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: 201607618, Orkney NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / Diagnosis

Summary
Ms C, a support and advocacy worker, complained on behalf of Ms B about the care and treatment provided to Ms B's son (Mr A) when he was admitted to Balfour Hospital (the hospital) following a road traffic accident. Ms C said that when Mr A arrived at the hospital his spine was not x-rayed despite him reporting pain in his back, and that when Mr A was later transferred to another hospital it was found that he had a spinal fracture. Ms C also complained that a wound to Mr A's leg was not cleaned appropriately and said this led to infections.

We took advice from an emergency consultant and an orthopaedic surgeon. We found multiple significant failings in the care and treatment provided to Mr A. These included a failure to examine and x-ray Mr A's spine; a failure to obtain x-rays of Mr A's neck, chest and pelvis; a failure to assess and clean a wound in Mr A's arm in a timely manner; a failure to administer antibiotics in a timely manner; and a failure to administer appropriate pain medication. We also found that the treatment provided was not appropriately documented in the medical records. However, we determined that Mr A's leg wound was appropriately cleaned and therefore did not uphold this aspect of Ms C's complaint.

We had further concerns that the board's own investigation into Ms C's complaint failed to identify the serious clinical failings in this case and made recommendation regarding this.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Ms C:

Complaint number	What we found	What the organisation should do	Evidence SPSO needs to check that this has happened and the deadline
(a)	The Board failed to provide Mr A with appropriate clinical treatment in view of his presenting symptoms	Provide a written apology to Ms B and Mr A for failing to provide Mr A with appropriate clinical treatment in view of his presenting symptoms. This apology should be copied to Ms C	Copy of written apology which complies with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance By: 27 September 2017

We are asking the Board to improve the way they do things:

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	There were a number of significant failings in Mr A's care, including failure to: • examine and x-ray Mr A's spine; • obtain x-rays of Mr A's neck, chest and pelvis; • assess and clean Mr A's arm wound in a timely manner; • administer antibiotics in a timely manner; and • administer appropriate analgesics	The Board should provide a reasonable standard of trauma care, with adequate staff training and effective systems in place to support this	Evidence that the Board have carried out a significant event review in to this case, with the findings made available to Mr A's family By: 22 November 2017 Evidence that the Board has reviewed their systems and staff training for the initial management of seriously injured patients (including review of the competencies and training for consultants who are expected to lead the assessment and resuscitation of patients with major trauma) By: 22 November 2017

Complaint number	What we found	What should change	Evidence SPSO needs to check that this has happened and deadline
(a)	The Board's own investigation did not identify or address the serious failings in the care provided to Mr A	The Board's complaints handling system should ensure that failings (and good practice) are identified, and enable learning from complaints to inform service development and improvement	Evidence that the Board have reviewed why its own investigation into the complaint did not identify the failings highlighted in this report By: 25 October 2017
(a) & (b)	There was a failure to appropriately document the treatment provided in the medical records	All treatment should be appropriately documented in medical records	Documentary evidence that this finding, and what action will be taken to ensure medical records are adequate in the future, has been shared and discussed with relevant staff. This could include, for example, minutes of discussion at a staff meeting or copies of internal memos, emails or notes of feedback given about this complaint By: 27 September 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 Ms C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Ms C, who works for an advice and support agency, complained to the Ombudsman about the clinical treatment provided to her client (Ms B)'s son (Mr A) by Orkney NHS Board (the Board) after he was involved in a road traffic accident. The complaints from Ms C I have investigated are that the Board failed to:

(a) provide Mr A with appropriate clinical treatment in view of his presenting symptoms (*upheld*); and

(b) appropriately clean Mr A's leg wound (*not upheld*).

Investigation

1. My complaints reviewer and I considered all of the information provided by Ms C and the Board. We also sought independent clinical advice from a consultant in emergency medicine (Adviser 1), and an orthopaedic surgeon (Adviser 2). In this case, I have decided to issue a public report on Ms C's complaint because of the significant nature of the failings identified.

2. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, although I have not included every detail of the information considered, my complaints reviewer and I have reviewed all of the information provided during the course of the investigation. Ms C and the Board were given an opportunity to comment on a draft of this report.

Background

3. Mr A was in a road traffic accident on 20 August 2016 and was brought to the emergency department of Balfour Hospital (Hospital 1). He had an open fracture (a bone fracture in which a broken bone pierces the skin) on his right shin, amongst other injuries. He was taken to operating theatre and the wound at the fracture site was cleaned, the fracture repositioned, and a long back slab (a type of cast) placed. Mr A was then transferred by air to a hospital in another health board (Hospital 2) for further treatment.

4. When Mr A arrived at Hospital 2, an x-ray revealed that he had a spinal fracture which needed surgery. Mr A also developed an infection in the wound in his leg.

(a) The Board failed to provide Mr A with appropriate clinical treatment in view of his presenting symptoms

Concerns raised by Ms C

5. Ms C said that when Mr A arrived at Hospital 1 he was complaining of a sore back but it was not x-rayed and that he was just given painkillers. She said that Mr A was being manoeuvred and sat upright by staff at Hospital 1, but that when he arrived at Hospital 2 he was laid flat and immediately sent for an x-ray which showed a fracture in his spine. Ms C said that Mr A could have been paralysed due to the poor treatment he received at Hospital 1.

The Board's response

6. In responding to Ms C's initial complaint, the Board asked the consultant surgeon that had provided Mr A's treatment at Hospital 1 to comment. The consultant was not able to access Mr A's medical records so provided his response from memory. The complaint response said that when Mr A arrived at Hospital 1, he had suffered an open fracture on his right shin and had some superficial bruises. It said that his chest and abdomen were clear and there was no sign of head injury. The response went on to say that the consultant surgeon cleared Mr A's spine but that there was some limitation of the physical examination because Mr A could not be log rolled (a technique to safely move patients which minimises spinal movement) due to the unstable open fracture on his right shin.

7. The response said that there were no neurological signs (symptoms which indicate damage to the spinal cord, such as loss of sensation) and that the consultant surgeon did not recall Mr A complaining of back pain. The response said that from the information provided to the consultant surgeon they could see that fractures of the spine were missed, and that they were very sorry that there was a failure to undertake an x-ray of the spine. They said that an explanation for this could be because of the limited physical examination they were able to undertake due to the shin fracture. The response acknowledged that the care provided could have been better.

Medical advice

8. My complaints reviewer asked Adviser 1 to comment on whether the clinical treatment provided to Mr A by Hospital 1 was reasonable in view of his presenting symptoms. Adviser 1 first commented that there appeared to be only one page of notes written by medical staff in the emergency department at Hospital 1, which were brief and did not describe the limb injuries sustained by

Mr A. Adviser 1 said that there was no note made by medical staff of Mr A having back pain and no note of his spine being assessed. Adviser 1 said that the documentation in general was brief and many important pieces of information were not recorded. They considered this to be unreasonable.

9. Adviser 1 then went on to discuss the assessment of Mr A's spine. Adviser 1 noted that Mr A attended Hospital 1 at 01:50 on 20 August 2016, and that the nursing record from the initial assessment stated 'pain in lower back'. Adviser 1 said that the ambulance report also stated that Mr A had pain in his lower back, and that complaints of back pain were documented when Mr A later arrived at Hospital 2.

10. Adviser 1 said that in accordance with normal trauma care practice and the standard of care internationally recognised for the early assessment and management of trauma (Advanced Trauma Life Support standards), Mr A should have been carefully logrolled and his back examined. Adviser 1 said that a failure to do this was unreasonable, especially as Mr A had clearly complained of back pain.

11. Adviser 1 noted that in the Board's response, they said that they had been unable to examine Mr A's back as they could not log roll him due to his shin fracture. However, Adviser 1 said that the presence of a limb fracture is no contraindication to log rolling a patient and examining their back. Adviser 1 said that many patients who have multiple injuries will have painful limb injuries, and that there are no reasons that this should stop a doctor examining, x-raying, or computerised tomography (CT) scanning to assess for spinal injuries. Adviser 1 also said that an absence of neurological signs in no way rules out the presence of a spinal fracture.

12. Adviser 1 said that Mr A's injured leg could have been placed in a splint or a plaster case to allow log rolling to take place with less pain, and that opiate pain relief would have facilitated log rolling in the presence of a limb fracture. Adviser 1 said that given the fact Mr A had been in a road traffic accident, and the presence of lower back pain, an x-ray or CT scan of Mr A's lower spine should have been carried out. They also said that in the presence of multiple limb injuries, Mr A should have had x-rays of his pelvis, chest and neck in the emergency department of Hospital 1. Adviser 1 considered it very unreasonable that there was a failure to do this.

13. Adviser 1 further noted that Mr A had been allowed to sit up in Hospital 1. Adviser 1 said that as Mr A had an unstable spinal fracture, allowing him to sit up created a considerable risk of him sustaining an injury to his spinal cord and becoming paralysed. Adviser 1 said that Mr A being allowed to move in this way without a spinal injury first being ruled out with examination and x-ray is seriously concerning.

14. Adviser 1 also commented that with regards to antibiotic provision, Mr A was not given intravenous (administered into a vein) antibiotics for the open fracture on his right shin until over four hours after he arrived at Hospital 1. Adviser 1 explained that this was unreasonable because patients with open fractures require intravenous antibiotics at the earliest opportunity to reduce the risk of infection. Adviser 1 also said that National Institute for Health and Care Excellence (NICE) guidelines on assessment and management of complex fractures state 'in the emergency department administer prophylactic [preventative] antibiotics immediately to people with open fractures if not already given'. Adviser 1 explained that the later antibiotics are administered the greater the risk of infection occurring.

15. Adviser 1 further noted that an arm wound was examined and cleaned on the ward by nursing staff around five hours after Mr A had arrived at the emergency department, but that there was no medical staff note describing the wound, and no note of the wound being cleaned or examined prior to this even when Mr A was in the operating theatre under general anaesthetic. Adviser 1 said that there appears to have been a considerable delay to cleaning a traumatic wound and no note of an examination of the wound; ie depth, potential damage to underlying structures and the function of the limb. Adviser 1 said that this is concerning and not a reasonable standard of care.

16. Additionally, Adviser 1 noted that Mr A was documented as receiving intravenous paracetamol at 02:15, but that there was no record of Mr A receiving opiate analgesia (strong pain relief such as morphine) in Hospital 1. Adviser 1 said that Mr A would have been in considerable pain given the injuries he sustained, and that they would have expected him to require opiate analgesia on a regular basis after his admission to Hospital 1.

17. Adviser 1 stated that their opinion was that the standard of care provided to Mr A in the emergency department of Hospital 1 fell seriously below modern, internationally accepted standards of trauma care.

(a) Decision

18. The complaint I have considered is that the Board failed to provide Mr A with appropriate clinical treatment in view of his presenting symptoms. The advice I have received is that there were multiple failings in the treatment provided to Mr A. I accept this advice.

19. I note Adviser 1's particular concern that Mr A's back was not assessed, despite records of him having complained of back pain both in the ambulance on the way to Hospital 1, and during the nursing assessment upon arrival. Adviser 1 said that this failure could have resulted in very serious consequences for Mr A, including paralysis. Adviser 1 further commented on the failure to administer Mr A with antibiotics in a timely manner, the failure to assess and clean an arm wound in a timely manner, and the failure to administer appropriate analgesics. These are serious failings in care and treatment, and, therefore, I uphold this complaint.

(b) The Board failed to appropriately clean Mr A's leg wound

Concerns raised by Ms C

20. Ms C said that when Mr A was transferred to Hospital 2, grit was found in his leg wound and that this indicated that it had not been cleaned properly at Hospital 1. Ms C said that the failure to clean Mr A's leg wound resulted in an infection and subsequent delay to Mr A's treatment while the infection cleared.

The Board's response

21. In response to Ms C's complaint, the Board said that when Mr A was taken to theatre, the wound on his leg was carefully cleaned and a sterile dressing was put in place. They said that the fracture was then repositioned and a cast was placed.

22. The Board explained that in the presence of a compound fracture there is a higher risk of infection due to the nature of the injury, and that Mr A was started on antibiotics to limit the risk of this infection.

Advice obtained

23. I asked Adviser 2 whether they considered that staff at Hospital 1 had cleaned Mr A's leg wound appropriately when he went into surgery on 20 August 2016.

24. Adviser 2 said that the operation notes from Hospital 1 are not detailed, but on review of the available records it appeared that the wound was debrided (damaged tissue and foreign objects removed) by the surgeon. Adviser 2 said that there was no record of contamination of the wound or presence of dirt or grit at the initial surgery. I asked Adviser 2 to comment on Ms C's assertion that grit was found in the wound when Mr A was transferred to Hospital 2. Adviser 2 reviewed the clinical records from Hospital 2 and said that they mention that the wound edges and bone ends were contaminated and had to be debrided, but that there was no mention specifically of presence of dirt or grit in the wound.

25. Adviser 2 went on to explain that the British Orthopaedic Association Standards for Trauma guidelines recommend that primary wound debridement should be done only at specialist centres unless the patient cannot be transferred early. In this case, Adviser 2 said, Hospital 1 appropriately took the patient to theatre to clean the wound as there was a delay in transfer due to weather conditions, and they were of the opinion that the surgeon cleaned the wound according to his experience and capabilities. Additionally, Adviser 2 said that it is good practice to preserve as much soft tissue as possible at first debridement unless it is being done at a specialist centre under plastic surgery guidance.

26. I asked Adviser 2 whether they considered the infection that Mr A subsequently suffered from to be due to a failure to clean Mr A's leg wound appropriately in Hospital 1. Adviser 2 said that Mr A had a severe open fracture of his shin, which involved severe soft tissue injury, stripping of the membrane surrounding the bone, and bone exposure. They said that this type of wound often needs multiple debridement procedures and plastic surgery cover and has a high risk of infection. Adviser 2 said that it is likely the wound becoming infected was related to the severity of the initial injury, and did not think that staff at Hospital 1 failed to clean the wound appropriately.

(b) Decision

27. The complaint I have investigated is that the Board failed to appropriately clean Mr A's leg wound. The advice I have received is that there is no evidence that this was the case. I accept that advice.

28. Adviser 2 said that there was no evidence, from the records, that grit or dirt was left in Mr A's leg wound. I also note Adviser 2's comments that, as Hospital 1 was not a specialist centre, they followed good practice by trying to

preserve as much soft tissue as possible. Given the above, I do not uphold this complaint.

29. Although I do not uphold the complaint, I note Adviser 2's comments that the operation note was not detailed and I will make a recommendation about this.

30. 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.

Recommendations

What we are asking the Board to do for Ms C:

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Terms used in the report **Annex 1**

Adviser 1	a consultant in emergency medicine
Adviser 2	an orthopaedic surgeon
CT	computerised tomography
debrided	damaged tissue and foreign objects removed
Hospital 1	Balfour Hospital
Hospital 2	a hospital in another health board
intravenous	administered into a vein
log roll	a technique to safely move patients which minimises spinal movement
Mr A	Ms B's son
Ms B	Ms C's client
Ms C	the complainant, who works for an advice and support agency
neurological signs	symptoms which indicate damage to the spinal cord, such as loss of sensation
NICE	National Institute for Health and Care Excellence
open fracture	a bone fracture in which a broken bone pierces the skin
opiate analgesia	strong pain relief, such as morphine