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: Glasgow

Case ref: 201603057, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Mr C complained on behalf of his sister (Miss A) who had amongst other things profound learning difficulties, type 2 diabetes and was blind. He said that after falling out of bed and hurting her neck on 12 December 2015, she attended the Emergency Department (ED) of Glasgow Royal infirmary. Although the board maintained that Miss A had been treated reasonably, Mr C said that staff did not take into account her serious disabilities when examining and treating her and she was discharged home. Miss A's condition deteriorated and she returned to the ED where she was later given an x-ray and CT scan which showed fractures in her neck. She was admitted to the National Spinal Injuries Unit.

We took independent advice from a consultant in emergency medicine and from a registered nurse. We found that despite the fact that Miss A had serious and profound learning difficulties which were detailed in documentation that accompanied her to the ED, these were not properly taken into account, a senior opinion was not obtained nor were available objective assessment tools used. Mr C's opinions were not sought to establish whether he could input into the findings of her examination. We upheld the complaints.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) make a formal apology to Mr C and Miss A for the shortcomings identified;	26 May 2017
(ii) staff involved in Miss A's care on the day concerned should be made aware of the content of this report to allow them the opportunity to reflect and also consider it at their next formal appraisal;	26 July 2017
(iii) apologise to Miss A (copied to Mr C) that when communicating with her, staff failed to take her learning difficulties into account;	26 May 2017
(iv) apologise to Mr C for not reverting to him for his	26 May 2017

assistance in this matter; and

(v) review their advice to staff members about treating people with disabilities to establish whether or not it is currently fit for purpose. If it is not, they should provide updated advice and guidance. — 26 July 2017

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

Introduction

1. Mr C complained to the Ombudsman on behalf of his sister (Miss A) about the care and treatment she received in the Emergency Department (ED) of Glasgow Royal Infirmary on 12 December 2015.

2. The complaints from Mr C that I have investigated are that on 12 December 2015, staff at Glasgow Royal Infirmary:

(a) failed to provide Miss A with appropriate clinical treatment for her reported neck injury *(upheld)*; and

(b) failed to appropriately take into account that Miss A had lifelong learning difficulties when communicating with her (*upheld*).

Investigation

3. In order to investigate Mr C's complaint, my complaints reviewer has given careful consideration to all the information provided by Mr C and Greater Glasgow and Clyde NHS Board – Acute Services Division (the Board) including the complaints correspondence and Miss A's relevant clinical records). They have also obtained independent advice from a consultant in emergency medicine (Adviser 1) and a registered nurse (Adviser 2). In this case, we have decided to issue a public report on Mr C's complaint because of the significant injustice caused to Miss A.

4. While this this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

5. Mr C complained on behalf of Miss A who, amongst other things, has lifelong learning difficulties and is registered blind. He said that after a fall at home, she attended the ED at Glasgow Royal Infirmary on 12 December 2015. However, he complained that Miss A was not properly examined and treated, and was discharged home without having had an x-ray.

6. Mr C said that as her condition deteriorated, Miss A attended the ED again on 18 December 2015. After examination, she was admitted to a ward. Although an x-ray was requested for her, she was unable to tolerate it but was eventually x-rayed and scanned on 21 December 2015. The scan revealed that she had a significantly unstable fracture of her seventh cervical vertebrae with a

less significant fracture of her sixth cervical vertebrae and she was later admitted to the National Spinal Injuries Unit.

7. Mr C believed that had Miss A been properly examined and x-rayed on 12 December 2015, her injuries would have been identified sooner. He said that the failure to do so could have caused her further injury and discomfort. He maintained that Miss A's learning and communication difficulties were not taken into account when she first attended the ED.

8. On 10 February 2016, Mr C submitted a complaint to which the Board responded on 22 April 2016. Essentially, the Board said that Miss A had been reasonably and appropriately examined when she attended the ED on 12 December 2015; she had not been complaining of neck pain; there had been no bony tenderness; and she could move her neck freely. Accordingly, they said that an x-ray had not been required and Miss A was discharged home.

9. However, when Miss A next attended hospital (on 18 December 2015), she was admitted and subsequently scanned which revealed the fractures to her neck. The Board said that staff had been fully aware of her lifelong health conditions and had dealt appropriately with her.

10. Mr C remained unhappy and so complained to me. He said that he wanted the Board to apologise for what he considered the inadequate treatment given to Miss A and that when considering treatment staff took more notice of people with learning disabilities.

(a) On 12 December 2015, staff at Glasgow Royal Infirmary failed to provide Miss A with appropriate clinical treatment for her reported neck injury

11. Miss A was 57 years old at the time of her presentation to ED. She had fallen out of bed at home at about 01:00 on 12 December 2015. She complained of neck pain and an ambulance was called. However, Miss A refused to travel to hospital and became very agitated. The paramedics contacted NHS 24 and requested a GP review her within the hour. A GP attended Miss A at home and in a handwritten letter to the ED they noted Miss A's profound learning difficulties and that she was blind and had type 2 diabetes. They queried an underlying infection and noted that she had had previous UTI (urinary tract infection)s. Further, they recorded that Miss A was difficult to assess and queried whether she needed an x-ray of her cervical

spine. The GP also documented that Miss A could become very agitated and that she did not want to go into hospital and they assessed Miss A's capacity to make a decision about this. They concluded that Miss A was incapable of making decisions about the assessment of her cervical spine injury, her diabetes and other underlying conditions and completed a Certificate of Incapacity, which was to accompany her to hospital. At 03:35 Miss A was given medication to reduce her anxiety and the paramedics were able to persuade her to attend hospital. Mr C accompanied her.

12. Miss A was booked in to the ED at 05:10 and initial observations showed that she was not feverish and she had normal blood pressure and respiratory rate but she had significant tachycardia of 122 (a significantly fast heart rate). The circumstances of Miss A's fall were noted, as was the GP's referral and the fact that Mr C had come to hospital with her. A Foundation Year 2 doctor, that is a doctor in the second year of postgraduate medical training (Doctor 1), then saw her and made notes at 07:30. Mr C said that he told Doctor 1 of Miss A's fear of hospitals and of her tendency to answer questions in the way she thought the questioner wanted. Doctor 1 notes said that Miss A did not complain of any pain but that she was difficult to assess due to her learning difficulties. On further examination Doctor 1 noted no bony tenderness and that Miss A was able to move her neck well with no complaints. Doctor 1 concluded that there was no obvious trauma or injury and no need for an x-ray. The plan was for discharge and a letter to Miss A's GP confirmed this.

13. Miss A deteriorated after her return home and she returned again to the ED on 18 December 2015. Her family were very concerned, as her mobility was now very poor. A doctor (Doctor 2) noted that Miss A had decreased mobility and was lethargic; she was not herself and was not eating although she denied any pain. She was noted to be holding her neck at a tilt (in his comments on a draft of this complaint, Mr C said that this had been the case since the time of her fall) but was happy to move it around when asked. On examination, there was no cervical spine tenderness and a full range of movement was noted. There was no soft tissue tenderness. It was concluded that Miss A had a urinary tract infection (UTI) and the plan was to admit her to hospital to give her oral antibiotics and intravenous fluid to rehydrate her.

14. The next day, Miss A was reviewed on the Acute Medicine Unit by a doctor in their second year of a GP training scheme (Doctor 3), who was able to obtain a little history from her although, generally, her ED history was relied

upon. She was said to be able to move all her limbs. Mr C was not present at the time. Later that day, Miss A was reviewed by a consultant who noted her severe learning difficulties and that she was only able to communicate with single words. She was described as being comfortable and her neck was mobile with no pain or tenderness but that she had a reduced range of movement. The diagnosis was of a UTI, a fall with decreased mobility and increasing needs. The plan was to x-ray her neck, encourage oral intake, await the results of urine tests and to arrange for physiotherapy/occupational therapy assessment. The consultant considered that Miss A might be able to be discharged home within 48 to 72 hours, with a full package of care.

15. On 21 December 2015, it was noted that Miss A was waiting for an x-ray of her neck and afterwards her notes recorded a call from radiology to the effect that a scan had shown a fracture of C6 and C7 and that this was an 'unstable' injury. Miss A was then reviewed by an orthopaedic doctor, who documented that the scan had shown marked degenerative changes. Advice was taken from the spinal injuries team and a soft collar was recommended (if Miss A could tolerate it). Miss A was to be nursed at 15 degrees upright and, on 22 December 2015, was transferred to the Queen Elizabeth University Hospital spinal injuries high dependency unit where she later had a halo device fitted.

Clinical advice

16. Adviser 2 commented that when Miss A was initially booked into ED, the level of input from nursing staff was minimal. They said that a brief nursing assessment was documented but that it contained little more than a brief account of the circumstances surrounding the GP referral. Adviser 2 said that nothing was recorded in relation to Miss A's clinical presentation and while a National Early Warning (NEWs) – a scoring tool) chart was available in the notes, the box to record the presence of pain had been left blank on each of the three occasions the chart was 'completed'.

17. Adviser 1 also reviewed Miss A's clinical records. They said that at the time of Miss A's fall, there was no specific guidance in place although emergency medicine clinicians had, for many years, been using decision making tools, for example, the Canadian C spine rule (a decision making tool used to determine when radiography imaging should be used), as part of established good practice to identify those patients who required imaging. Both Adviser 1 and Adviser 2 noted that there was no evidence to suggest that any special measures or clinical tools were used to help in Miss A's pain

assessment process. Adviser 1 went on to say that it was their view that on the day concerned, her examination and treatment were not reasonable. They said that there was a failure to consider how her learning difficulties impacted on the assessment of the risk of a neck injury and on the need for cervical spine imaging. They said that Doctor 1 failed to note or consider her diabetic control, the significance of her tachycardia and failed to act upon the GPs concern that there might be an infective cause behind her fall; neither was an available urine sample tested in relation to a UTI. Adviser 1 went on to say that Doctor 1 did not appreciate the extent of Miss A's anxiety (likely the cause of her significant tachycardia) and the fact that she did not wish to be in hospital (and having been deemed not to have capacity in this regard) and how these matters might have impacted on her behaviour and responses in addition to her learning disability (see paragraph 12).

18. Adviser 1 said that Miss A was noted to have no pain on examination of her neck and was seen to move it freely and commented that the lack of complaints of pain or tenderness, coupled with the fact that Miss A was seen to move her neck, appeared to have been heavily relied upon in the initial and subsequent assessments to conclude that an injury to the neck was unlikely and that imaging (for example, scanning) was unnecessary. They added that:

> 'while it was true that in a conscious patient, [with] no complaints of pain, the absence of tenderness on examination, a full range of neck movement, in the absence of painful districting injuries and no neurological symptoms, eg, tingling after a non-dangerous mechanism of injury, would give a clinician confidence that a significant neck injury was unlikely in a patient with normal cognitive abilities where the findings on examination can be relied upon.'

19. In assessing Miss A's care and treatment, Adviser 1 commented that she had learning difficulties and was described as 'difficult to assess' by both the GP and Doctor 1 so they said that, at the very least, they would have thought that Doctor 1 (who would have only been in post since the beginning of the month) should have obtained senior advice. They went on to say that in their opinion, it had not been reasonable to discharge Miss A home on 12 December 2015 without this senior review and that, given the difficulty on subjective examination, a more objective assessment should have been made to obtain cervical spine x-rays in the first instance. They added that, on discharge, no safety net advice was documented.

20. Adviser 1 said that an x-ray was requested only after Miss A was seen by a consultant on 19 December 2015, when it was noted that she was only able to communicate with single words and although she had a non-tender neck, a reduced range of movement was also noted. Nevertheless, they said that the delay in diagnosing and treating Miss A's spinal injury did not worsen her condition or outcome but that the failure to diagnose and treat her UTI would have made a contribution to her subsequent general deterioration. Adviser 1 said that the overall care and treatment given to Miss A was not reasonable. They concluded by saying that people with learning difficulties posed particular challenges to clinicians in terms of communication and assessment and there were potential pitfalls. As a group, they were more likely to have osteoporosis and osteopenia (bone conditions) than the general population and were, therefore, more at risk of fractures following minimal trauma.

(a) Decision

21. The advice I have been given is clear and is not reflective of reasonable and appropriate treatment of Miss A's injury on 12 December 2015. Despite the fact that a letter and a Certificate of Incapacity accompanied Miss A into hospital, neither nursing nor medical staff took particular cognisance of these. Nursing staff appeared to make no comment about whether or not Miss A was in pain and Doctor 1 did not explore or act upon the GP's concerns and, not withstanding that they knew she was 'difficult to assess', they did not seek a senior view or a more objective method (such as an x-ray of the cervical spine) to try to establish the level of Miss A's pain. While Miss A was accompanied by Mr C on her attendance to the ED, neither the nursing nor medical notes made any reference to him and whether or not he could input into the findings of the examination. Despite the acknowledgement that Miss A's disabilities made assessment difficult, no special measures or clinical tools were used.

22. For these reasons, I uphold the complaint that Miss A did not receive appropriate clinical treatment for her neck injury. The Board should make a formal apology to Mr C and Miss A for the shortcomings that I have identified. Furthermore, those staff involved in Miss A's care on the day concerned should be made aware of the content of this report to allow them the opportunity to reflect and also consider it at their next formal appraisal.

(a) Recommendations

23. I recommend that the Board: *Completion date*

(i)	make a formal apology to Mr C and Miss A for the shortcomings that I have identified; and	26 May 2017
(ii)	staff involved in Miss A's care on the day concerned should be made aware of the content of this report to allow them the opportunity to reflect and also consider it at their next formal appraisal.	26 July 2017

(b) On 12 December 2015, staff at Glasgow Royal Infirmary failed to appropriately take into account that Miss A had lifelong learning difficulties when communicating with her

24. When Miss A was admitted to the ED, a GP letter and Certificate of Incapacity accompanied her, confirming that she was unable to make her own decisions. Her learning difficulties were described as severe and profound. In relation to this, Adviser 2 told me that while there were no specific national guidelines covering nursing input to the care and treatment of a person with an intellectual disability in the ED setting, there was general advice from the Scottish Government to health boards who had important responsibilities to ensure that they provided as full a health service for people with learning difficulties as they provided to anyone else (Same as You: a review of Services for People with Learning Difficulties). Similarly, all nurses were required (by Promoting Health Supporting Inclusion, 2003) to support and meet the health needs of all those with intellectual disabilities. Adviser 2 said that in these circumstances, all clinicians should have had at least an awareness and understanding of the difficulties faced by people with intellectual disabilities in the clinical setting and that they were flexible in recognising and responding appropriately to improve service access and reduce inequality. However, Adviser 2 said that there was no evidence in the records to show that medical and nursing staff took adequate account of Miss A's intellectual disabilities in the course of their assessment in the ED. Despite it being acknowledged that her disabilities made assessment difficult, no special measures or tools were implemented to help in the communication process. Neither was there evidence that Mr C had been consulted about Miss A's usual pain responses. Adviser 2 said that, in their view, this was both unreasonable and discriminatory and had the effect of denying Miss A the level of service she should have received. Adviser 1 agreed. They said that there was no documented discussion with Mr C about what, if any, behaviour Miss A might display if she was in pain. They commented that Doctor 1 did not take into account Miss A's learning difficulties when communicating with her or interpreting his findings on examination. While Doctor 1 concluded that Miss A's learning difficulties made

her 'difficult to assess', there was a failure to seek senior advice or to look further into the matter.

(b) Decision

25. The assessment of pain and discomfort in a person with severe and profound disability is a difficult undertaking. The person may be unable to verbally communicate their discomfort or comprehend the questions being put to them. People with intellectual disabilities may not express their pain in the ways others do and disabilities can create challenges for other people. It is, therefore, important that clinicians use what tools and information that are available to them and also use the insight and expertise of carers and /or relatives who know the people well and have an insight into their behaviour. Regrettably this did not happen in Miss A's case, amongst other things, the Board appear to have given little cognisance to the GP's letter and the Certificate of Incapacity which accompanied Miss A to the ED and they did not ask Mr C for his view about Miss A. For these reasons, I uphold the complaint.

26. The Board should now apologise to Miss A (copied to Mr C) that when they were communicating with her, they failed to take her learning difficulties into account. They should also apologise to Mr C for not reverting to him for his assistance in the matter. Had they done so, Miss A's care may have been improved. Further, the Board should now take steps to ensure that a similar situation does not occur again; they should review their advice to staff members about treating people with disabilities and establish whether their advice is currently fit for purpose. If it is not, they should provide updated advice and guidance.

(b) Recommendations

27. I recommend that the Board:	*Completion date*
(i) apologise to Miss A (copied to Mr C) that when they were communicating with her, they failed to take her learning difficulties into account;	26 May 2017
(ii) also apologise to Mr C for not reverting to him for his assistance in the matter; and	26 May 2017
(iii) take steps to ensure that a similar situation does not occur again; they should review their advice to staff members about treating people with disabilities and establish whether their advice is	26 July 2017

currently fit for purpose. If it is not, they should provide updated advice and guidance.

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

Annex 1

Explanation of abbreviations used

Mr C	the complainant
Miss A	Mr C's sister
ED	Emergency Department
the Board	Greater Glasgow and Clyde NHS Board –Acute Services Division
Adviser 1	a consultant in emergency medicine
Adviser 2	a nursing adviser
UTI	Urinary tract infection
Doctor 1	a trainee doctor
Doctor 2	another doctor
Doctor 3	a GP trainee

Annex 2

Glossary of terms

Canadian C spine rule	a decision making tool used to determine when radiography imaging should be used
osteoporosis and osteopenia	bone conditions
tachycardia	a significantly fast heart beat