SPSO decision report

Case: **201507632, Fife NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: upheld, recommendations

Summary

Mrs C complained that the board failed to provide appropriate nursing care to her husband (Mr A).

Mr A suffered from ischaemia (inadequate blood supply), which had previously resulted in the amputation of his right leg below the knee. He was admitted to hospital with ischaemia of his left foot and an ulcer. There was no surgical option available to address this issue and the plan was to delay amputation as long as possible. Mr A was being seen twice a week by district nurses following discharge from hospital.

Some months after discharge, a nurse identified deterioration in Mr A's foot and contacted Mr A's GP practice. The GP prescribed antibiotics; however, the district nurses did not schedule a further visit at that time. A nursing visit did not take place until six days later. The nurse who attended discovered a maggot infestation in Mr A's wound. Mr A was subsequently taken to hospital and received an above-knee amputation of his left leg.

Mrs C complained about the missed visit. She also complained about the board's communication. The board acknowledged failings had occurred and apologised to Mrs C.

After receiving independent advice from a nurse, we upheld Mrs C's complaint. We found that the board had failed to ensure twice weekly visits as required under Mr A's care plan. We also found the board's communication was below a reasonable standard. In addition, we found that while the board generally complied with wound management guidance, formal wound assessments were not conducted regularly. We made a number of recommendations to address these issues.

Recommendations

We recommended that the board:

- confirm they will audit district nursing formal wound assessment charts to ensure that they meet local and national guidelines and provide evidence of this;
- remind staff of the importance of ensuring requested visits are followed up and documented within patients' records;
- provide evidence that there are improved systems in place for communicating a patient's plan of care between team members and other healthcare providers;
- consider a scheme of each patient having a named nurse to contact if they have concerns outwith their scheduled visits;
- consider a scheme for planned visits to be on set days of the week; and
- apologise for the failings identified in this investigation.