SPSO decision report

Case: **201904839, Dumfries and Galloway NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment their late partner (A) received during two consecutive admissions to Dumfries and Galloway Royal Infirmary. A had a number of existing medical problems and spent around four weeks in hospital, including 18 days in critical care, before being discharged. C complained that A was inappropriately discharged with pneumonia, and required readmission 12 hours later. A spent almost a further three weeks in hospital before being discharged again, and died two months later. Whilst in hospital, A developed a severe pressure ulcer. C complained that nursing staff failed to take reasonable measures to prevent the pressure ulcer from developing.

We took independent advice from a consultant geriatrician (a doctor who specialises in medicine of the elderly). We found that A's suitability for the first discharge was assessed over a number of days and blood tests and basic observations did not indicate an underlying pneumonia at that time. We considered that it was reasonable for A to be discharged and we did not uphold this aspect of C's complaint.

We also took advice from a tissue viability nursing specialist (a nurse who provides advice and care to patients with, or at risk of, developing wounds). We found that, while the risk of pressure damage was identified and care prescribed to mitigate this, this was not adhered to. Risk assessment, skin inspections and repositioning were not carried out as often as required, and the pressure ulcer was initially graded incorrectly. Inappropriate dressings were also used and there was a delay in providing a pressure relieving mattress. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to provide reasonable pressure area care to A. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The board should take steps to ensure staff are competent in pressure area care, with particular focus on the deficiencies identified in A's care, and that they are aware of current best practice/adhere to the board's own guidance (Active Care Prescribing Sheet & Wound Assessment Chart) as well as Healthcare Improvement Scotland's Prevention and Management of Pressure Ulcer Standards (2016).
- The board should take steps to review why pressure relieving equipment was not readily available in this case and address any system failure which contributed to this delay.

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.