SPSO decision report

Case: **201606439, Lothian NHS Board - Acute Division**
Sector: health
Subject: nurses / nursing care
Decision: some upheld, recommendations

Summary

Mrs C complained about the nursing care that her father (Mr A) received whilst he was an in-patient at the Western General Hospital. During his admission, Mr A developed a pressure ulcer and Mrs C was concerned that this was not maintained hygienically or to a reasonable standard. Additionally, Mrs C complained that her father's discharge home was unreasonably delayed by a member of nursing staff.

We took independent advice from a nursing adviser. We found that Mr A's risk of developing a pressure ulcer had not been accurately assessed and that pressure ulcer care had not been provided in line with relevant guidance. The advice we received highlighted a number of issues with record-keeping in relation to pressure ulcer care and also hygiene, including that a wound assessment chart was not completed for Mr A. We also found that a pressure relieving mattress was not ordered for Mr A until he had already developed a pressure ulcer. There was also no evidence that appropriate specialist input was sought with regards to Mr A's care. We upheld Mrs C's complaint about maintaining Mr A's hygiene and the pressure ulcer.

Regarding Mr A's discharge, the advice we received was that the delay of a few hours was reasonable as nursing staff were concerned that there may not have been anyone at home to be with Mr A when he arrived. We did identify communication issues around this, which were drawn to the board's attention, however, we found that the actions of nursing staff were reasonable and we did not uphold this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise for the failings in pressure care. The apology should comply with the SPSO guidelines on making an apology, available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Appropriate risk assessments for pressure ulcers should be carried out accurately and all pressure care should be provided in line with the board's Pressure Area Care Pathway (2015).
- Patients should be nursed on a surface suitable to manage their risk of developing pressure ulcers, in line with the board's Protocol for Ordering Therapeutic Mattresses (2013).
- Wound assessment charts should be completed for patients like Mr A and injuries should be treated appropriately, in line with the relevant guidance.
- Appropriate referrals should be made for patients when specialist input is required.
- Full and accurate nursing care records should be kept for patients.

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 set.