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The investigation of a complaint
against
Hywel Dda University Health Board

Draft in confidence

A report by the
Public Services Ombudsman for Wales
Case: 202302872

What we investigated

1. We investigated Mrs A's complaint against Hywel Dda University Health Board ("the Health Board"). The investigation considered the following:

- a) a delay in the provision of pain relief for her mother, Mrs C, during her wait in an ambulance outside Glangwili General Hospital ("the First Hospital") on 13 March 2022
- b) a delay in carrying out her mother's surgery to her right hip following her admission on 14 March 2022
- c) delays in reviewing her mother's moisture sores.

What we found

2. The Health Board as part of its investigation had identified that on occasions there were shortcomings in measuring Mrs C's pain levels. That said, the Ombudsman found the Health Board's explanation for the delay in administering a nerve block (a medical procedure to help manage pain) procedure was reasonable. Given the injustice caused to Mrs C regarding her pain management this part of her complaint was upheld. The Health Board was also asked to consider any learning from Mrs C's case, given the national problem of patients having prolonged waits in ambulances outside of Emergency Departments ("ED") before being transferred.

3. We did not uphold Mrs A's complaint about the delays in carrying out hip surgery as it did not have a longer-term impact on Mrs C's care or her clinical outcome. We found that Mrs C's care needs when it came to her personal hygiene skin management were broadly satisfactory. Although the Health Board had identified occasional episodes where Mrs C's care was not carried out within set timescales, we were satisfied that this did not have an adverse impact on Mrs C. This aspect of Mrs A's complaint was also not upheld. We invited the Health Board to remind all nursing staff of the need to ensure that skin integrity checks are consistently carried out in a timely manner.

4. As part of our recommendations the Health Board was asked to apologise to Mrs A for the failing identified in the report and to share this report with its Quality and Patient Safety Committee as part of its quality assurance.

What we considered

5. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mrs A. I also obtained professional advice from one of the Ombudsman's professional advisers a Consultant in Acute Medicine ("the Adviser"). [The Adviser will be named in the final report.]

6. The Ombudsman considers complaints about the care and treatment that patients have received from the NHS in Wales. In doing so, the Ombudsman's role is to determine whether the standard of care was appropriate by making reference to relevant national standards, or any regulatory, professional or statutory guidance, that applied at the time of the events complained about, where necessary. The Ombudsman must consider the care provided in light of the information that was reasonably known at the time and cannot judge events with the benefit of hindsight. In order to uphold a complaint, the Ombudsman must conclude that there has been service failure or maladministration on the part of the authority concerned, which has then caused injustice to the complainant or person on whose behalf the complaint is made.

7. This report does not include every detail from all the documents that I have considered during the investigation, but I am satisfied that nothing of significance has been overlooked. The chronology of events below summarises key events that occurred throughout the period under investigation and is not intended to be a comprehensive timeline of events.

8. Both Mrs A and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

What happened?

9. Mrs C had a fall at home on 13 March 2022 and an ambulance was called. On arrival, the paramedics gave Mrs C paracetamol (1g) at 23:00 and she was taken by ambulance to the ED of the First Hospital and arrived at 23:55. Given the pressures in the ED and no bed availability in the First Hospital Mrs C remained on the ambulance stretcher and she was managed by both the ambulance crew and the ED nurses/clinicians at various point. In the early hours of 14 March nursing staff reviewed Mrs C. At 02:00, a computerised tomography (“CT scan” – a scan that uses X-rays and a computer to create detailed images of the inside of the body) head scan, Electrocardiogram (“ECG” - a test to check the heart’s rhythm and electrical activity) and other investigations were carried out on Mrs C in the ED.

10. Nursing staff reviewed Mrs C at 03:10 and gave her intravenous (“IV”) paracetamol (1g) and oral morphine (10mg) at 03:20. Nursing records at 04:00 documented that Mrs C was asked if she was comfortable or in pain, however, no pain score was recorded. Records show that Mrs C was given more paracetamol by a paramedic at 07:20, although no pain score was recorded. At 07:40 Mrs C’s pain score was documented as 2 (moderate). Mrs C was reviewed by an ED Junior doctor 20 minutes later. An X-ray confirmed that Mrs C had a hip fracture. She was given a nerve block at 09:45. Mrs C’s pain score 25 minutes later was noted to be moderate. She was transferred to Withybush Hospital (“the Second Hospital”) later that afternoon as no beds were available at the First Hospital. Nursing records that evening show Mrs C was assisted in moving and turning. Her pressure areas were noted to be intact.

11. Mrs C was reviewed on 15 March by a Locum Consultant in Trauma and Orthopaedics (“the Orthopaedic Consultant”) with a view to carrying out surgery the same.

12. On 18 March a pressure sore skin check noted Mrs C had a bruise on her left heel which was thought to be a deep tissue injury. She was assessed by a second nurse who came to the same conclusion and discussed this with a Tissue Viability Nurse who advised that Mrs C’s left leg needed to be elevated to prevent pressure. A further nursing entry the next day noted that

Mrs C's pressure areas had been checked and the left heel bruise was still there and her leg was elevated while in bed and when sat in a chair.

13. A post operative review by the Orthopaedic Consultant on 20 March noted that Mrs C had significant fractures affecting her femur and her right elbow. He noted a conversation he had had with Mrs C and her daughter and that neither Mrs C nor her daughter were keen for Mrs C to have further surgical intervention given the risks. They had opted for conservative management for the fracture. The Orthopaedic Consultant noted that Mrs C was engaging with physiotherapy/occupational therapy on the ward.

14. Mrs C's nursing records show that she had regular skin care reviews as part of her nursing care. Her left heel was managed by keeping the left leg elevated. On 26 March Mrs C's right heel was noted to be "feeling spongy" and this led to both feet being elevated. Mrs C's skin care and management continued until her discharge.

15. Mrs C's clinical records show that her family wished for her to return home before she was ready for discharge given, she caught the COVID-19 virus and felt she and her family were of the view that Mrs C would do better at home. Mrs C was discharged home on 1 April and sadly she died on 5 April.

16. Mrs A complained to the Health Board about her mother's management and care. In its response the Health Board set out why a nerve block for pain management was not administered and the delay in Mrs C having surgery. Mrs A remained unhappy with the Health Board's response and complained to the Ombudsman.

What Mrs A said

17. Mrs A said it was unacceptable that her 92-year-old mother had been left for 10 hours in an ambulance in pain and without any pain relief. She said that whilst the Health Board had apologised for this, it had not said what it was going to do to ensure it did not happen again. Mrs A wanted the Health Board to ensure inpatient care, especially for the elderly, was improved in these circumstances.

18. Mrs A said that to leave the pressure areas unchecked for 5-6 hours was totally unacceptable. She added that the Health Board had admitted that her mother did not have surgery within the required 36 hours. Mrs A referred to the clinical records which “falsely” stated that there was no delay, and that surgery was carried out within 36 hours.

What the Health Board said

19. The Health Board said that Mrs C was given repeated doses of pain medication while in the ambulance, but acknowledged that the pain relief given would not have been as good as a nerve block. It said that logistically it can be difficult to administer a nerve block in an ambulance, as it would need to be monitored. The Health Board said that its ED Lead had commented that the nerve block procedure would usually take place in a dedicated room where ambulance patients are assessed so that they are in a controlled environment and its nurses can do the required observations post-procedure. The ED Lead added that as Mrs C was on blood thinning medication, which is a relatively contraindication (meaning it is generally not advised as a course of treatment for patients on blood thinning medication) to administering a nerve block, so the pros/cons would need to have been explained to Mrs C prior to the nerve block. This decision seems to have been deferred to the on-call Trauma and Orthopaedics team. The ED Lead reiterated that the bulk of the delay was due to patients having to wait a long time to be seen, as opposed to staff not being able to perform the procedure. The pressures faced by the ED on the night in question were significant and were compounded by there being issues around the ability to discharge patients from the First Hospital in a timely manner. This added to the pressures within the ED resulting in overcrowding. The Health Board acknowledged and apologised for the delay in administering the nerve block.

20. The Health Board acknowledged that there were shortcomings around documenting Mrs C’s pain score and it provided evidence of the measures it has put in place in response to previous Ombudsman’s recommendations.

21. In relation to Mrs C not receiving the hip surgery within 36 hours, the Health Board said that its Trauma Pathway Coordinator had advised that the National Hip Fracture Database “time to theatre” calculation starts from the time of the patient’s admission to the hospital carrying out the operation

to the time a patient is taken to theatre. Therefore, given that Mrs C arrived at the Second Hospital at 15:10 on 14 March and was taken to theatre at 12:00, her time from admission to theatre was 20 hours and 50 minutes. The Health Board said that Mrs C arrived at the First Hospital's ED at 23.55 hours on 13 March and her time to theatre was 36 hrs 5mins.

22. The Health Board said that its Orthopaedic Consultant was of the view that this delay did not seem to have affected Mrs C's outcome as the surgery was uneventful and she made a satisfactory recovery in terms of the wound and her mobility.

23. Commenting on the delays in reviewing the moisture lesions, the Health Board's Senior Nurse Manager advised that moisture damage to the natal cleft was first identified by ward staff on 24 March. From her admission, Mrs C was already being nursed on an appropriate mattress and skin checks were generally maintained 2-4 hourly, although the Health Board acknowledged that there was occasion where skin checks were not undertaken for 5-6 hours. The Senior Nurse Manager noted that it is essential that areas of skin with moisture damage are kept clean and dry and there was evidence in the nursing records and the intentional rounding charts that Mrs C was assisted with her personal hygiene needs daily and, on some occasions, more frequently. The Health Board said that the lack of repositioning might lead to a deterioration of the skin condition, however there was no evidence to suggest the area deteriorated whilst Mrs C was in hospital. The Health Board noted that the ward staff referred Mrs C to a district nurse on discharge for ongoing monitoring, with the first call being planned for 4 April 2022.

What our Adviser said

24. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. The Ombudsman determines whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

25. The Adviser said that the explanation provided by the Health Board about Mrs C's care and management was reasonable. He agreed that whilst the pain medication Mrs C received would not have been as effective as the nerve block, he agreed that administering a nerve block at the back of an ambulance would not have been ideal.

The guidance and information we have considered

26. In considering this case, I have had regard to the following:

- National Institution of Care and Excellence ("NICE") Hip fracture: management Clinical guidance [CG124] published on 22 June 2011 updated on 6 January 2023.
- Royal College of Physicians – National Hip Fracture database. The key performance indicator for the National Hip fracture database, which recognises that patients that have their surgery within 36 hours have better outcomes than those that do not.
- The Welsh Frailty Fracture Network Hip Fracture Anaesthesia Welsh Guideline 2019 states "Aim for surgery within 36 hours of admission".
- Association of Ambulance Chief Executives – Delayed hospital handovers: Impact assessment of patient harm. November 2021.
- The Royal College of Emergency Medicine ("RCEM") Acute insight series – Crowding and its consequences (November 2021).

The reasons for what we found

27. In reaching my conclusions I have considered the advice that I have received from the Adviser, which I accept. However, the conclusions reached are my own. I will address each of Mrs A's concerns in turn.

- a) **a delay in the provision of pain relief for her mother during her wait in an ambulance outside the First Hospital on 13 March 2022**

28. I note that the Health Board has acknowledged and apologised for the delay in administering the nerve block and set out the reasons why a nerve block was not administered (see paragraph 19). I consider the explanation to be reasonable. I am pleased to note that the Health Board has identified that pain scoring was not recorded on occasions, which would have indicated the level of pain Mrs C was experiencing. This failing meant that Mrs C's needs were not fully met or understood, and this was an injustice to her. Accordingly, I **uphold** this aspect of Mrs A's complaint. Given the actions the Health Board has already taken to address issues around pain documentation, I am making no further recommendations.

29. I am mindful that the issue of prolonged handover delays outside EDs is a national problem across Wales and such delays may potentially have a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective, and dignified care to patients. As such I suggest the Health Board considers any learning from this case in order to tackle the root causes of delays in patients being transferred.

b) a delay in carrying out her mother's surgery to her right hip following her admission on 14 March 2022

30. The Health Board has highlighted that it was under extreme pressure on the night in question. I accept that the delays in Mrs C being triaged and admitted to the First Hospital was longer than they should have been in normal circumstances and must have been distressing for her and her family. However, I am satisfied, based on the available evidence, that the delay did not have a longer-term impact on Mrs C's care or the clinical outcome on this occasion. I therefore **do not uphold** the complaint against the Health Board.

c) delays in reviewing her mother's moisture sores.

31. I am satisfied from the evidence that I have seen that Mrs C was assisted with her personal hygiene needs daily and, on some occasions, more frequently. The Health Board has acknowledged that there were occasions where skin checks were not undertaken for 5-6 hours. This was a failing, as Mrs C's needs were not fully met. However, I have not

seen that this delay has had any adverse impact on Mrs C and therefore I **do not uphold** this aspect of Mrs A's complaint.

32. As a point of learning I would invite the Health Board to remind all nursing staff of the need to ensure that skin integrity checks are consistently carried out in a timely manner.

What the Health Board should do to put things right

33. I recommend that within **1 month** of the final report, the Health Board should:

- a) apologise to Mrs A for the failing and injustice identified in this report
- b) as part of its quality assurance, share this report with its Quality and Patient Safety Committee.

34. **The following paragraph will appear in the final version of the report if Health Board agrees to the above recommendations:** [I am pleased to note that in commenting on the draft of this report **Health Board** has agreed to implement these recommendations.]

Layla Hoque
Swyddog Ymchwilio/Investigation Officer

15 February 2024

This is a report issued under s27 of the Public Services Ombudsman (Wales) Act 2019 and under the delegated authority of the Ombudsman.

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