SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201305035, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the care and treatment she received in the Royal Alexandra Hospital. She had been transferred there from a community hospital in another board's area after injuring her upper back and neck.

We obtained independent advice on the complaint from one of our medical advisers, after which we upheld both of Mrs C's complaints. We found that although Mrs C was triaged (triage is the process of deciding which patients should be treated first based on how sick or seriously injured they are) within ten minutes of arriving in the hospital, there was some confusion about whether the orthopaedics team (who deal with conditions involving the musculoskeletal system) were told that she had been transferred there. She was not seen by a doctor from that team until nearly four hours after her arrival. During this time, staff in A&E failed to escalate the matter to ensure that she was seen by a clinician, and failed to record her neurological status. After Mrs C was eventually seen by the orthopaedics team, there was then a further 45-minute delay before she was reviewed by a more senior doctor and an additional delay in obtaining a CT scan (a scan that uses a computer to produce an image of the body).

We also found that, although it had been reasonable for staff to carry out a rectal examination (a physical examination during which a doctor or nurse inserts a finger into the rectum/back passage) to assess the extent of Mrs C's spinal injury, this was not adequately explained to her. The overall quality of the medical notes was good, but there was a failure in relation to the prescription of morphine in the drug chart. There was also a delay in arranging an ambulance for Mrs C when it was decided that she should be transferred to the national spinal injuries unit.

Mrs C also complained about the board's handling of her complaint. We found that their investigation into the problems in her care was inadequate. There was no in-depth review of the communication failures that caused the delay in her being reviewed by the orthopaedics team, and formal statements had not been taken from the key members of staff involved in her care and treatment to establish their views directly. As a result of all of this, opportunities both to identify a possible cause of the poor experience she had and to learn and rectify behaviours and improve care for the next patient were lost. In addition, the board delayed in responding to the complaint.

Recommendations

We recommended that the board:

- carry out an significant clinical incident review regarding the care and treatment provided to Mrs C;
- remind staff in the orthopaedics team to clearly explain the need for a rectal examination to patients before it is carried out;
- provide evidence that they have taken steps to try to prevent the recurrence of the problems that occurred in relation to the handling of Mrs C's complaint; and
- issue a written apology to Mrs C for the failings identified during our investigation.