Scottish Parliament Region: Highlands and Islands

Case 200702119: Highland NHS Board

Summary of Investigation

Category

Health: Clinical treatment/Diagnosis

Overview

The complainant, Mrs C, complained on behalf of her husband, Mr C, about the nursing care he received while he was a patient in Raigmore Hospital.

Specific complaint and conclusion

The complaint which has been investigated is that while Mr C was in Raigmore Hospital he failed to receive appropriate nursing care in that proper hygiene (in relation to his skin) was not given and sustained (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board write to Mr and Mrs C apologising for the condition of Mr C's skin on his discharge from hospital. Further, she suggests that where the risk of skin ulcers has been identified, as in Mr C's case, an appropriate care plan be formulated and followed. Thereafter, on discharge, a record be made in the notes confirming whether or not the situation has been resolved.

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

Main Investigation Report

Introduction

1. On 12 November 2007, the Ombudsman received a complaint from Mrs C on behalf of her husband (Mr C) concerning the nursing care he received whilst he was a patient in Raigmore Hospital between 28 August and 6 September 2007. Mrs C said that when Mr C was discharged home from hospital on 6 September 2007, she found his buttocks were 'excoriated, red, skinning and bleeding'. His groin and thighs were similarly affected. Mrs C said she was sufficiently concerned to telephone the ward immediately and, the next day, to seek assistance from her GP.

2. The complaint which has been investigated is that while Mr C was in Raigmore Hospital he failed to receive appropriate nursing care in that proper hygiene (in relation to his skin) was not given and sustained.

Investigation

3. The investigation of this complaint involved obtaining and reading all the relevant documentation, including correspondence between Mrs C and Highland NHS Board (the Board). I have also had sight of Mr C's relevant medical records, the Board's complaints file and a note of a home visit to Mr C by his GP on 7 September 2007. I have obtained advice from an independent nursing adviser (the Adviser) and on 4 February 2008 made a formal enquiry to the Board advising them of my intention to investigate. Their response was dated 26 February 2008.

4. While I have not included in this report every detail investigated, I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: While Mr C was in Raigmore Hospital he failed to receive appropriate nursing care in that proper hygiene (in relation to his skin) was not given and sustained

5. Mrs C said that her husband was admitted to Ward 7C (the Ward) of Raigmore Hospital on 28 August 2007 from Aberdeen Royal Infirmary where he had undergone neurosurgery. While in Aberdeen, he had started treatment for a urinary infection and she said this treatment was continued at Raigmore.

6. Mrs C said that Mr C remained on the Ward until his discharge home on 6 September 2007. However, she complained that upon his arrival, when assisting him to change, she noticed that his buttocks were 'excoriated, red, skinning and bleeding'. She said that on further inspection she discovered that this was more widespread and extended between his buttocks and groin area with a rash extending down both thighs. She said she treated this as best she could and telephoned the Ward immediately to voice her concerns. The next day, she said she felt she needed to contact her GP who made a home visit to her husband and prescribed anti-fungal and antibiotic creams to be administered for ten days. She said she was advised to call out the doctor again if there had been no improvement over five days.

7. On 10 September 2007 Mrs C made a formal complaint to the Board about Mr C's condition on discharge and she received their reply on 15 October 2007. It was the Board's view that correct levels of nursing care had been maintained and that staff involved with Mr C had not noticed any problems with his skin. They maintained that had such a problem as that described by Mrs C existed, medical staff would have been asked to review Mr C's condition and medication. Mrs C did not consider this response satisfactory and pursued her complaint with the Ombudsman (see paragraph 1).

8. From the clinical notes available to me, I am aware from the Nursing Assessment/ Transfer Document dated 27 August 2007 (from Aberdeen Royal Infirmary to Raigmore Hospital) that Mr C was, 'Incontinent' and, 'can be incontinent of urine and faeces'. Also, that his sacral area was red. The Common Admissions Document made reference to a Urinary Tract Infection (UTI). On 29 August 2007 Mr C was noted to be, 'incontinent+1' and the next day to have a 'small break on the cleft of his buttock – sudocreme applied'. On 6 September 2007, the day that Mr C was discharged, a nurse recorded in the clinical notes that she noticed, 'dry skin on buttock after showering but no broken areas'. Mrs C's telephone call to Raigmore Hospital that day was also recorded in the nursing notes (see paragraph 6).

9. As stated at paragraph 6, on 7 September 2007, Mrs C had called her GP and the note of his visit to Mr C said, 'Discharged Raigmore yesterday- in for 1/52 following surgery in Aberdeen for shunt revision. Skin around perianal area/groins appears raw, inflamed. Nurses on ward said ok when in ward. UTI while in hospital, completed antibiotics. Wife very concerned re state of skin. O/E Erythematous, inflamed skin. Dry patches. Imp-?fungal?bacterial element.

Plan – for canestan HC +fuscidic acid. R/v if not settling. Uses sudocreme as a barrier cream'.

10. In making their comments to me (see paragraph 3), the Board said that the staff nurse looking after Mr C noted no incontinence on the nights she looked after him. This included the night of 29 August 2007 (but see paragraph 8 above). The staff nurse looking after Mr C the next day said if Mr C's skin had been hot, red or painful she would have taken appropriate action. The Board further commented that there was no incontinence that day and Mr C was being nursed on a specialist mattress suitable for people with a high risk (up to 20) Waterlow score. (A Waterlow score is a risk assessment scoring system for pressure ulcers, a score greater than 10 indicates a risk.) They maintained that Mr C's skin had been checked on 31 August 2007 when he showered and that sudocreme had been applied to a small break in his skin. A Waterlow score was completed on 1 September 2007 and Mr C was assessed as scoring 11. No incontinence was recorded nor was there a note of any broken skin and, on 3 September 2007, Mr C was noted as passing urine well. On the day of his discharge, the staff nurse involved with Mr C said that he had not been suffering incontinence or broken areas of skin.

11. In view of Mr C's GP's note of 7 September 2007 (see paragraph 9), I particularly asked the Board for their comments but they could offer no explanation and said that their investigation did not support them (that is, the GP's notes that Mr C's skin was in poor condition). They were confident that Mr C's care in the Ward had been appropriate for his condition.

12. The Adviser provided me with her opinion on the nursing care offered to Mr C and she confirmed that it was a fact that his medical records noted that there were some issues concerning his skin (see paragraphs 8 and 10). She pointed out that there was no clear statement confirming that these problems had been resolved. She said she would have expected a check to have been made prior to Mr C's discharge and the outcome of that check noted in the records and discharge summary. There was not, although there was a note confirming Mrs C's call to the Ward after her husband had been discharged complaining that his skin was broken and bleeding. The Adviser said it was her view that this state of affairs was backed by the GP (see paragraph 9). She further commented that, on balance, she was of the view that Mr C's skin problems were likely to have been in existence and, therefore, observable, to some extent, on the day of his discharge.

Conclusion

13. In clinical matters I have to be guided by the Adviser. Mr C's hospital records confirmed that Mrs C telephoned to complain about the condition of his skin on the day of discharge. His GP records further confirm that his skin was raw and inflamed within hours of discharge. Accordingly, the Adviser has concluded that the situation must have existed when Mr C was in Raigmore Hospital. The medical records make scant mention of the condition of Mr C's skin after the end of August 2007 and the only treatment mentioned in relation to this was the application of sudocreme. This, despite a Waterlow score of 11 (see paragraph 10). Notwithstanding that I note that while Mr C was a patient in Raigmore Hospital he was being nursed on a bed to cope with much higher scoring patients (see paragraph 10), no other treatment was mentioned. Accordingly, I am persuaded by the complainant's argument, reinforced by the GP's note of visit, and I uphold the complaint.

Recommendations

14. The Ombudsman recommends that the Board write to Mr and Mrs C apologising for the condition of Mr C's skin on his discharge from hospital. Further, she suggests that where the risk of skin ulcers has been identified, as in Mr C's case, an appropriate care plan be formulated and followed. Thereafter, on discharge, a record be made in the notes confirming whether or not the situation had been resolved.

15. The Board have accepted the recommendations and will act on them accordingly. In this connection, the Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's husband
The Board	Highland NHS Board
The Adviser	An independent nursing adviser
The Ward	Ward 7C, Raigmore Hospital
UTI	Urinary Tract Infection