# SPSO decision report

**Case:** **201606241, Tayside NHS Board**
**Sector:** health
**Subject:** nurses / nursing care
**Decision:** some upheld, recommendations


## Summary

Mrs C's mother (Mrs A) broke her ankle in a fall. Although Mrs A had a complex medical history, including cancer and diabetes, the decision was taken at Ninewells Hospital to fix the ankle surgically. After a period of care in the hospital, Mrs A was discharged to a nursing home. During an out-patient review, it was discovered that the ankle wounds had broken down and that the metal work used to fix the fracture had become exposed. Mrs A was admitted to hospital again and underwent further surgery to remove the metal work. Mrs A was discharged back to the nursing home a few weeks later. At a further out-patient follow up, it was found that Mrs A had an infection in the ankle wound and that the bone had not grown back together. She was admitted to hospital again for treatment with antibiotics and wound care. It was considered that amputation could be necessary to control Mrs A's pain and to improve her quality of life. Amputation surgery did not take place and Mrs A was later discharged back to the nursing home.

Mrs C complained about the skin and pressure care that her mother received at the hospital across these admissions as Mrs A had developed pressure ulcers on her heel and lower back. Mrs C also complained about communication with the family in relation to amputation surgery. Mrs C and her siblings held power of attorney for Mrs A and they were concerned that the surgery was planned to go ahead without appropriate discussions with them. During their own consideration of this complaint, the board identified areas for improvement in relation to a number of areas, including pressure and skin care.

After taking independent advice from a nursing adviser, we upheld Mrs C's complaint about skin and pressure care. We found that there was a lack of evidence to demonstrate appropriate skin and pressure care had been provided. The advice we received highlighted that pressure injury to Mrs A's foot could have been avoidable with different care and that pressure area risk assessment documentation had not been properly completed for Mrs A. The board's policy on pressure ulcer prevention was not considered to have been appropriately followed in this case. The nursing adviser was asked to review the improvement plan implemented by the board following their own consideration of this complaint. The advice we received was that this did not adequately address all the failings identified. We made a number of recommendations about this as a result.

In relation to Mrs C's complaint about the board's communication with the family regarding amputation surgery, we took additional independent advice from a consultant orthopaedic surgeon. The advice we received was that it was reasonable to consider amputation in Mrs A's case, although this was not the only option available for her care and treatment. Mrs C was concerned that Mrs A had been listed for theatre and that surgery would have proceeded if she had not happened to visit her mother at the hospital. Mrs C was shocked to be told by nursing staff that Mrs A was listed for theatre the next day and spoke to a doctor to explain that she did not consider amputation to be the right thing for her mother. The advice we received was that it was reasonable to list Mrs A for theatre when the final decision on surgery had not yet been made as this avoids delay. We found that there was no evidence that amputation surgery would have gone ahead without Mrs C or her siblings being consulted further. We did not uphold this complaint.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in pressure care. The apology should meet the standards set out in the SPSO guidance on apology, available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- We said that:
- The appropriate risk assessment documentation should be correctly completed by nursing staff caring for patients.
- Pressure injuries and moisture lesions should be accurately diagnosed and graded.
- Wound assessment should be carried out for pressure ulcer care and wound assessment charts should be completed.
- Accurate records should be maintained in relation to nursing care, in line with the Nursing and Midwifery Council Code on record-keeping.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we have set.