss C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

## Introduction

1. Miss C complained to the Ombudsman about the care and treatment provided by Dumfries and Galloway NHS Board (the Board), following an injury to her hand at work. The complaints from Miss C I have investigated are that the Board:

(a) unreasonably performed a procedure to which Miss C did not consent (*upheld*); and

(b) unreasonably failed to follow up their initial discussion with Miss C (*upheld*).

## Investigation

2. In order to investigate Miss C's complaint, my complaints reviewer took advice from a consultant orthopaedic surgeon (the Adviser). They also made multiple enquiries of the Board. In this case, we have decided to issue a public report on Miss C's complaint because of the serious issues raised.

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

*Background*

4. Miss C was employed on a dairy farm where her duties included working in the milking parlour with the dairy cows. On 1 February 2015 a cow stood on Miss C's hand, causing a crush injury to her left ring finger. Miss C attended the Accident and Emergency department at Dumfries and Galloway Royal Infirmary (the Hospital). She was seen by an orthopaedic registrar (Doctor 1) and taken to theatre. Miss C was operated on and discharged later that evening.

5. On 4 March 2015, Miss C spoke to the Board's Patient Experience Team in the Orthopaedic Outpatients Department (OOPD). Miss C said she was unhappy with the surgery that was performed on her. Miss C said she had been told by a consultant orthopaedic surgeon (Doctor 2) responsible for her that she would undergo the amputation of the tip of her left ring finger. Miss C said she had discovered when the bandanging was removed several weeks later this was not what had been done.

6. On 4 March 2015, Doctor 2 wrote to Miss C's GP. They said the majority of Miss C's interactions had been with Doctor 1. A terminalisation had been performed on her left ring finger. Doctor 2 said he believed Miss C felt the

finger was healing well, but that because the finger was not amputated, she could not return to her work sooner, as a result of which she had lost her job.

7. Doctor 2 went on to explain they had discussed treatment options with Miss C and asked if she wished to continue with dressings for a couple of months and the possibility of a further procedure at a later date. Doctor 2 had offered the alternative of performing an amputation of the finger as an emergency procedure. Doctor 2 said Miss C had informed them it did not matter if her treatment took 'a few months or a few years, because she had already lost her job'. Doctor 2 said Miss C had now conveyed clear consent that she wished to continue treatment with the dressings.

8. Doctor 2 said they had asked the Patient Liaison Service to meet Miss C and discuss her concerns. Doctor 2 said they suspected there were communication issues at the Hospital and problems at Miss C's workplace which were behind her distress.

9. ON 31 March 2015, PASS sent a formal complaint to the Board on Miss C's behalf. This set out the primary areas of complaint as follows:

- Miss C was not given the surgery she consented to;
- the surgeon had proceeded without the appropriate consent;
- the doctor failed to give a reasonable explanation as to why she was not woken up and given the choice of having a new dressing; and
- why there was no follow up to Miss C's discussion with patient services, forcing Miss C to raise a formal complaint.

10. The letter contained a separate statement from Miss C. In this she said she had given consent for surgery on the basis that an amputation of her finger was going to be performed. Miss C said she was happy with this, as this involved only a ten day recovery period.

11. Miss C recalled going into surgery at 15:00 and was provided with ring block twice, before receiving a general anaesthetic. Miss C awoke from surgery with the finger bandaged and was released at 19:00. Miss C was unaware of what type of surgery had been performed until she attended to have the finger dressed. At this point, Miss C became aware the surgery she had consented to had not been performed. Miss C said medical staff had explained to her that a new type of dressing had been tried out, which had been used successfully on

other body parts and her finger had been ideal to try this out. Miss C had asked why she had not been woken up and told she was not receiving the procedure she had agreed to, but had not been provided with a reasonable explanation. Miss C now faced the prospect of months of healing.

12. The letter also complained Miss C had discussed this with a charge nurse, and a member of the Patient Experience Team. The letter said they had agreed Miss C should have been woken up and that the issue should be followed up with her, however this had not happened.

13. The Board acknowledged the complaint in writing on 9 April 2015. They also issued a response on the same day, which was based in part on the conversation Miss C had had with staff previously about her dissatisfaction. The Board said the investigation was focussed on discussions with staff involved in Miss C's care. The Board said they were sorry if Miss C's recovery had caused her financial difficulties and that they recognised it had been an extremely slow process and the distress and anguish this had cause her.

14. The Board stated they were sorry Miss C had been led to believe the procedure carried out was not the one she had consented to. Miss C had signed a consent form for terminalisation of the left ring finger. Miss C had sustained a traumatic partial amputation of her fingertip. During surgery the exposed bone was removed and the surrounding damaged soft tissue removed. The Board said this treatment option provided the best outcome and normal function could still be achieved. The Board apologised if this was not fully explained to Miss C at the time.

15. The Board said it was not possible to wake patients up during surgery. It was the policy to discuss, where possible the options prior to surgery. Sometimes, however, during the procedure when the surgeon had a clearer view, the options changed. In this situation the procedure is discussed after surgery. The Board noted Doctor 1 had discussed Miss C's case with Doctor 2. Miss C's concerns had been noted and the role of informed consent had been reinforced.

16. In respect of their response to Miss C's complaint, the Board said members of the Patient Experience team were asked to attend the OOPD as Miss C had voiced concerns about her care. Upon arrival they found Miss C had already discussed the issue at length with Doctor 2, who had offered to

place her on a waiting list for partial amputation. Miss C had declined this offer as she had felt the wound was now healing well.

17. Miss C had subsequently told staff she did not wish to raise a formal complaint. She merely asked for her concerns to be raised with the appropriate people. An informal enquiry was, therefore, carried out, rather than a formal complaint investigation.

18. Miss C was subsequently referred to Greater Glasgow and Clyde NHS Board, for an assessment by the plastic surgery unit. They noted that her finger had been debrided and cleaned out, with healing achieved by secondary intention (the wound was not stitched, but left open and dressed regularly).

**(a) The Board unreasonably performed a procedure to which Miss C did not consent**

*Concerns raised by Miss C*

19. Miss C said she was clear about the procedure she thought was going to be performed. Miss C was told the end of the bone would be cut off and a flap of skin would be stitched over the end. Miss C said that she had been taken into surgery at 15:00, her ring block injection failed on two separate occasions and so the decision had been taken to use general anaesthesia. Miss C woke up to bandaged finger and believed her operation had taken place as planned.

20. Miss C said that she was unaware until three or four days after the procedure when the dressing was taken off this had not happened. Instead a different procedure had been used, where instead of stitching the skin, it was to be allowed to grow and heal by itself. Miss C said she was told a new type of dressing had been tried out, which had been successful on other body parts. Her finger had been ideal to try this out on.

21. Miss C said as a consequence, instead of a ten day recovery period, her finger had taken six months to heal. Miss C had been unable to work during this period, and had been obliged to visit the Hospital regularly for dressing changes. Miss C felt it was not right for medical staff to have changed their mind about the type of procedure carried out whilst she was unconscious.

22. Miss C said she felt the correct approach would have been for her to have been brought round from the anaesthetic she was under. Once this had happened, she would have been able to decide if she wished to proceed with

the new procedure. This could, if required, have taken place at a later date. Miss C said that when she had asked why she had not been given an appropriate opportunity to consider this treatment, she did not receive a reasonable explanation.

23. Miss C said that she had suffered from months of twice weekly hospital visits, experiencing considerable pain every time due the changing of the dressing on her finger. Miss C said this had prevented her from driving or working and she was faced with a further operation to the finger before she could anticipate working again. Miss C was particularly concerned that the operation that was performed on her was not the one that she had been asked to consent to.

*The Board's response*

24. The Board's initial response to this office stated they were satisfied Miss C signed a consent form for the terminalisation of her left ring finger and that this was the procedure carried out. The Board said it was not possible to wake patients up during surgery. It was instead the policy to ensure all possible options were discussed prior to surgery. As with their response to Miss C's complaint, the Board said an apology had been offered to Miss C if she felt her treatment options had not been fully explained to her. The Board noted she had declined further surgery as she felt the wound was healing well. The Board said the issue of informed consent had subsequently been raised with the relevant staff.

*Medical advice*

25. The Adviser said they did not consider the way Miss C had been consented for surgery to have been reasonable. They noted an initial clerking in the Emergency Department, followed by a clerking by a junior doctor, which indicated that Miss C required review by a more senior member of medical staff. The Adviser noted the two sections within the consent form specifically designed for this purpose, entitled 'Surgical Middle Grade Review' and 'Consultant Opinion' were both blank.

26. Two consent forms were on the file, one signed by Doctor 2 for 'terminalisation of the left ring finger'. The other was for 'photography of the left ring finger for educational purposes'. The Adviser said it was clear from Miss C's account, her understanding of the procedure was to be the removal of the damaged bone and soft tissue, followed by the shortening of the finger, to

ensure good coverage through healthy tissue, with direct suturing at the level of the terminalisation and amputation. The Adviser said the benefit of this procedure was, as noted by Miss C, healing of the injury in approximately ten days. The Adviser said this appeared to be what had been explained to Miss C and was also what they would understand as terminalisation. The Adviser stated that the procedure performed on Miss C was not, in their view, a terminalisation.

27. The Adviser said there were no records of any discussion of treatment with Miss C by Doctor 1. Nor was there any record of any examination by Doctor 1, or conclusions as to the type of treatment required and their proposed plan for the patient. The Adviser's view was Miss C's medical history and current occupation should have been recorded. This should have been followed by an examination of the injury and a treatment plan, including a record of a discussion of the best options with Miss C, allowing her to give informed consent to the proposed procedure.

28. The Adviser said they believed the consent process had not adhered to General Medical Council (GMC) guidance *Consent guidance: Sharing information and discussing treatment options* this states that patients must be given the information they want or need about the options for managing or treating the condition, as well as the potential risks, benefits and burdens. It goes on to emphasise that doctors should check patients have understood, as well as encouraging them to ask questions and acknowledging any concerns they may have. In terms of recording the decision, the guidance states that the patients' medical records or consent form should be used to record the key elements of the discussion with the patient of their treatment. This should include the information discussed, any specific requests from the patient, and details of any decision made. The Adviser noted that none of this had been done.

29. The Adviser said that Miss C's wound was debrided and the wound was left open to heal, by secondary intention using IV3000 dressings. The Adviser noted these dressings were not standard for this type of procedure, being originally designed for intravenous sites. The Adviser said it was impossible to ascertain from the records what the plan for Miss C was from the operating surgeon's perspective, what options had been considered and what would happen if something were discovered during the operation which forced a change of plan.

30. The Adviser said the operation was started under local anaesthetic, as Miss C was recorded as receiving two ring block injections. Miss C was, therefore, awake at the start of surgery. Had there been a change of plan it would have been perfectly feasible and appropriate to discuss this with Miss C at this stage. The surgery must have commenced at this point in the Adviser's view, since it was noted in her medical records that Miss C was unlikely to be able to tolerate the pain of the wound debridement.

31. The Adviser emphasised there was nothing in the note to indicate the procedure was changed due to untoward circumstances occurring after Miss C was placed under general anaesthetic. The impression the Adviser had, was that the operation Doctor 1 intended to take was a debridement of the wound, followed by healing through secondary intention even though it appeared they had described an amputation to Miss C prior to surgery, with wound closure achieved by stitching the wound shut.

32. In light of the Adviser's concerns, I asked the Board to provide further detail on the use of the IV3000 dressing. I also asked for an explanation of the lack of senior review documented prior to surgery taking place and the absence of any meaningful treatment plan. I also requested the Board to provide evidence of any actions taken following Miss C's complaint.

*The Board's subsequent response*

33. The Board said that no formal statements were taken from staff as part of the complaint investigation. Doctor 2 had provided the response to the questions my complaints reviewer posed in light of the Adviser's comments. Doctor 2 stated that following terminalisation, the aim was to preserve Miss C's finger. Different dressing materials could be used for this purpose, including IV3000. The IV3000 dressing was used in many hospitals for treatment of this type and was supported by the available medical literature. An article detailing this use was provided by Doctor 2. Doctor 2 said no patient went to theatre without the appropriate consultant being aware of it. There was, however, no need for consultant review of every minor case. On occasions, the patient might even have been discharged before the consultant's ward round took place, so the consultant would not see them at all.

34. Doctor 2 said that Miss C had also been seen by a specialist in hand surgery. Miss C had been discussed at a weekly orthopaedic meeting and it

was agreed a referral for a plastic surgery opinion would be appropriate. Doctor 2 had discussed the case with Doctor 1 and at the weekly orthopaedic meeting. Communication and consent had been discussed and the importance of informed consent discussed with Doctor 1.

35. Doctor 2 said the fact the consent form was signed was evidence the clinician had discussed with the patient the options available, possible outcomes, contraindications and anaesthetic to be used. This had to have taken place in order for the patient to consent and for the clinician to sign the form. It was standard practice at the Board and in this case Miss C had signed her consent to the terminalisation of her finger, which was what had been performed.

*Further Medical Advice*

36. The Adviser said the evidence provided by the Board did support the use of IV3000 dressings for finger injuries. He noted the Board's evidence, however, was dated June 2015, some months after Miss C's treatment had taken place.

37. The Adviser said that consent was a process and did not relate solely to the signing of the consent form. The Adviser said the GMC guidelines indicated it was important to document the consent process, including any discussions held prior to the form being signed. The Adviser re-iterated that it was not satisfactory or reasonable that there was no documented senior review prior to treatment. It was also unsatisfactory that there was no documentation of any of the discussions with Miss C about the treatment she was to undergo, or any indication that she understood and agreed with the treatment.

38. The Adviser said despite the Board's claims to the contrary, there was no question that the procedure carried out on Miss C was not a terminalisation. Terminalisation would have shortened the digit so that primary closure could be achieved, through the use of stitches. Miss C's finger was debrided and then dressed, which meant she had an area of raw soft tissue and bone, which took a considerable period of time to heal. It was in the Adviser's view clear from Miss C's comments that the operation she was expecting was a terminalisation, with the end of the finger stitched and a relatively short period of healing, after which she could return to work. The Adviser said it was clear that from Miss C's perspective, the length of time she was to be off work was a significant consideration.

**(a) Decision**

39. Miss C complained that the procedure which was performed on her finger was not that which she consented to. The Board maintain that Miss C consented to a terminalisation of her injured finger, which was duly carried out.

40. The advice I have received states the procedure Miss C underwent was not a terminalisation. The advice notes the consent process was not properly completed, with an unacceptable standard of record-keeping by medical staff. As a result there is no evidence Miss C received an explanation of the procedure that was to be carried out on her prior to it occurring. The advice is clear it believes Miss C expected a procedure to be carried out which was different to the operation she underwent.

41. I am highly critical of the Board for maintaining the position that the procedure carried out on Miss C was a terminalisation. Had a terminalisation been carried out on Miss C, primary closure would have been achieved (stitching of the finger), rather than an area of raw flesh, covered with a dressing. The Board have provided no adequate explanation for this discrepancy. Nor have the Board at any point explained why it was felt appropriate to achieve healing by secondary intention, despite Miss C's priority clearly being her ability to return to work as quickly as possible.

42. The Board's records of the consent process are inadequate and are not in keeping with GMC guidance. As a consequence it is impossible to ascertain if discussions were had with Miss C about her treatment and no treatment plan is recorded. The advice notes that on occasion surgical procedures have to be changed during surgery. It also notes, however, that there is no indication in the operation notes that this took place. I agree, therefore, with the advice received that it is likely that Doctor 1 did not change the planned procedure as there was no indication of any difficulties within the operation notes which would have required this. I conclude that Doctor 1 performed a procedure which was substantially different to the one Miss C wished to have performed and which has had a significant negative impact on her life.

43. I am concerned that the Board maintain they are satisfied consent was obtained properly even though the evidence shows it was thought appropriate to reinforce to Doctor 1 the role of informed consent. It is unclear why this was necessary if the Board were entirely satisfied that Miss C's consent had been

appropriately obtained. I also note that in the clinic letter sent on 4 March 2014, Doctor 2 refers to Miss C having 'conveyed clear consent now that she wants treatment to continue with the dressings'. This suggests there was ambiguity about what Miss C had consented to. I am also concerned given the failure to adhere to GMC guidance, that the Board believe that Miss C's informed consent was properly recorded.

44. I find that the Board did not obtain informed consent from Miss C. They failed to document the consent process to a reasonable standard or record an appropriate treatment plan. Furthermore, they have maintained that Miss C underwent the procedure she consented to, when I have been advised explicitly this is not the case.

45. I uphold the complaint and make the following recommendations

**(a) Recommendations**

| 46. I recommend that the Board: | *Completion date* |
|---|---|
| (i) review their process for obtaining informed consent, taking account of the failings this investigation has identified and relevant guidance in this area; | 21 December 2016 |
| (ii) provide evidence Doctor 1 has undergone training and suitable continuing professional development courses to improve their communication skills and understanding of the consent process; | 21 December 2016 |
| (iii) carry out a significant event analysis ensuring that Doctor 2 reviews his understanding of the consent process and the definition of a finger terminalisation procedure; and | 21 December 2016 |
| (iv) provide evidence that both Doctor 1 and Doctor 2 have reflected on the failings identified in this report as part of their appraisal process. | 26 April 2017 |

**(b) The Board unreasonably failed to follow up their initial discussion with Miss C**

47. Miss C said that once she was aware of what had been done, she was not properly communicated with by the Board. Miss C said that she had a meeting with the Patient Experience team and they were supposed to follow the matter up. She did not feel this had been done properly and she had consequently been forced to make a formal complaint. Miss C said that she had suffered

significant financial consequences from the failure to provide a treatment that allowed her to return to work quickly. She had lost her job on a dairy farm and her job working in a kitchen as she was forced to travel to Dumfries twice a week for dressing changes. Miss C said she had been forced to borrow money in order to cover her household expenses.

*The Board's response*

48. The Board said on 4 March 2015, the Acute Services complaints team were asked to attend OOPD to speak to a patient who wished to raise concerns regarding her care and treatment. The Board said Miss C had not wished to raise a formal complaint at this time. The Board said the understanding of the complaints team was that an informal enquiry would be sufficient, since Miss C wished her objections to be passed onto to the medical staff involved.

49. As she was seeking to recover lost earnings the Board said Miss C was advised of the legal process of how to make a claim to the Board and how to seek legal advice, because the NHS Complaints Process did not usually award financial compensation. The Board said Miss C had declined to do this.

50. The Board said a response to Miss C's informal concerns had been completed in draft. It had been passed to management for sign off on the day that Miss C's written complaint had been received by the Board. In the circumstances, the Board decided it was appropriate not to send the initial response to the informal complaint, but to wait, to allow the issues raised in the formal complaint to be addressed. The Board said they accepted that this was not explained to Miss C and that, therefore, she was unaware of the course of action they were following. For this reason Miss C may have believed her informal concerns were not followed up on by the Board. The Board said they were sorry for this and any distress it had caused her.

*Advice Received*

51. The Adviser felt the Board's response did reflect the available records, but said it was surprising the Board's investigation did not comment at all on the fact there was no evidence of any discussion with Miss C and no documentation of the consent procedure at all. The Adviser said it was not reasonable for the Board to imply that the treatment option selected for Miss C, which was to allow the wound to heal by secondary intention, was the best one for her. The Adviser said there was no evidence to support this suggestion and that Miss C

had in fact been placed at a significant disadvantage in terms of her occupation as a result.

**(b) Decision**

52. Miss C feels the Board failed to follow up on the concerns she raised on 4 March 2015 with the Patient Experience Team. Miss C feels that the Board did not address the issues she raised appropriately.

53. Although the Board did follow up on Miss C's concerns, I am critical of the Board's investigation into Miss C's complaint. The complaint response does not accurately represent the internal correspondence. Additionally, the Board did not obtain statements from medical staff involved. There is, therefore, no explanation from Doctor 1 of the reasoning behind the procedure that was carried out and subsequent treatment plan for Miss C, or of his understanding of the discussions he had with Miss C prior to her operation.

54. The Board's complaint response letter does not accurately reflect some of the interactions between Miss C and Doctor 2. It states that when Miss C met with the Patient Experience Team, she had already had a long discussion with Doctor 2 and that Miss C declined the offer for a partial amputation as 'she felt the wound was now healing well'. I note however, that Doctor 2's letter to Miss C's GP of 4 March 2015 states the following:

> 'She says she does not care about how long the treatment is going to take, whether it takes a few months or a few years, because she has already lost her job. She has conveyed clear consent now that she wants to continue treatment with the dressings.'

The Board's response letter fails to address the issues raised by Miss C about the impact of the procedure upon her financially, it also gives the impression that Miss C was satisfied with the treatment she was receiving, which does not reflect Doctor 2's note of their conversation. I further note the impression Doctor 2's record gives is that there was dubiety about Miss C's consent to the procedure. If there was not, then there would be no reason to highlight her 'clear consent now' to the use of the dressing.

55. Additionally the advice I have received is that the Board's investigation failed to identify the complete absence of consent documentation, or the absence of any treatment plan for Miss C post-surgery. I do not consider it was reasonable for the Board to conclude Miss C had given her informed consent

for the procedure carried out on her. The advice also notes the failure to address the discrepancy between Miss C's wishes and the procedure which was carried out on her.

56. I uphold the complaint

**(b) Recommendations**

| 57. I recommend that the Board: | *Completion date* |
|---|---|
| (i) review their complaints investigation in light of the comments from the Adviser; and | 21 December 2016 |
| (ii) review their handling of Miss C's complaint in order to identify areas for improvement and ensure compliance with their statutory responsibilities as set out in the Can I Help You? guidance. | 21 December 2016 |

**General Recommendation**

| 58. I recommend that the Board: | *Completion date* |
|---|---|
| (i) apologise for the failings identified in this report, acknowledging that the procedure performed on Miss C was not the one that she wished to have carried out. | 7 December 2016 |

59. 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**

| | |
|---|---|
| Miss C | the complainant |
| the Board | Dumfries and Galloway NHS Board |
| the Adviser | a consultant orthopaedic surgeon |
| the Hospital | Dumfries and Galloway Royal Infirmary |
| Doctor 1 | an orthopaedic registrar |
| OOPD | orthopaedic outpatients department |
| Doctor 2 | a consultant orthopaedic surgeon |
| PASS | Patients Advisory Service Scotland |
| GMC | General Medical Council |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| amputation | surgical removal of a limb, or part of a limb |
| clerking | a history and examination by a doctor taken on admission to hospital |
| debride | the removal of dead, infected or foreign material from a wound to improve its ability to heal |
| finger terminalisation | surgical shortening of the finger with closure of the wound achieved by stitching |
| general anaesthetic | the use of drugs to create a state of controlled unconsciousness |
| healing by secondary intention | allowing a wound to heal without stitches, using only regular dressing changes |
| IV3000 | a type of bandage, originally for intravenous sites, which can be used for finger injuries |
| ring block | injections of local anaesthetic around a finger to allow minor surgery to take place |
| suturing | closure of a wound using stitches |