SPSO decision report

Case: **201403030, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C, an advocate, complained on behalf of Mrs A about the care and treatment of her late husband (Mr A). Mr C raised concerns that the board failed to appropriately manage Mr A's skin condition and that, as a result, he developed pressure ulcers. He submitted a photograph demonstrating that Mr A had a pressure ulcer on the day he was discharged from hospital to a care home, complaining that he should not have been discharged with his skin in such condition.

We took independent advice from one of our nursing advisers. She was critical that a specific care plan for the management of Mr A's skin, which was identified as being at high risk of pressure ulcers, was not begun until his skin showed signs of deterioration. She told us that the photograph from the time of discharge showed a small yet established pressure ulcer. Whilst this would not have provided grounds for keeping Mr A in hospital, she highlighted that sufficient information on the care of his skin should have been passed to the care home to allow them to carry this on.

We concluded that the board had not consistently followed their pressure ulcer prevention policy and we upheld the complaint. We were concerned that, in responding to the complaint, the board maintained that Mr A's skin was intact at the time of discharge when the records did not demonstrate this clearly and the photographic evidence suggested otherwise. That said, we welcomed the comprehensive remedial actions the board had already taken further to the complaint. However, we recommended that they take additional action to ensure that sufficient information is passed on at the time of discharge. We also recommended that they apologise to Mrs A for the failings we identified.

Recommendations

We recommended that the board:

- remind staff of the importance of providing sufficient information on handover to ensure continuity of care; and
- apologise to Mrs A for the failings this investigation has identified.