Scottish Parliament Region: North East Scotland

Case 200602998: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Treatment

Overview

The complainant (Mr C) raised a number of concerns that his father (Mr A) had received inadequate treatment while he was a patient at Ninewells Hospital (the Hospital).

Specific complaints and conclusions

The complaints which have been investigated are that there was:

(a) inadequate treatment for Mr A's pressure sores (*upheld*);

(b) inadequate monitoring of Mr A's pressure sores (*upheld*); and

(c) an inappropriate decision to continue with a course of treatment for Mr A's pressure sores (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) provide evidence of a robust standard for records and record-keeping and provide evidence of measures that are in place to audit this area of practice;

(ii) provide evidence that there is a programme of formalised education and training of the staff on Ward 11 with reference to the transfer of patients which includes the importance of effective communication and proactive nursing in relation to this process;

(iii) provide assurances that they have a robust policy in place regarding inter-ward transfers;

(iv) devise a quality assurance system whereby all patients suffering from pressure sores have care plans which are sufficiently detailed and also highlight the monitoring arrangements for the patient;

(v) apologise to Mr A for the failings which have been identified; and

(vi) reiterate to all relevant staff at the Hospital the importance of clearly recording the factors which lead to a decision regarding continuing or changing treatment.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 2 January 2007 the complainant (Mr C) complained to the Ombudsman's office that his father (Mr A) received inadequate care while a patient at Ninewells Hospital (the Hospital). The evidence demonstrated that the complaint had exhausted the complaints procedure of Tayside NHS Board (the Board), therefore, the case was eligible for investigation by the Ombudsman's office. The complaint focuses primarily on the care and management of three separate pressure sores.

2. The complaints from Mr C which I have investigated are that there was:

(a) inadequate treatment for Mr A's pressure sores;

(b) inadequate monitoring of Mr A's pressure sores; and

(c) an inappropriate decision to continue with a course of treatment for Mr A's pressure sores.

Investigation

3. In conducting my investigation I obtained and reviewed evidence from both Mr C and the Board. The evidence included a copy of the relevant sections of Mr A's medical records and a copy of the complaints correspondence. I also obtained the views of the Ombudsman's medical adviser (the Adviser), which were extremely helpful in arriving at my conclusions.

4. Prior to moving onto the individual heads of complaint, I believe it is of benefit to the reader to provide a brief outline of the key events in this case. Paragraphs 5 to 8 provide a useful summary of the key events.

5. On 15 June 2006 Mr A was admitted to Ward 11 of the Hospital for the investigation and treatment of a stenosis (narrowing) of his right radial artery. He was discharged home on 7 July 2006. On 27 July 2006 he was admitted via his GP with an ischaemic (reduced blood supply) right hand and arm, and an ulcer to his right wrist. This was found to be non-reconstructable and he, therefore, underwent amputation of his right arm below the elbow. This operation was performed on 4 August 2006 and he was transferred post-operatively to Ward 19. On 6 September 2006 Mr A was discharged from hospital but re-admitted two days later and required plastic surgery to pressure ulcers.

6. On admission to hospital on 27 July 2006, it was also noted that Mr A had three small pressure sores with one on each buttock and one to his right hip. While on Ward 11 he was nursed on a profiling bed with a pressure-relieving mattress. The bed was on trial on Ward 11 from the manufacturer.

7. Mr A underwent surgery on 4 August 2006 and was transferred to Ward 19 post-operatively. The profiling bed which Mr A had used on Ward 11 was not transferred to Ward 19 with him. This bed was on trial on Ward 11 from the manufacturer in line with an organisational study relating to the use of these beds. These beds could also be hired from the manufacturer at a daily cost to the Board. Ward 11 staff were aware the day before of Mr A's transfer to Ward 19 but had not informed Ward 19 of the need for a profiling bed or pressure-relieving equipment.

8. Mr A made a good recovery following his surgery but discharge from the Hospital was delayed as a result of his increased dependency due to his physical condition. He required an increased care package which could not be provided immediately due to a lack of community resources. He was discharged home on 6 September 2006. On 8 September 2006, after only two days at home, he was admitted to Ward 27 for management of his pressure sores.

9. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report. I turn now to the specific points of complaint.

(a) There was inadequate treatment for Mr A's pressure sores

10. As stated previously, I was assisted in my investigation by the Adviser who has significant experience of Hospital related issues. The Adviser's views are set out at paragraphs 11 to 17.

Adviser's comments

11. Mr A was admitted to Ward 11 from home on July 2006 and it was noted that he had a history of stenosis of his right radial artery and he was advised that an amputation would be necessary. He was paraplegic as a result of a previous spinal infarction (a condition which results in loss of use of large sections of the body, generally limbs). On admission to hospital he had three

small broken areas of skin, one on each buttock and one on his right hip. The pre-admission grading of these pressure sores is not available but Mr A indicated to nursing staff that the area was red and scuffed and was being treated with the application of sudocrem. A Waterlow Assessment (pressure sore risk calculation) of 25 was recorded on 27 July 2006 indicating that Mr A was in a very high risk category of developing pressure sores.

12. There is no evidence to suggest that an assessment of Mr A's pressure sores was undertaken. There are no care plans or indication of interventions used in the management of his pressure sores or measures to prevent their deterioration and the development of further pressure sores.

13. According to the Board, Mr A was nursed on a profiling bed with a pressure-relieving mattress. This bed was on trial on Ward 11 from the manufacturers in line with an organisational study related to the use of these beds. Mr A was transferred to Ward 19 post-operatively but a profiling bed and mattress was not available for him. This was due to the fact that as the bed was on trial and not hired, it was not felt appropriate to transfer the bed to Ward 19 with the patient and this, in the Adviser's opinion, does seem to have been a flawed decision. The needs of the patient were paramount and it is the Adviser's opinion that attempts should have been made to discuss the situation with the research co-ordinator prior to Mr A's surgery. The Adviser is of the view that an arrangement could at least have been discussed which allowed the bed to be transferred to Ward 19.

14. An incident report completed on 4 August 2006 indicated that no formal handover relating to Mr A and his care needs was given to Ward 19 by nursing staff on the early shift on Ward 11. Ward 19 staff were, therefore, unaware of the need for a profiling bed and specialist pressure-relieving mattress. It was necessary for Ward 19 staff to contact Ward 11 to ascertain information regarding Mr A. Significantly even if the trial bed could not have been used it is important to note that Ward 11 staff were aware of Mr A's scheduled surgery a day prior to it taking place. The Adviser considered that it would have been good practice to have liaised with Ward 19 staff at this time to ensure that an appropriate profiling bed and mattress were available for Mr A on his return from theatre. The Adviser's view is that this aspect of Mr A's care was not acceptable.

15. The nursing documentation on Ward 11 was, in the Adviser's view, poor. An admission assessment was completed (the chart identified the ward as Ward 9) but a care plan reflecting assessed needs was not developed. The care planning documents that were available were core plans and focused on Mr A's arm, catheter and personal hygiene. There is little additional information to portray the holistic needs of Mr A and, as previously identified, his pressure sores had not been identified. Much of the nursing documentation was incomplete; examples include a pressure area treatment plan review which was blank, other blank documents, lack of signage on care plan reviews and accurate records of care given.

16. From the clinical records available to me it is clear that the assessment of Mr A's pressure areas began on the day of transfer to Ward 19 and continued throughout his stay. As a result of the lack of formal handover from Ward 11 nursing staff, there was a delay in obtaining a profiling bed and mattress, however, it is noted in the clinical records that Mr A was nursed on a pressure-relieving mattress (air mattress) whilst awaiting the delivery of a profiling bed and mattress which arrived on 6 August 2006. The Adviser considered this course of action to be reasonable in the circumstances.

17. On Ward 19, the pressure areas were assessed in relation to site and stage of pressure sores with accompanying wound drawings. There is also a clear description of wound treatment and records of appropriate medication used to treat the area. The Adviser, however, suggested that it would have been helpful for nursing documentation to include a rationale underpinning decisions made to use the different wound care products and reason for change in product type, for example, when the choice of product was changed from inadine to intrasite.

(a) Conclusion

18. Having reviewed the evidence and taken account of the Adviser's comments, which I accept, I uphold this aspect of complaint. The care provided, in relation to the pressure sores, was completely unacceptable and this resulted in further suffering for Mr A, exemplified by the fact that he was re-admitted two days following discharge for plastic surgery. The Hospital failed Mr A when delivering significant aspects of his care and this causes significant concern.

(a) Recommendation

19. The Ombudsman recommends that the Board:

(i) provide evidence of a robust standard for records and record-keeping and provide evidence of measures that are in place to audit this area of practice;

(ii) provide evidence that there is a programme of formalised education and training of the staff on Ward 11 with reference to the transfer of patients which includes the importance of effective communication and proactive nursing in relation to this process; and

(iii) provide assurances that they have a robust policy in place regarding inter-ward transfers.

(b) There was inadequate monitoring of Mr A's pressure sores

20. I am aware that some of the issues involved in this point of complaint are raised in the evidence previously highlighted, however, there are more specific points to raise in relation to this head of complaint.

21. From the records available it is evident, in the Adviser's opinion, that assessment of Mr A's pressure sores was undertaken on transfer to Ward 19 and that this was on-going throughout his stay. The wound diagrams are good as far as they go but do not give a clear picture of wound size. Measurement of wound size is a useful indicator of progress or deterioration, and also a factor in wound management, such as selection of appropriate dressing size. Appropriate and regular measurement provides an indicator of treatment outcome and can indicate the need to review the wound management plan. In the case of Mr A it is the Adviser's opinion that the most reliable way of measuring the surface area of his pressure sores would have been to take a tracing of his wound using a tool with a grid system to measure the surface area.

22. The Adviser felt that other indicators of on-going assessment did include good descriptions of the stage and site of the pressure sores and the treatment given. It appears from the nursing records that pressure areas were showing signs of improvement with granulated (healthy pink) tissue seen at the wound edges. When the wounds became malodorous (having a bad smell), a wound swab was taken which was, in my opinion, a reasonable course of action to take. After discussion with medical staff regarding the results of the wound swabs, they were of the opinion that even though micro-organisms were identified, treatment with oral or intravenous medication would be inappropriate.

Nursing staff were advised to continue with the current treatment regime of dressings. Carbon dressings were applied to the outer dressings to reduce the odour.

23. It is evident from the nursing records that Mr A spent a great deal of time in his electric wheelchair. According to nursing staff, Mr A had a 'roho' cushion in place which provided the optimum level of pressure relief as advised by the manufacturers and wheelchair service at the Hospital. The Adviser considered, however, that it is important to recognise that Mr A's care needs had changed considerably following his right below elbow amputation as he now had only one fully functioning limb. The Adviser stated that these changed circumstances should have been taken into consideration and, at the very least, Mr A should have had a formal assessment of his moving and handling needs and of his capacity to relieve his pressure areas independently when in his wheelchair.

24. During the assessment process nursing staff would have been able to discuss the importance of changing position and relief of pressure, and consideration could have been given to the length of time Mr A spent in his wheelchair. Most importantly, Mr A would have been engaged in the decision-making process and this could have been documented in his care plan. In my opinion, it is apparent that more could have been done by nursing staff to assist and encourage Mr A to change his position in terms of engaging him in the decision-making process and undertaking a formal assessment and devising a plan of care that reflected that assessment.

(b) Conclusion

25. Taking into consideration the evidence available, it does appear that the monitoring of the pressure sores was reasonable under the circumstances. I do, however, consider that given Mr A's past medical history (particularly his spinal cord infarction and resultant paraplegia), it would have been appropriate to have sought expert advice from a tissue viability nurse specialist regarding the current management of his pressure sores and future plan of care. Furthermore, I have concerns regarding the care planning for Mr A which also impacts upon monitoring arrangements.

26. Therefore, in conclusion I uphold this complaint. Although action was taken to monitor Mr A, I am of the opinion that seeking further advice, given Mr A's medical history, would have been appropriate in this case as would a

more detailed care plan which may have facilitated a more appropriate monitoring arrangement.

(b) Recommendation

27. The Ombudsman recommends that the Board devise a quality assurance system whereby all patients suffering from pressure sores have care plans which are sufficiently detailed and also highlight the monitoring arrangements for the patient. The system should take account of Best Practice statements on Pressure Ulcer Prevention and the Treatment and Management of Pressure Ulcers issued by NHS Quality Improvement Scotland (March and November 2005 respectively).

(c) There was an inappropriate decision to continue with a course of treatment for Mr A's pressure sores

28. This point of complaint relates to Mr C's assertion that the decision taken by the multi-disciplinary team to continue with a course of treatment to manage Mr A's pressure sores was incorrect. According to the Board, the multi-disciplinary team engaged in the care of Mr A decided that his treatment was appropriate and the decision not to refer him to a plastic surgeon was based on the evidence that the wound was healing and there was a reduction of necrotic (dead) tissue in the wound.

(c) Conclusion

29. The Adviser carefully scrutinised the clinical records and found no written evidence regarding the multi-disciplinary team decision not to refer Mr A to a plastic surgeon. The lack of documentation regarding this decision is unsatisfactory. The importance of documenting facts cannot be over-emphasised. Accurate records are the highest form of evidence of care delivery and good record-keeping is the mark of a skilled and safe practitioner.

30. In considering the reasonableness of the decision to continue with the course of treatment being administered, I am of the opinion that, in the circumstances, despite evidence of wound healing and a reduction of necrotic tissue because of Mr A's associated medical conditions it is likely, in the Adviser's view, that he would have benefited from expert review by a tissue viability nurse specialist or a plastic surgeon prior to discharge. This may have allayed some of Mr A's anxieties particularly in view of the fact that he was readmitted to hospital only two days after discharge from Ward 19 and required plastic surgery for his pressure ulcers. In conclusion, given the Adviser's view

that the Board could have done more to consider Mr A's treatment, I have decided to uphold this complaint as it is my view, and the view of the Adviser, that there were some serious shortcomings in the standard of care delivered to Mr A during his period of hospitalisation at the Hospital.

(c) Recommendation

31. The Ombudsman recommends that the Board:

(i) apologise to Mr A for the failings which have been identified; and

(ii) reiterate to all relevant staff at the Hospital the importance of clearly recording the factors which lead to a decision regarding continuing or changing treatment.

32. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	Mr C's father
The Hospital	Ninewells Hospital
The Board	Tayside NHS Board
The Adviser	The Ombudsman's medical adviser