Investigation of a complaint against Belfast Health & Social Care Trust

Report Reference: 202002342

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Case Reference: 202002342
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint was about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to his late wife (the patient) for injuries she sustained following a fall at home on 26 February 2021. In particular, the complaint related to the care and treatment the patient received from the Emergency Department (ED) at the Royal Victoria Hospital (RVH) and the Trust's Trauma and Orthopaedics Service (T&O).

The complainant stated ED staff failed to identify the patient's fractures and questioned whether they undertook X-rays of her injuries as they told her she had no broken bones. The complainant also raised concerns regarding ED's care and treatment of the patient's foot and ankle. He said the patient developed blisters from wearing a walking boot, and ED staff removed these blisters using unsterile equipment.

The complainant said T&O failed to identify the patient's fractures at a review meeting. He said the patient did not attend RVH for a CT scan on 27 February 2021, as T&O claimed. The complainant further stated the patient attended RVH on 28 February 2021 and stayed overnight on that date, but RVH said it did not have any records of this. The complainant also raised concerns about the care and treatment T&O provided the patient. He said it delayed her surgery, and she developed cellulitis despite attending regular wound management appointments. The complainant said T&O failed to inform the patient about the cellulitis and questioned the appropriateness of the treatment. He said T&O failed to provide follow up care for the patient's foot and ankle following her discharge from RVH on 27 May 2021. In relation to T&O's care and treatment of the patient's upper arm and shoulder injuries, the complainant raised concerns about the timeliness of an Avascular Necrosis (AVN) diagnosis.[1] He also stated delays in surgery were not appropriate.

[1] AVN is the death of bone tissue. It occurs due to a lack of blood supply and can lead to tiny breaks in the bone which cause it to collapse. AVN can cause a joint to collapse, which can cause pain.

The investigation established there were failures in ED's care and treatment on 26 February 2021. ED failed to identify the patient's ankle and elbow injuries, appropriately assess and treat her foot and ankle injuries, and take steps to potentially minimise the development and severity of her blisters due to the failure to diagnose and appropriately treat the ankle fracture.

The investigation established there were failures in T&O's care and treatment of the patient's foot and ankle. T&O failed to act on the second read report of X rays which identified the fractures. This caused a delay in the identification of the foot and ankle fractures until 1 March 2021 and delayed treatment. It failed to document relevant clinical findings in nursing notes regarding the patient's foot wound on 3 May 2021. Staff failed to complete wound charts to monitor the patient's foot wound and did not request a doctor to review the foot wound when there were probable signs of cellulitis. Had the Trust diagnosed cellulitis, it would most likely have commenced the patient on oral antibiotic and may have prevented her admission to hospital on 5 May 2021 and the need for intravenous antibiotic treatment. Following admission, T&O failed to undertake swabs and to discuss the results with the Microbiology Team to ensure it used the most appropriate antibiotic. It also did not provide follow-up care for the patient's foot and ankle condition. There was no clear rationale for the oral antibiotics it prescribed and no plan for monitoring their use. Finally, the Trust failed to provide the patient with shoulder surgery for her AVN within a reasonable timeframe. The patient's shoulder was causing her considerable pain and ultimately, she died following a further hospital admission without the shoulder surgery taking place.

I recommended the Trust provides a written apology to the complainant for the injustices caused by the failures I identified in this report. I also made further recommendations for the Trust to instigate service improvements to prevent similar failings recurring.

I wish to convey my heartfelt condolences to the complainant for the sad loss of his wife.

THE COMPLAINT

1. This complainant was about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's late wife (the patient) from 26 February 2021 to 28 September 2021. Specifically, the complainant raised concerns about the care and treatment the patient received from the Emergency Department (ED) at the Royal Victoria Hospital (RVH) and the Trust's Trauma and Orthopaedics Service (T&O Service). The patient sadly passed away on 28 September 2021.

Background

2. On 26 February 2021, the patient fell at home and sustained injuries to her right upper and lower limbs. She travelled by ambulance to ED at RVH. ED staff fitted a Aircast boot[2] to the patient's right foot and a polysling[3] to her right arm and discharged her home the same day.

3. On 1 March 2021, the patient attended a Fracture Clinic outpatient appointment at RVH. At this appointment, the Trust confirmed she had fractures in her right shoulder and elbow and admitted her to hospital to await surgery. Later that day, the patient had a computerised tomography scan (CT scan) of her foot and ankle. On 2 March 2021, the Trust diagnosed the patient with fractures to her right foot and ankle[4]. Subsequently on 2 March 2021, the patient underwent surgery[5] to her right shoulder under the care of a Consultant Orthopaedic Surgeon (Consultant A). On 10 March 2021, the patient underwent surgery[6] to her right foot and ankle injury under the care of a different Consultant Orthopaedic Surgeon (Consultant B). The Trust discharged her on 12 March 2021.

[2] An Aircast boot fits around a foot to support the ankle and restrict or limit motion. This may be necessary to prevent instability due to muscle weakness, protect the ankle prior to surgical repair following an injury, or to protect the ankle following surgical repair.
[3] A polysling supports an arm and shoulder to prevent movement.
[4] The CT scan findings of 1 March 2021 were fracture of the base of the fifth metatarsal; avulsion fracture of the lateral malleolus with associated soft tissue swelling; intra-articular fracture of the anterior calcaneal; and significant soft tissue swelling around the ankle joint.
[5] The surgery was Proximal Humerus Internal Locking System plating surgery.
[6] The surgery was Open Reduction and Internal Fixation surgery.

4. On 15 March 2021, the patient attended the Fracture Clinic at RVH because she was experiencing pain and discomfort around her ankle. During this appointment, staff noted the patient's surgical wound was red and swollen with slight discharge. They prescribed her antibiotics and advised her to attend an upcoming review appointment due to take place on 22 March 2021.

5. On 22 March 2021, staff at the fracture clinic in RVH decided the patient should attend nurse led clinics to monitor the progress of her ankle wound. Subsequently, the patient attended wound management clinics at RVH and Musgrave Park Hospital (MPH) on a near weekly basis from April 2021 to 3 May 2021.

6. On 29 April 2021, the patient attended an appointment at RVH with Consultant A. During this appointment, the patient underwent X-rays of her shoulder. Consultant A diagnosed the patient with Avascular Necrosis (AVN)[7], and advised her she required further surgery to remove the screws from her joint space. Consultant A agreed to provisionally book the patient's shoulder surgery for 7 May 2021.

7. On 5 May 2021, the Trust admitted the patient to RVH Fracture Ward 4C to receive intravenous antibiotic treatment for her ankle wound. The patient's shoulder surgery did not take place as scheduled on 7 May 2021. The Trust discharged the patient on 27 May 2021, while she was awaiting the shoulder surgery.

8. On 24 June 2021, the patient attended an outpatient review appointment with Consultant A who advised her shoulder surgery could now take place. Consultant A informed the patient he would proceed to plan this surgery on the next available trauma list.

9. The Trust provisionally booked the patient's shoulder surgery for 29 July 2021. On 28 July 2021, the Trust notified the patient by telephone it had cancelled her surgery. On 9 September 2021, the Trust notified the patient by telephone that

[7] AVN is the death of bone tissue. It occurs due to a lack of blood supply and can lead to tiny breaks in the bone which cause it to collapse. AVN can cause a joint to collapse, which can cause pain.

a provisional date for her shoulder surgery was now set for 28 September 2021.

10. The patient attended ED in RVH on the evening of 17 September 2021 with symptoms of lower respiratory tract infection and episodes of confusion and unsteadiness on feet. She was subsequently admitted on 18 September 2021. The patient sadly passed away on 28 September 2021.

Issue of complaint

11. I accepted the following issue of complaint for investigation:

Issue: Whether the Trust's care and treatment of the patient was appropriate and reasonable.

INVESTIGATION METHODOLOGY

12. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. The Investigating Officer also obtained the patient's GP records.

Independent Professional Advice Sought

13. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- Consultant in Emergency Medicine, MD MPH FRCEM with 24 years' experience working in Emergency Medicine (ED IPA).
- Consultant Surgeon in Trauma & Orthopaedics, MBBS, MRCSEd, MRCSGlas, MSc, FRCS (Trauma and Orthopaedics), MBA, with over 15 years' experience in clinical orthopaedics (O IPA).
- Registered General Nurse with 21 years' experience across primary and secondary care (N IPA).

I enclose the clinical advice at Appendix Two to this report.

14. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However,

how I weighed this advice, within the context of this complaint, is a matter for my discretion.

Relevant Standards and Guidance

15. To investigate complaints, I must establish a clear understanding of the general standards, and the specific standards relevant to the circumstance of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles[8]:

- The Principles of Good Administration.

16. The specific standards and guidance are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance);
- The Royal College of Surgeons' Good Surgical Practice – A Guide to Good Practice, May 2019 (the RCS Guidance);
- The British Orthopaedic Association Standards for Trauma, August 2013 (the BOA Guidance);
- Nursing & Midwifery Council (NMC) The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates, October 2018 (the NMC Code);
- Nursing & Midwifery Council (NMC) Future nurse: Standards of proficiency for registered nurses, March 2018 (Nursing proficiency standards);
- Health and Social Care Northern Ireland Formulary, NI Wound Care Formulary, January 2020 (Wound Care Formulary); and
- The Belfast Heath and Social Care Trust's Aseptic Non-Touch Technique (ANTT), May 2016 (the Trust's ANTT).

[8] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

I enclose relevant sections of the guidance at Appendix Three to this report.

17. I did not include all information obtained during the investigation in this report. However, I am satisfied I considered everything relevant and important in reaching my findings.

18. A draft copy of this report was shared with the complainant and the Trust whose actions are the subject of the complaint, to enable them to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations.

THE INVESTIGATION

Whether the Trust's care and treatment of the patient was appropriate and reasonable.

In particular, this will consider the patient's care and treatment in relation to her shoulder/arm injuries and ankle/foot injuries, provided by:

- The Emergency Department in RVH; and
- The Trust's Trauma and Orthopaedics Service.

Detail of Complaint

The Period from 26 to 28 February 2021

19. The complainant stated ED staff failed to identify any of the patient's fractures when she attended ED on 26 February 2021. He said the ED doctors told the patient they concur there are no broken bones. The complainant also stated the Trust failed to identify the patient's fractures at RVH's T&O meeting on 27 February 2021. The complainant explained the failure to diagnose the fractures on two occasions raised questions about whether the Trust X-rayed her injuries when she attended ED.

20. The complainant stated the Trust discharged the patient home on 26 February 2021 because it failed to identify her fractures. He said she experienced extreme pain from 26 to 28 February 2021 as a result. The complainant explained the patient's pain became severe on 28 February 2021, so he contacted RVH by telephone and staff advised him to bring her to the Fracture

Clinic. The complainant said the patient subsequently attended and stayed overnight in RVH on 28 February 2021. However, the complainant was dissatisfied the Trust said it had no records the patient attended and stayed overnight in RVH on this date. He also stated the patient did not have a CT scan on 27 February 2021, as the Trust claimed.

21. The complainant stated the patient developed blisters from wearing a metatarsal walking boot ED staff applied to her right foot. He raised concerns about how the staff deroofed[9] her blisters. The complainant said the blister deroofing occurred on 28 February 2021, and the staff did not use sterile scissors. The complainant contended this failure to properly deroof the patient's blisters led to the patient later developing infections, including cellulitis. He also stated the improper blister deroofing caused a delay in the patient undergoing foot surgery.

Evidence Considered

Legislation/Policies/Guidance

22. I considered the following guidance:
    - The Trust's ANTT.

Trust's response to investigation enquiries

23. The Trust stated the patient attended ED on 26 February 2021 and underwent X-rays of her right humerus (upper arm), right shoulder, and right tibia and fibula[10] (lower leg). It explained the Orthopaedic junior doctor thought the patient possibly had a dislocated ankle. Therefore, the Trust applied a walking boot. On the 27 February 2021, the Trust discussed the patient's case at the T&O X-ray meeting. It acknowledged the staff did not identify the foot and ankle fracture on the available plain film imaging at that time. However, it said both ED and T&O staff diagnosed the fracture in the patient's arm. The Trust said the delay in diagnosing the ankle and foot fractures would not have changed its initial management of the patient's injuries.

[9] Deroofing involves removing blisters to expose viable tissue. It allows medical professionals to assess a wound bed and remove non-viable tissue to promote healing.
[10] The tibia and fibula are the two long bones located in the lower leg. The tibia is the larger bone on the inside, and the fibula is the smaller bone on the outside.

24. The Trust stated it checked its RVH electronic patient administrative system (PAS) and ED Symphony system and there is no record of the patient attending any department in RVH on 28 February 2021.

25. The Trust stated the normal practice for de-roofing is in line with the Trust's Aseptic Non-Touch Technique. It explained its scalpels, scissors, and dressing packs are individual use and sterile, and staff open these instruments aseptically on a sterile field. The Trust stated staff may prepare the instruments in the clinical area and bring them to the patient's bedside on a sterile trolley. It said the 1 March 2021 nursing notes confirm staff conducted the blister de-roofing procedure and dressed the wound aseptically. It said these records also show staff explained the procedure to the patient and she gave consent.

Relevant records

26. I considered the patient's medical records for the period 26 February 2021 to 28 February 2021. These included the patient's X-ray and CT scan images. In addition, I considered the records dated 1 March 2021 in relation to the deroofing of the patient's blisters. I also considered the patient's GP records. I have included relevant extracts from these records at Appendix Four.

Relevant Independent Professional Advice

27. The ED IPA provided advice about the care and treatment the patient received from ED staff on 26 February 2021. In addition, the O IPA provided advice about the care and treatment the Orthopaedic doctor provided on 26 February 2021. The ED IPA's and O IPA's full advice reports are at Appendix Two to this report.

Analysis and Findings

Missed fractures in ED and T&O Meeting

28. The ED IPA advised on the process of identifying fractures. They explained staff working in an ED request radiological images depending on the clinical condition of the patient. Once they take these images, the requesting clinician reviews them together with the patient's condition and makes an assessment.

The ED IPA noted it is good practice for this clinician to record their interpretation of the X-rays. A different member of the radiology staff should then carry out a 'second read' by reviewing the images and recording their clinical assessment. The ED IPA stated second reads can greatly reduce missed injuries, as they allow staff to recall patients for review after discharge from ED if they later identify fractures.

29. The ED IPA advised the ED doctor requested X-rays of the patient's right shoulder and right ankle and lower leg on 26 February 2021. An ED doctor first reviewed the X-rays, followed by an Orthopaedic doctor. However, the ED IPA explained this was not an "official" second read as the Orthopaedic doctor was not a radiology staff member. The complainant questioned whether the ED staff performed any X-rays. Having reviewed the available records, I accept the ED IPA advice and am satisfied ED staff did perform X-rays of the patient's injuries.

30. The ED IPA advised the X-rays showed the patient had a right humeral head fracture (shoulder) and radial head fracture (elbow). They also showed she had a fracture at the base of her fifth metatarsal and lateral malleolus (ankle). Therefore, the patient had fractures in her shoulder, elbow, and ankle.

31. The ED IPA advised the ED doctor identified the shoulder fracture. They stated this diagnosis was a "correct and reasonable interpretation" of the patient's shoulder X-ray. The ED IPA also said the Trust staff planned shoulder surgery to repair the humeral head fracture and organised a follow-up outpatient appointment. I note the medical, nursing, and physiotherapy notes demonstrate the Trust developed a treatment plan. Therefore, I am satisfied ED staff diagnosed the patient's shoulder fracture when she attended ED on 26 February 2021.

32. However, the ED IPA advised the ED staff did not identify the elbow or ankle fractures on 26 February 2021. In response to this office and the complainant, the Trust acknowledged it did not identify the ankle fractures at ED on 26 February.

33. The ED IPA also advised on the reasonableness of the ED staff's reading and

reporting of the images. They stated the reading and reporting of the images by the ED staff was reasonable regarding the missed ankle facture, as this fracture is only visible on one view of the images and is relatively subtle. However, they noted the overall ankle assessment was not adequate as the ED doctor did not consider clinical concerns, such as the clear history of dislocation and evidence of vascular compromise from the Northern Ireland Ambulance Service, gross swelling and tenderness, or the patient's inability to bare weight. The ED IPA noted these clinical concerns were very suggestive of a significant right ankle injury and needed further assessment and treatment. The ED IPA concluded ED staff's overall assessment on 26 February had several red flags, and these should have prompted senior staff to review or conduct further imaging, but this did not happen.

34. The ED IPA advised the Trust's overall assessment of the patient presumed the ankle had a dislocation. They explained, due to this presumptive diagnosis, the Trust fitted a walking boot to the patient's right ankle. The ED IPA concluded this treatment was not appropriate as the patient should have had a full plaster cast to immobilise the ankle. They noted if the Trust had identified the ankle fractures, it would have advised the patient to elevate and immobilise her leg and apply ice. I found no evidence within the records to indicate the Trust provided this advice.

35. T&O met on the 27 February 2021 to review the patient's case. I note with concern the Trust does not have any records from this meeting, and this has contributed to the complainant's uncertainty in this case. The Trust accepts it also failed to identify the ankle fractures on this date.

36. The Trust apologised for its failure to identify and diagnose the ankle fractures in its response to the complainant on 14 March 2022. I consider this apology to be appropriate. It is also the case the ED and T&O staff also failed to identify and diagnose the patient's elbow injuries. I am concerned the Trust did not inform the complaint it failed to identify the patient's elbow fracture when it apologised.

37. The complainant stated the Trust failed to identify any of the patients fractures

at ED on 26 February 2021 and at its T&O meeting on 27 February 2021. Although the Trust identified the patient's shoulder fracture, I am satisfied it did not identify her ankle or elbow fractures. Furthermore, I note the ED IPA advised the overall assessment and treatment of the patient's ankle was not reasonable. I consider this delay in diagnosis and assessment to be a failure in care and treatment. Therefore, I uphold this element of the complaint.

38. Regarding the impact of this failure in care and treatment, the ED IPA advised the delay in identifying the elbow fracture was likely minimal. They noted the treatment the patient received for her shoulder was also appropriate for her elbow. I accept this advice.

39. Regarding the ankle fracture, the ED IPA advised the delay in diagnosis likely caused the patient to experience a period of increased pain and discomfort. I note the complainant explained the patient was in considerable pain following the ED discharge. I accept the ED IPA advice and conclude the delay caused the patient to sustain the injustice of increased pain and discomfort, as detailed by her husband.

40. I note the complainant stated he and his sons had to assist the patient during this period of increased pain and discomfort. I acknowledge this caused the complainant to experience unnecessary distress and concern for his wife and sustain the injustice of uncertainty. It is evident the complainant and his sons endeavoured to provide the best care for his wife, and ensure she was as comfortable as possible.

41. The complainant questioned whether the walking boot treatment resulted in the patient developing blisters. Both the ED and O IPA provided advice on this issue and concurred that blisters are common following ankle fractures. The failure to diagnose the fracture and treat it properly with immobilisation, application of ice, and elevation for the ankle, increased the chance of blister formation and perhaps the severity. Although I am unable to determine if the blisters formed due to the inappropriate treatment, I am satisfied the Trust failed to minimise the risk and the severity of the blisters and this contributed to the patient's injustice of experiencing unnecessary pain and discomfort.

Second Read Report

42. The complainant was correct to assert the Trust failed to identify the patient's ankle and elbow fractures at ED on 26 February 2021 and at its T&O meeting on 27 February 2021. However, having reviewed the notes and IPA advice, I note a radiographer separate to the T&O meeting did carry out a second read of the X-rays from ED taken on the 26 February 2021. This radiographer carried out the second read at 09.42 on 27 February 2021, before the T&O meeting took place. Having reviewed the second read report, I accept the ED IPA advice the reviewer did identify the shoulder, elbow, and ankle fractures. I am therefore satisfied the Trust did correctly diagnose the patients fractures outside of ED and the T&O meeting.

43. However, the ED IPA advised second read reports involve reviewing radiology images and communicating with patients to recall them for review, if necessary. I found no evidence to show the Trust reviewed the second read reports to assess the appropriateness of the patient's treatment and recall her for review or provide that information to the T&O meeting on the 27 February or the fracture clinic on 1 March. Furthermore, I note the records indicate the patient underwent a CT scan on 27 February (the complainant disputes this took place, see paragraph 48). I found no evidence to show the Trust's staff informed the patient of the second read findings and the extent of her injuries on these dates.

44. I note with concern the available records show the Trust did not act on the second read report. I conclude the Trust missed an opportunity to rectify the missed fracture diagnosis and prevent the patient sustaining a period of increased pain and discomfort. I considered this a failing in care and treatment.

45. The ED IPA advised it is unclear what communication mechanisms the Trust has in place when a patient is discharged home, and it later identifies injuries it did not initially diagnose. However, they suggested the Trust consider service improvements in this regard. I expect the Trust to consider the ED IPA's advice regarding these service improvements.

Medical Documentation

46. In addition to the failure to identify the fractures at ED and the T&O meeting, and to act on the second read report, the ED and O IPA advised on the quality of the Trusts records. The ED IPA advised the medical notes do not detail the ED doctor's specific interpretation of the X-rays, per good practice. Furthermore, the O IPA advised the medical documentation from the orthopaedic doctor is "very poor". They explained, given the lack of documentation, it is difficult to determine what assessments the orthopaedic doctor undertook. Consequently, the O IPA concluded it is difficult to determine whether this doctor assessed the patient properly or provided a proper explanation, diagnosis, and plan of management. They noted there is no mention of an examination of the patient's various areas of pain in the notes, the handwriting is almost illegible, and the information is minimal. They considered the assessment and documentation inappropriate.

47. I accept the IPA's advice regarding the quality of the medical documentation. I expect the Trust to give due regard to the IPA advice on this matter. Although I do not believe the medical notes directly impacted the patient's care and treatment, I considered this to be a service failure.

T&O Care and Treatment

48. The complainant stated the patient did not return to hospital on 27 February 2021 for a CT scan. He further stated the patient's pain was so severe he called ED, and it advised him to bring her to the Fracture Ward on the 28 February 2021. The complainant stated the patient stayed overnight in RVH on that date. He explained RVH transferred the patient to the Fracture Outpatient clinic on the 1 March 2021.

49. I appreciate the complainants strong and unwavering view the patient did not have a CT scan on 27 February 2021 and was instead at home all day. However, the Trust provided this office with the radiological image of the CT scan and its subsequent radiology report. The ED IPA and O IPA reviewed these and advised they state the CT scan did take place on 27 February 2021.

The Trust explained the CT scan and report dates populate automatically through a third-party system, and staff cannot alter the date. I am satisfied these records show that a CT scan did take place on 27 February 2021. I have been unable to reconcile the complainant's recollection with the existence of the CT scan. Therefore, I do not uphold this element of the complaint.

50. In response to investigation enquiries, the Trust confirmed it checked its records and found no evidence the patient attended RVH on 28 February 2021. Having examined these records, I also found no evidence. During this investigation, an Investigating Officer visited RVH and examined the admission records for all Fracture Wards dated 28 February 2021. In doing so, the Investigating Officer found no evidence to support the complainant's view. In the absence of evidence, I am unable to conclude on this matter.

Blister Deroofing

51. The complainant said the patient told him auxiliary staff deroofed her ankle blisters without using sterile equipment. He said this occurred when the patient attended RVH on 28 February 2021. As I referenced above, I found no records to indicate the patient attended RVH on 28 February 2021. However, the nursing records of 1 March 2021 document Consultant B noted the patient had circumferential blisters on her right ankle on that date. On examination of these records, I note they also document the patient was wearing a metatarsal boot. They also document that upon the boot's removal there were multiple blisters, and Consultant B reviewed the foot and advised deroofing. The nursing record documents a nurse cleaned the blisters with saline and deroofed them aseptically after explaining the procedure to the patient and receiving her verbal consent. Based upon the available records, I am satisfied the Trust deroofed the patient's blisters on 1 March 2021.

52. The O IPA advised the nurses notes indicate the Trust deroofed the blisters in an aseptic manner. Similarly, the N IPA advised the nursing notes confirm the nurse used an aseptic technique, the equipment was sterile, and the technique was non-touch. I found no evidence to indicate nursing staff used non-sterile equipment to deroof the patient's blisters or they performed this in an unsterile manner. I am satisfied the evidence indicates a nurse appropriately deroofed

the patient's blisters on 1 March 2021 and not on 28 February 2021. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

T&O Service's care and treatment of the patient's foot/ankle

53. The complainant said there was a delay in performing surgery to the patient's foot and ankle. He also raised concern that, following the patient's surgery, the patient developed infections. In particular, the complainant said the patient developed cellulitis and infected metal work in her ankle and foot despite having attended regular nurse led appointments for wound management care. The complainant also said the Trust failed to inform the patient she had cellulitis. He said the complainant only learned of this diagnosis after opening a letter meant for her GP.

Evidence Considered

Legislation/Policies/Guidance

54. I considered the following guidance:
    - The NMC Code.
    - Nursing Proficiency Standards.
    - Wound Care Formulary.
    - The GMC Guidance.
    - The RCS Guidance.
    - The BOA Guidance.

Trust's response to investigation enquiries

55. The Trust explained the patient's ankle was swollen at ED and had blisters at the fracture outpatient clinic on 1 March 2021. It noted surgery only proceeded once the blisters were dry and the swelling settled. The Trust explained waiting for the blister and swelling to heal was in line with best surgical practice and reduced the risk of wound breakdown and infection.

56. Regarding the complainant's concern despite wound management care, the patient developed cellulitis, the Trust said the nursing notes and wound chart documentation did not indicate infection. It stated the post-operative wound

swab on 15 March 2021 showed “nil growth”. The Trust admitted the patient and commenced intravenous antibiotics on 5 May 2021 as her inflammatory markers had elevated.

57. The Trust explained cellulitis is a soft tissue infection and involves a clinical diagnosis. It said staff explained the risk of infection to the patient pre-operatively, and took steps to reduce those risks, including administrating antibiotics. The Trust said infection and cellulitis most likely developed as a complication of the soft tissue injury, surgical procedure, and delayed wound healing, or a combination of these. It noted infection was a counselled and accepted risk of surgery. The Trust said it would be important to emphasise that a fracture is primarily a soft tissue injury with an associated underlying bone injury.

Relevant records

58. I considered the patient’s records and have included relevant extracts in Appendix Four to this report.

Analysis and Findings

T&O’s care and treatment of the patient’s foot and ankle

Delay in foot and ankle surgery

59. The O IPA advised the medical and nursing notes from 8 March 2021 indicate the Trust delayed the lower limb surgery due to ankle blisters. The surgery took place two days later, on 10 March 2021. The O IPA concluded given the swelling of the right ankle and presence of blisters the timing of the surgery was reasonable and appropriate. They stated the two-day delay was in the patient’s best interests.

60. The ED records from 26 February 2021 and the second read report from 27 February 2021 acknowledge the patient’s ankle was ‘grossly swollen’ upon admission. As I previously stated, I accept blister formation is common in ankle fractures. I cannot be certain that blisters would not have formed if the Trust had appropriately treated the patient’s ankle with immobilisation, application of ice, and elevation of the ankle. I consider the failure to treat the fracture of the

ankle correctly increased the risk of blister formation and perhaps the severity of the blisters. However, I do not find the Trusts failures caused the delay. Although a delay occurred, I am satisfied it was appropriate given the patient's condition and in her best interests. I therefore do not uphold this element of the complaint.

Ankle wound management

61. The N IPA advised the systematic assessment of a wound is essential in the care and treatment of a patient. They said, during assessments, staff gather information to evaluate the wounds healing progress and determine whether the treatment is working. For this reason, staff should carry out regular assessments and keep clear records of their findings in a wound chart. I note this advice is in keeping with the Wound Care Formulary.

62. The records indicate the patient attended ten wound management appointments from 15 March 2021 to 3 May 2021. The records show Trust staff removed the patient's metatarsal boot during these appointments, assessed her wound for infection, and changed her dressing. They also show the Trust diagnosed the patient with cellulitis on 5 May 2021 and admitted her to hospital straight from the fracture clinic appointment.

63. The N IPA advised the nursing notes from 3 May 2021 state the patient's wound is '*partially sloughy'* and the surrounding skin '*slightly red/pinkish'*, which are signs of cellulitis. However, the N IPA also advised the nurse did not seek to assess if the 'slightly red/ pinkish' surrounding skin could have been a sign of cellulitis on 3 May 2021. I note there are no records from 3 May 2021 relating to the patient's wound or clinical conditions. The N IPA stated there are no records documenting whether the skin was hot to touch or painful, if there was odour from the wound, or if the patient was unwell. Although the records reference staff using a wound chart on 5 May 2021, the Trust provided only one wound chart dated 19 April 2021. Due to the lack of records, the N IPA noted it is not possible to definitively conclude whether the patient had cellulitis on 3 May 2021.

64. The N IPA advised due to the slow healing of the patient's wound she saw a doctor at most of her wound management appointments, as well as nursing staff. However, they noted a doctor did not review the wound on 3 May 2021. Having reviewed the records of 3 May 2021, I accept the N IPA's advice Nursing staff failed to either document why the patient's wound was not infected or failed to ask for a doctor's medical review of the wound.

65. I consider the Trust not regularly completing wound charts and not requesting a doctor review the wound on 3 May 2021, to be a failure in care and treatment. I accept the N IPA's advice Nursing staff failed to adhere to the Standards of Proficiency and NMC Code, in this instance. I therefore uphold this element of the complainant. I am satisfied the Trust did not manage the patient's wound appropriately.

66. The O IPA advised these failures possibly prevented the patient from having an earlier cellulitis diagnosis. They note if the Trust had acted upon the early signs of cellulitis the patient may have received antibiotics earlier, which may have prevented the further spread of infection. I accept this advice and am satisfied this failure in care and treatment caused the patient to sustain the injustice of losing the opportunity to potentially have started antibiotic treatment earlier. I consider this failure in care and treatment also caused the complainant to sustain the injustice of uncertainty.

Appropriateness of cellulitis treatment

67. The O IPA advised on good medical practice for treating and managing cellulitis. They said good practice involves sending swabs of the infected wound for assessment before starting a patient on antibiotics. As the patient in this case had underling metalwork, the O IPA said good practice would involve staff treating the wound having a discussion with the Trust's microbiology team regarding the appropriate antibiotic.

68. The O IPA advised the Trust admitted the patient to RVH on 5 May 2021. It prescribed an antibiotic Flucloxacillin to treat the cellulitis. The O IPA noted the cellulitis appears to have improved on this treatment and the patients test

results indicated the antibiotic was effective in controlling the infection. The O IPA also noted the Trusts records show microbiologists discussed the patient's case and recommended additional antibiotics on 26 May 2021.

69. However, the O IPA further advised they were unable to find any records showing the Trust staff sent wound swabs for assessment before starting the patient on the Flucloxacillin. They also found no records showing the Trust staff discussed the patient's case with the microbiology team before starting her on the antibiotic. The O IPA concluded although it was appropriate to start the patient on an IV antibiotic, the Trust did not do so in line with good medical practice.

70. I accept the O IPA's advice. I do not uphold the complaint the Trust failed to properly treat the cellulitis. However, I am satisfied it failed to follow good practice before administering the antibiotic. I consider this to be a failure in care and treatment. Although I note the O IPA advised this failure did not impact the patient, I expect the Trust to reflect on the advice regarding the importance of conducing wound swabs and having discussions with the microbiology team.

Informed about cellulitis

71. The complainant said the Trust did not inform the patient she had cellulitis. He said the patient only learned of having this infection after she read a letter meant for her GP. On review of the records, I accept the O IPA's advice it is not explicitly documented either in the nursing notes or admission records the Trust informed the patient she had cellulitis. However, the O IPA also advised they would have to assume the Trust made the patient aware of the infection given the description in the notes and the commencement of IV antibiotics. I consider this assumption to be reasonable. However, in the absence of any evidence to support or disprove this element of the complainant, I am unable to conclude on it.

Follow up care and treatment for foot and ankle injuries

72. The Trust admitted the patient to RVH on 5 May 2021 and discharged her on 27 May 2021. The O IPA advised the ward round dictations, discharge letter,

and nursing notes indicate the patient was to continue with oral Levofloxacin antibiotics on discharge. I note the records also indicate the Trust prescribed the patient Rifampicin and she was to attend a review in two weeks for a clinical assessment and X-rays. The O IPA advised there was no documented rationale within the records for choosing to prescribe the patient Levofloxacin and Rifampicin. The O IPA also advised the records did not include any documented plan for monitoring weekly LFT levels as required for Rifampicin or indicate when the patient should stop taking the medication.

73. The O IPA advised there should have been further follow up of the patient's foot and ankle condition and the Trust should have monitored the effects of the antibiotic treatment on the wound. The available records do not contain evidence to show any such follow up of the foot and ankle occurred. Moreover, there is no documentation within the medical records regarding the patient's foot and ankle following the discharge letter dated 27 May 2021. The O IPA stated this part of the patient's care was *'very unsatisfactory'*.

74. I accept the O IPA's advice, and I am satisfied the Trust did not provide appropriate follow-up care for the patient's foot and ankle condition. I consider a failure in care and treatment and uphold this element of the complaint.

75. I am satisfied this failure in care and treatment caused the patient to experience the injustice of a loss of opportunity to have her foot wound monitored to ensure satisfactory resolution of her infection. I am also satisfied this failure in care and treatment caused the patient to experience a loss of opportunity to have her antibiotic intake monitored. I am satisfied this failure in care and treatment caused the complainant to experience the injustice of uncertainty.

Detail of Complaint

Care and treatment of the patient's AVN

76. The patient developed AVN following her shoulder surgery on 2 March 2021. The complainant questioned whether the Trust should have identified the AVN sooner. The complainant explained the AVN caused the patient extreme pain, so she required urgent surgery. He was dissatisfied the Trust postponed the

surgery in April, May, and July 2021. The complainant explained he was particularly distressed the patient passed away in pain from her shoulder while waiting on the surgery.

Evidence Considered

Legislation/Policies/Guidance

77. I considered the following policies and guidance:
    - GMC Guidance;
    - The RCS Guidance; and
    - The BOA Guidance

The Trust's response to investigation enquiries

78. The Trust stated AVN can take up to two years to develop. It said staff diagnosed the patient with AVN from X-rays on 29 April 2021.

79. The Trust said upon diagnosing AVN it advised the patient she needed surgery which was best delayed due to her foot infection. It said it was concerned this infection could develop in her shoulder during surgery. The Trust therefore discharged the patient on 27 May 2021 with oral antibiotics. It later planned a provisional date of 29 July 2021 for the surgery.

80. The Trust said unfortunately at this time it continued to experience ongoing significant difficulties with access to theatre lists for patients, other than emergency or time critical patients requiring surgery. It explained this was due to a reduction of theatre access during and after the Covid pandemic. In addition, within the T&O service, the Trust said the demand for surgery for emergency patients exceeded the capacity available. It therefore only scheduled patients deemed as emergency or time critical for surgery.

81. The Trust stated although the patient's surgery may have been urgent, she did not meet the criteria for emergency surgery. It said there were other more emergency cases, and it prioritised these per the relevant guidance at that time.

Relevant Trust records

82. I considered the patient's medical records for 2021 and have enclosed a summary of the relevant records at Appendix Four to this report.

Analysis and Findings

T&O's care and treatment of patient's arm/shoulder

Timeliness of AVN Diagnosis

83. The records show the patient attended an outpatient appointment at the Fracture Clinic on 29 April 2021 for a review of her shoulder fracture. The O IPA advised consultant A assessed the patient and found the shoulder fracture to be dry and healthy. He noted the patient reported pain radiating down her arm. Consultant A then X-rayed the patient. The O IPA advised the X-rays show the patient's shoulder joint had started to break down and the screws were prominent in her joint space. The records show consultant A explained to the patient she needed surgery to remove the metal work from her shoulder. They also show consultant A wanted to defer this surgery to allow the fracture to consolidate. However, the patient stated she was having considerable pain and requested it sooner. I am satisfied, based on these records and advice, the Trust identified the AVN diagnosis on 29 April 2021.

84. The O IPA advised the X-rays from 12 April 2021 also indicated the patient had AVN. However, they note she was attending an appointment that day for an ankle review. They explained even if the Trust staff had identified signs of AVN on 12 April 2021, the patient would have required another appointment with a consultant to receive a diagnosis. For that reason, the O IPA advised the AVN diagnosis was timely. I accept this advice and do not uphold this element of the complaint.

Initial deferral of surgery following AVN diagnosis

85. As I noted above, the records from 29 April 2021 show the patient stated she was in considerable pain and wanted to have surgery to remove the metal work as soon as possible. Consultant A wanted to defer the surgery to give the fracture time to consolidate. The Trust delayed the surgery.

86. The O IPA advised the patient had surgery on her shoulder eight weeks before the AVN diagnosis. They stated consultant A's decision to delay the surgery was entirely appropriate because it gave the fracture time to consolidate, so when the surgeon removed the metal work the fracture would not fall apart. I accept the O IPA's advice and do not uphold this element of the complaint.

Failure to perform surgery on 7 May 2021

87. The O IPA advised the records show the Trust planned to remove the metalwork from the patient's shoulder on 7 May 2021. However, it admitted her to RVH on 5 May 2021 with cellulitis in her foot wound. The O IPA advised the Trust deferred the surgery due to the acute infection in her foot and this was appropriate. They explained, had the surgery taken place the patient could have developed an infection around her shoulder as well. Based on the O IPA's advice, I am satisfied the decision not to perform surgery on the patient's shoulder on 7 May 2021, was appropriate. I do not uphold this element of the complaint.

Cancellation of AVN surgery on 28 July 2021

88. The records indicate the patient attended a review appointment with Consultant A on 24 June 2021. Following assessment, Consultant A decided to proceed to book the patient's surgery on the next available trauma list. The Trust provisionally scheduled this surgery for 29 July 2021. It called the patient on 28 July to cancel the surgery. The Trust advised the complainant on 17 August 2022, it was cancelling the surgery on this date due to more urgent cases and a backlog of patients requiring time critical treatment.

89. The O IPA acknowledged the Trust said the patient did not undergo her surgery due a backlog of patients requiring time-critical treatment. They stated they were unable to conclude whether the delay was appropriate or reasonable for this reason without knowing the case load of the orthopaedic department at that time.

90. However, the O IPA commented on the overall reasonableness of the delay in July 2021. They stated although the surgery to remove the patient's metalwork

from her shoulder was not an emergency, as it was not life threating, it was urgent given the screws where in her shoulder joint space and causing her pain. They stated the time between the initial diagnosis of AVN on 29 April 2021 and the final scheduled surgery date of 28 September 2021 was excessive for an urgent case.

91. The O IPA explained emergency trauma coming through the doors of a busy hospital can disrupt trauma lists. They advised the only way for the Trust to ensure it done the patient's surgery in a timely and prompt fashion would have been for it to list her on a planned surgical list. The O IPA stated they believed the Trust could have prioritised this case on a planned surgical list rather than scheduling it on the trauma lists that risked cancellation. They indicated had the Trust done this it may have prevented the delay. For this reason, the O IPA did not think it was reasonable for the Trust to postpone the patient's surgery in July.

92. I acknowledge and accept the Trust's explanation it experienced significant difficulties with access to theatre lists for patients, and prioritised emergency cases per the relevant guidelines. The Trust have provided extensive records to support the decisions that its clinicians took. However, while accepting the Trust found itself in a very difficult situation trying to meet competing demands I am satisfied the time from the diagnosis to the final surgery date was excessive for this case and not in line with good practice for the management of AVN. I find the Trust did not offer the patient surgery for her shoulder in a reasonable timeframe or take steps to place her on a preplanned surgery list that would minimise the likelihood of other cases superseding hers. I therefore uphold this element of the complaint and find the delay in surgery was not in line with good practice and unreasonable.

93. This delay in care and treatment caused the patient to experience a loss of opportunity to undergo the surgery to remove the metalwork in her shoulder sooner. I am satisfied this delay caused the patient to experience the injustice of upset, uncertainty about the future date of her surgery, and prolonged pain and discomfort which caused distress.

94. I am also satisfied the complainant experienced upset and distress in response to his wife experiencing pain and discomfort due to this delay. I consider the complainant's upset and distress regarding this matter was compounded when the patient sadly passed away without having had the metalwork in her shoulder removed.

CONCLUSION

95. I received a complaint about the care and treatment the Trust provided to the patient for injuries she sustained on 26 February 2021. The complaint related specifically to the care and treatment RVH's ED, and the Trust's T&O provided to the patient. I upheld elements of the complaint for the reasons I have outlined in this report. I consider these elements to be failures in care and treatment.

96. I recognise the impact the failures caused the patient and the complainant, and the injustice sustained in this report. I hope the findings and recommendations address their outstanding concerns.

97. I offer through this report my condolences to the complainant for the loss of his wife.

Recommendations

I recommend:

98. The Trust provides the complainant with a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice stemming from the failures, within one month of the date of this report.

99. The Trust share the findings of this report with relevant staff within RVH's ED and relevant staff within T&O.

100. The Trust considers the ED IPA's advice regarding the implementation of 'hot reporting', which involves appropriate staff carrying out second reads of radiological images in real time.

101. The Trust considers its communication mechanisms for notifying patients identified as having fractures following second reading where they have left ED.

102. The Trust considers the O IPA's advice regarding the importance of staff discussing metalwork infections with the Microbiology team and undertaking wound swabs before administering antibiotics.

103. The Trust implements an action plan to incorporate these recommendations and should provide me with an update within six months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action.

SEAN MARTIN
Deputy Ombudsman

March 2025

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.