SPSO decision report

Case: **202307598, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of a family member (A) about the care and treatment that A received during two presentations to hospital following a fall at their home. Prior to their fall, A was fit and well and independent for activities of daily living.

During our investigation the board had accepted that there were failings and had taken action to address these. This included using this case as a case study to ensure any training and development requirements were implemented, delivering training sessions on significant adverse events review and carrying out a review of the duty of candour arrangements which would include training.

We took independent advice from a consultant in emergency medicine and a trauma and orthopaedic consultant. We found serious failings in A's care and treatment and that a number of red flags (specific symptoms or signs that indicate a potentially urgent or serious underlying condition requiring immediate medical attention) had been missed in this case. In particular, we found that there was a failure to take into account relevant national guidance and to perform imaging which meant that the fractures of the vertebrae in A's thoracic spine were undiagnosed. There was also a failure to take account of the National Institute for Health and Care Excellence guidance which the board had accepted.

We found that it had been unreasonable that A had been left to sit during their second visit to hospital for a prolonged period before being assessed given their symptoms. There were also missed opportunities to complete a more thorough neurological examination with a failure to appreciate the presence of a spinal injury and to realise the significance of the signs of limb weakness and incontinence. We also found that the board failed to immobilise A while awaiting the results of a CT scan and during their transfer between hospitals. In view of the failings identified, we upheld C's complaint.

During our investigation, we identified issues with the board's handling of the complaint. We made a recommendation to the board to support improvement of their complaint handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failings identified in this decision. The apology should meet the standards set out in the SPSO guidance on apology available at www.spso.org.uk/meaningful-apologies.

What we said should change to put things right in future:

- Patients attending the emergency department should be appropriately assessed and thoroughly examined, taking into account relevant guidance and, where appropriate, imaging performed. Account should also be taken of presenting symptoms, for example where a patient is presenting with ongoing

back pain and new incontinence they should be laid flat and where appropriate immobilised, for example during patient transfer.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the board’s complaint handling procedure and the NHS Model Complaints Handling Procedure. When an incident occurs that falls within the Duty of Candour legislation, the board’s Duty of Candour processes should be activated without delay. Staff should be aware of the board's adverse event review processes and ensure they are appropriately applied.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.