# SPSO decision report

**Case:** **202110475, Lanarkshire NHS Board**
**Sector:** Health
**Subject:** Nurses / nursing care
**Decision:** upheld, recommendations

## Summary

C complained on behalf of their deceased grandparent (A) about care and treatment provided by the board during an admission to hospital following a fall and broken hip. C complained that A received poor nursing care, poor rehabilitation support, had not received enough nutrition and fluids, and had developed necrotic (dead) tissue on the back of their heels. C also complained that communication with the family and the incident management response had been unreasonable.

We took independent advice from a nursing adviser. We found that pain relief, personal care and rehabilitation support had been appropriate. However, we found that there was no evidence that assistance was provided with eating and drinking, and that fluid and nutrition charts had been poorly completed. We also found that the pressure sores on A's heels were poorly managed, that there were significant gaps in repositioning and that effective preventative measures were not appropriately implemented.

We found that information given to the family was insufficient and incorrect. We also found that the incident management response was unreasonable, as the necrotic heels were not deemed to be serious avoidable harm and therefore no serious adverse event review or duty of candour was undertaken. We therefore upheld C complaints.

## Recommendations

What we asked the organisation to do in this case:

- Apologise to C for not offering sufficient support with eating and drinking and for not preventing and treating the pressure ulcers on A's heels appropriately. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for not recognising the seriousness of the incident and the avoidable harm caused. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to C for providing incorrect and incomplete information about their grandparent's condition. 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:

- Nursing staff are aware and correctly implement HIS Pressure Ulcer Prevention Standards 2020 (including introducing 2 hourly repositioning, therapeutic mattress and skin protection at the point that skin becomes red). Nursing staff know how to correctly diagnose and grade pressure ulcer damage (including “ungradeable”), correctly follow CPR for feet guidelines (such that they make timely referral to a Tissue viability specialist) and develop person centred treatment plan for the pressure ulcer. Nursing staff provide relevant handover information and relevant equipment such as therapeutic mattress and boots when

moving a patient between wards.

- Nursing staff should ensure that fluid balance and MUST charts are completed to a reasonable standard. The board should also be reassured that they have appropriate processes in place to monitor performance in this area.
- That a duty of candour review is considered in the light of the SPSO findings.

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.