SPSO decision report

Case: **201404857, Lothian NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Mrs C complained to the board about the nursing care and treatment provided to her late grandfather (Mr A) during admissions to the Royal Infirmary of Edinburgh (RIE), Astley Ainslie Hospital (AAH) and Midlothian Community Hospital (MCH). Mr A had a fall at home and broke his hip. He was admitted to the RIE and underwent surgery. During his time as an in-patient at the RIE, Mr A developed pressure ulcers on his lower back and heel. Mr A was later transferred to AAH for rehabilitation, then moved to MCH to wait for a place in a nursing home. His condition deteriorated at MCH and it was decided that he would remain in hospital. Mr A died in MCH. Mrs C complained about Mr A's pressure ulcer care, hydration and nutrition, access to call buzzers, nursing care of his contracted leg, and communication with her family, particularly regarding the collection of Mr A's death certificate.

After taking independent advice from a nursing adviser, we upheld Mrs C's complaint. The adviser considered that Mr A's pressure ulcers could potentially have been prevented from developing if an appropriate care plan and other interventions had been used at the RIE. The adviser said that there was a reactive rather than proactive approach to pressure area care at the RIE. The adviser noted that risk assessments and care plans (Adapted Waterlow Pressure Area Risk Assessment and SSKIN (Surface, Skin inspection, Keep Moving, Incontinence, and Nutrition) bundle) were not completed at appropriate times during Mr A's care. Although the adviser considered that on Mr A's admission to AAH, appropriate assessments of his pressure areas were carried out, his subsequent care in this area was not reasonable. The adviser said that the SSKIN bundle care plan was not used until Mr A had been in AAH for several weeks, and interventions to prevent pressure had not been implemented at appropriate times.

We noted that the board had apologised to Mrs C about communication with her family regarding two visits by Mr A to other hospital sites during his admission at the AAH. We received advice that it is good practice to keep family informed unless the patient says otherwise. We also noted that the board had apologised to Mrs C for any distress caused about the death certificate. The adviser explained that nursing staff would have no control over when this was available. We considered that other areas of Mr A's care were reasonable.

Recommendations

We recommended that the board:

- issue Mrs C with a written apology for the failings in pressure care identified by this investigation;
- ensure that all relevant staff are aware of the requirements in completing the Adapted Waterlow Pressure Area Risk Assessment and SSKIN bundle;
- highlight to all relevant staff the adviser’s comments on the use of proactive preventative strategies for pressure care;
- take steps to remind relevant staff of the need to keep call buzzers within the reach of patients; and
- ensure that all relevant staff are made aware of the adviser’s comments on keeping family and carers informed of patients’ visits to other sites.