SPSO decision report

SPSO Scottish Public Services Ombudsman

Case: **201500611, Grampian NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Ms C and her cousin (Mr A), complained about the care and treatment Mr A's late mother (Mrs A) received at Kincardine Community Hospital. Mrs A had dementia and had been admitted to Kincardine Community Hospital from Aberdeen Royal Infirmary for a period of rehabilitation following a fall at home. Ms C and Mr A also complained about the board's handling of their complaint.

Mr A said that he raised concerns with nursing staff about his mother's care while she was a patient in Kincardine Community Hospital, in particular, in relation to her developing pressure ulcers. Staff at the hospital and Mr A were also not told for several weeks that Mrs A had been diagnosed with a pelvic fracture while she was in Aberdeen Royal Infirmary. When Mrs A was discharged to a nursing home she was found to have a pressure ulcer on her sacral area (at the base of the spine) but Mr A had not been informed about this.

We took independent advice from a nursing adviser who said there were serious failings in record-keeping and in compliance with guidance and best practice on the prevention and management of pressure ulcers. As a result, Mrs A's care was random and left to chance. Furthermore, although Mrs A was at high risk of developing pressure ulcers, there was a delay in managing her as high risk. We also found that the pelvic fracture incident had not been recorded as it should have been and there were failures in communicating with Mr A concerning aspects of Mrs A's care. Overall, the advice we received was that the standard of nursing care provided to Mrs A was very poor and we were critical of those failings.

In relation to the board's handling of Ms C and Mr A's complaint, although the board had apologised to them and had carried out a significant event analysis (SEA) we found that the board had not identified and acknowledged serious failings with Mrs A's nursing care and that, overall, the board's complaints handling was poor.

Recommendations

We recommended that the board:

- feed back the findings of the investigation to relevant staff, for reflection and learning;
- provide us with an action plan to address the failings identified in relation to record-keeping; skin and tissue viability care (to include a review of the education and training of nursing staff in skin and tissue viability care); and communication;
- apologise to Mr A and Ms C for the failure to provide reasonable care to Mrs A;
- feed back the findings of this investigation to the relevant staff who were involved in the SEA and complaints handling and reflect again on Mrs A's complaint by reviewing what went wrong with her care;
- consider a review of their SEA process and the training of staff who carry out such reviews, and give consideration to whether there should be an external independent review of how this is undertaken;
- provide evidence that the pelvic fracture incident has been reported and the date when it was recorded on the system;
- provide evidence of the review process concerning discharge documentation; and

- apologise to Mr A and Ms C for the failings to respond reasonably to their complaints.