Scottish Parliament Region: Glasgow

Case 200702913: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospital; Orthopaedics; clinical treatment and diagnosis

Overview

The complainant, Mr C[1], was concerned that his late father (Mr A) had suffered serious pressure sores while in the Southern General Hospital (Hospital 1) following an operation on both his knees. Mr C felt that the decision to operate had not been taken appropriately and that the care provided while Mr A was in Hospital 1 was inadequate. Mr C was also unhappy about the way the Board had responded to concerns raised by him and his family.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the decision to operate was not appropriate, in that further tests should have been taken prior to the operation (*upheld*);

(b) the post-operative care provided to Mr A was inadequate (*upheld*);

(c) communication with Mr A and his family, concerning Mr A's care and treatment, was not adequate (*upheld*); and

(d) the Board did not respond appropriately to the complaint raised by Mr C (*partially upheld, to the extent that there was a delay in responding with no reasonable explanation given for this*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) undertake a root cause analysis or similar tool to examine the reason why the pressure ulcers2 developed and why there was no proactive treatment once this occurred;

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[1] The complaint was raised by Mr A's family. Mr C was the main point of contact for this office.

[2] In a clinical context, pressure ulcer is the more correct term. Pressure sore remains more widely understood and, outside of the technical recommendations, is the term used throughout this report.

(ii) provide the policy/guidance for the assessment and treatment of pressure ulcers, with particular reference to the referral to the specialist teams in tissue viability, pain and nutrition; undertake an audit to review the processes; and provide an action plan to address any shortcomings;

(iii) undertake an audit of documentation to include nursing assessment, pain assessment and nursing care of Wards A and B;

(iv) provide evidence of the education and training programme provided to nursing staff in relation to the assessment and care of pressure ulcers;

(v) undertake an external peer review of the nursing care in Ward A, to include an examination of the clinical leadership and management, patient experience and quality of care. In undertaking the review, consideration should be given to Improvement Methodology and the Scottish Government initiatives outlined in Leading Better Care;

(vi) provide details of the action plan created as a result of the above recommendations and provide updates where relevant. Action plans should be specific, measurable, achievable, realistic and timely (SMART) and include robust quality indicators such as the Clinical Quality Indicator for Pressure Ulcer Prevention;

(vii) as a priority, review the documentation provided to patients and provide the Ombudsman with the results of this;

(viii) provide details of the audit made in response to report 200600345 and any action taken as a result;

(ix) if not covered by that audit, undertake a specific audit of communication within Hospital 1, to include communication with families, and between staff;

(x) reinforce to clinical staff the importance of responding to requests from complaint handling staff timeously; and

(xi) make a full apology to Mr C and his family for the failings identified in this report.

The Board have accepted the recommendations and will act on them accordingly. [3]

[3] In accepting these recommendations, the Board noted their intention to ensure that they would take a multi-disciplinary approach and involve the full clinical team involved.

Main Investigation Report

Introduction

1. On 1 September 2006, Mr A was referred for bilateral knee replacements. Before his operation was scheduled, Mr A was admitted to the Southern General Hospital (Hospital 1) on 16 November 2006 suffering from knee pain and decreased mobility. Following treatment for this, he recovered sufficiently to be discharged on 12 December 2006. Mr A had a subsequent period of hospital admission for confusion in January 2007, at a Hospital outwith the Board area (Hospital 2). On 4 March 2007, Mr A was informed there had been a cancellation and he was admitted on 7 March 2007 to Hospital 1. He had his knee replacements operation on 8 March 2007.

2. Mr A did not recover successfully from this operation. He remained in Hospital 1 until August 2007, during which time his condition deteriorated. On 24 August 2007, Mr A was admitted to a Hospital outwith the Board area (Hospital 3) for long term care. Sadly, Mr A died on 10 September 2007.

3. The complaints from the Complainant (Mr C) which I have investigated are that:

(a) the decision to operate was not appropriate, in that further tests should have been taken prior to the operation;
(b) the post-operative care provided to Mr A was inadequate;
(c) communication with Mr A and his family, concerning Mr A's care and treatment, was not adequate; and
(d) the Board did not respond appropriately to the complaint raised by Mr C.

Investigation

4. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mr A's medical records. Advice was also obtained from medical and nursing advisers (Adviser 1 and Adviser 2, respectively) to the Ombudsman. As a result of the advice, further enquiries were made of the Board. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

5. 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.

6. The references made in this report to the management of Mr A's pressure sores and pain relief will undoubtedly be very distressing for Mr C and his family. I hope that Mr C and his family can draw some comfort from the investigation of this complaint and the recommendations made.

(a) The decision to operate was not appropriate, in that further tests should have been taken prior to the operation

7. Mr A, then aged 79, had had rheumatoid arthritis for some time when he attended at an out-patient clinic at Hospital 1 in June, September and October 2006 for steroid injections in his knees. Following a clinic appointment on 1 September 2006, he was put on the waiting list for bilateral knee replacements. The decision to carry out surgery on both knees at the same time was made because it was thought this was the best way to ensure a shorter rehabilitation time. Mr A was also found to have swollen ankles and was started on a diuretic medication.

8. On 16 November 2006 Mr A was admitted to Hospital 1, following a referral to Accident and Emergency by his own GP. A letter from his GP said Mr A had been deteriorating over the last six weeks and was now unable to stand. On admission Mr A was noted to be hallucinating and distressed. It was recorded that Mr A's sodium levels were low. It was thought that this was the likely cause of his confusion and Mr A's diuretic medication was stopped. Mr A made some improvement in mobility and his distress lessened. He was discharged on 12 December 2006.

9. On 3 January 2007, Mr C wrote to Mr A's GP to say he was concerned about Mr A's health. Mr A was admitted to Hospital 2 on 5 January 2007. He was again suffering from hallucinations. Mr A was diagnosed with a urine infection and responded to the treatment of antibiotics he received. He was discharged on 17 January 2007.[4]

10. On Sunday, 4 March 2007, Mr A received a call to say there had been a cancellation and asked if he was able to attend at Hospital 1 for his knee replacement surgery. Mr A was admitted on 7 March 2007. Mr A was assessed by the anaesthetist prior to surgery. Adviser 1 noted that in assessing Mr A, the consultant who carried out the operation (the Consultant) had

[4] Mr A had no confusion at discharge following either admission.

recorded that Mr A's knees had become flexed, fixed in a bent position, and that this should be corrected in surgery. Sodium levels were noted to be normal.

11. The operation was carried out on 8 March 2007 and the notes taken of this indicated that it was technically successful. Mr A's knees were replaced and the flexion in the muscles surrounding the knees corrected.

12. Unfortunately, Mr A suffered from significant post-operative confusion. Records in the nursing notes record disorientation and an inability to comply with staff's instructions on 11 March 2007. On the date of transfer from Ward B to Ward A in May 2007, it was noted he had suffered from profound confusion since the operation. His mood varied and at times improvement was noted. The rigid flexion in the muscles surrounding his knees returned and Mr A did not regain mobility following the operation.

13. In complaining to the Ombudsman, Mr C said he was concerned that there had not been proper regard to Mr A's age, pre-existing conditions or his general level of fitness when assessing his suitability for the operation.

14. In reviewing the clinical records, Adviser 1 said a post-operative risk to Mr A's rehabilitation from his knee flexion had been noted appropriately by the Consultant in his examination of Mr A prior to the operation and taken into account. However, Adviser 1 was concerned that Mr A suffered from confusion following his operation and whether this could have been predicted, given his previous admissions when Mr A was noted to have been hallucinating and in distress. The confusion was said by the Board to have been a significant factor in his inability to re-mobilise and subsequent deterioration (see paragraph 21). Adviser 1 commented that the anaesthetist and the Consultant, who had decided on the suitability of Mr A for the operation, had not noted details of these previous admissions[5] and there was no evidence of an assessment of his mental condition.

15. In response to Adviser 1's concerns, I obtained the clinical records relating to Mr A's previous admissions in Hospital 1 and Hospital 2 and these were reviewed by Adviser 1.

[5] The records from the hospital outside the Board Area would not have been expected to have been available but there is no note of any discussion with Mr A about this or the previous admission in Hospital 1.

16. Adviser 1 added that, from the records, it was clear that in March 2007 Mr A's sodium level was normal. The infection which had caused his confusion in January 2007 had been treated.

17. However, Adviser 1 said, on the evidence available, it was not possible to be categorical about the cause of Mr A's post-operative confusion. This confusion could, Adviser 1 said, also be explained by pain, fever and Mr A's post-operative state as any underlying, undiagnosed cognitive impairment. In his view, it was also likely this was only a partial cause of Mr A's failure to recover. Mr A's fixed knee flexion, which had been noted pre-surgery and been corrected, had also recurred post-surgery and would have been a contributing factor. Nevertheless, Adviser 1 explained that undertaking both knee operations at the same time did increase the risk of failure to rehabilitate successfully and he remained concerned that, whatever the cause, Mr A's episodes of confusion which occurred before surgery were not appropriately considered when the decision to proceed with surgery was made.

18. In their response to my enquiries, the Board said that, at the time of Mr A's admission, orthopaedic case records were held separately from the general case record. At his admission, only the orthopaedic file would have been available and not the records of his previous admission to Hospital 1. They said that this practice had now stopped and a single case record was now being implemented for all patients. They also said that the practice of admitting patients to surgery at short notice had now stopped. In response to a recommendation on another report (200702270), which was published in September 2008, the Board have already agreed to implement mental health checks for elderly patients where appropriate.

(a) Conclusion

19. Given Mr A's failure to recover from his operation, Mr C's concern that this should not have gone ahead is understandable. Adviser 1 has reviewed not only the information available to those who made the decision to proceed but also considered the additional information relating to Mr A's previous periods of hospitalisation. His conclusion was that, while he had no concerns about the decision to operate on both knees at once in itself or in the presence of the knee flexion, he felt more effort should have been made to evaluate Mr A's mental condition prior to surgery, given previous admissions for confusion. It was possible this would not have led to a conclusion that there was a

contraindication to surgery but, equally, it was not now possible to be certain of this. This evaluation would, additionally, have provided a very useful baseline, given Mr A's subsequent confusion. On the basis of the advice I have received that there was a lack of assessment of Mr A's confusion prior to surgery and, given this, it is not possible to state with certainty that the decision to proceed was reasonable, I uphold this complaint.

20. While I uphold this complaint, I am pleased to note in the Board's response to this office that the practice of separate notes and admitting patients at short notice has ceased. I have also noted their response to our previous report. The Ombudsman, therefore, has no recommendations to make.

(b) The post-operative care provided to Mr A was inadequate

21. Following his operation on 8 March 2007, Mr A stayed in Hospital 1 until his transfer to Hospital 3 on 24 August 2007. During his stay in Hospital 1, Mr A suffered from significant post-operative confusion and contracted flexion in his knees, which made it difficult for him to mobilise, and his condition deteriorated during his stay. During his stay he was cared for in the orthopaedic ward (Ward A); spent time in a rehabilitation ward (Ward B); and briefly, following his operation, a High Dependency Unit (Ward C). On admission to Hospital 3 he was noted to have severe pressure sores and these were photographed on 1 September 2007.

22. Mr A's family raised concerns while he was in Hospital 1 about the care and treatment he was receiving. They were concerned that there appeared to be no overall plan of care and that Mr A was continuing to deteriorate. Following Mr A's death, additional detailed concerns about the care provided were also put to the Board by Mr C.

23. In the course of my investigation, Adviser 2 made initial comments which were put to the Board for further response.

24. In their comments to me, the Board accepted that they had not followed the standard care pathway in providing care to Mr A. They said they had initially been unable to do so because this required Mr A to regain mobility. This had initially been prevented by Mr A's post-operative confusion and he subsequently deteriorated. They, therefore, planned the care around Mr A's specific needs at the time.

25. The Board explained that, as part of the attempts to help Mr A rehabilitate, he had been transferred to a rehabilitation ward (Ward B) on 10 April 2007 and stayed there until 9 May 2007. They said Mr A was transferred to a standard integrated care pathway as a result of this move. On 16 April 2007, the consultant who reviewed him in Ward B was concerned that the flexion Mr A had on both knees and the pain he was experiencing meant he may not benefit from rehabilitation. He said he felt there had been no clear objectives for the move to Ward B and had asked for the orthopaedic team to again become involved.

26. In their response, the Board described actions taken to support Mr A's nutritional and other needs and the involvement of relevant specialists. They also said that, following the concerns raised by the family, meetings were held on 8 June and 20 July 2007. Members of Mr A's family attended these meetings.

27. Despite the Board's comments, Adviser 2 raised detailed concerns about both the overall care planning and specific aspects of Mr A's care. Adviser 2 said that Mr A suffered from one of the worst cases of pressure sores that she had seen in her career. Adviser 2 was critical of nursing staff who she said did not develop robust care plans, which would have contributed to an evaluation of care to ensure Mr A received the best care possible. There was no evidence that a full assessment had been undertaken on admission or of appropriate care planning throughout his stay in Hospital 1. She accepted that there were lengthy notes available but few of them reflected the assessment of planning of care to meet Mr A's specific needs. For example, she noted a good post-operative assessment while Mr A was in Ward C of Hospital 1 but no care plan was started when Mr A returned to Ward A. A care pathway was partially completed on 10 April 2007, following Mr A's transfer to Ward B of Hospital 1, but there was no evidence that care planning was initiated as a result of his assessment.

28. Adviser 2 also said there was a lack of communication between the clinical teams involved: orthopaedic, nursing and medical. She was concerned further about the information provided pre-transfer to Hospital 3. Mr A was transferred to Hospital 3 for long-term care. The Board said that there had been direct contact between staff in Ward A and Hospital 3 and between dieticians in each hospital. However, no formal discharge documentation was completed prior to

the transfer to Hospital 3 or note on file made of what was said by staff in Hospital 1 to staff in Hospital 3.

29. As well as commenting on care planning and communication, Adviser 2 commented specifically on the management of Mr A's pressure sores, pain management and nutritional care.

30. On the care given in relation to the pressure sores, Adviser 2 noted that as part of Mr A's post-operative assessment by Hospital 1, staff in Ward C indicated Mr A's heels were red and his sacrum discoloured. Mr A returned to Ward B and on 11 March 2007 a very high Waterlow score was recorded. The tissue viability nurse was contacted on 20 March 2007 but did not see Mr A until 23 April 2007. By 7 April 2007 Mr A was noted already to have a sacral sore 2.5 inches wide by one inch deep. Adviser 2 was concerned that there was only one turning chart which only began on 11 July 2007 and that a moving and handling assessment was not carried out until 22 May 2007. Adviser 2 accepted that there was lengthy information on what treatment was provided to the open sores but there was also ongoing documentation of new sores developing and there was no concern about this evidenced in the nursing records. For example, there was no sign that staff had raised this with the family. Adviser 2 said it was difficult not to conclude that the deterioration in the pressure sores which developed may not have occurred had the tissue viability nurse attended earlier. Adviser 2 said that Mr A was noted to have been confused and aggressive during his admission. She suggested that this was most likely to have arisen from pain caused by the wounds. While specialist care was sought for these, in her view the attempt to care for the pressure sores came too late in the admission.

31. Adviser 2 noted additional information provided by the Board about the management of Mr A's pain and the involvement of the pain nurse. She said that nursing staff did use the Standardised Early Warning System (SEWS) but there were limited entries relating to assessment of pain, although the nursing records included references to Mr A complaining of severe pain. Adviser 2 considered that if there had been regular assessments, this would have helped staff become aware of the early indications of pain. She noted a specialist pain nurse had been contacted but there was no information in the notes of the review and advice given. The notes recorded that Mr A needed a Patient Controlled Analgesia pump because of the severity of the pain he was experiencing, however, there was no reference to it being used.

32. Adviser 2 explained that the nutritional care of Mr A was significant because he presented as a vulnerable, elderly patient who had a reluctance to eat and drink. Early nutritional support would have been needed to support wound healing and the prevention of pressure sores. She noted that referral to a dietician did not occur until 20 April 2007. However, she also said there was evidence that the dietician had then been involved and fluid charts were reasonably well completed. There was indication in the notes of different methods being used to feed Mr A. In their comments, the Board accepted that Mr A's weight should have been taken on admission but was not. They said that medical problems meant it was not possible to weigh Mr A on all the occasions that this had been requested by the dietician.

33. Adviser 1 also commented on the post-operative care provided to Mr A. He said that, while Mr A's illnesses were dealt with in an appropriate and timely fashion from the medical point of view, there was no evidence of more holistic assessments and an overall control of his clinical management. There was evidence of a poor pre-operative assessment and poor recording of how Mr A's pain and confusion were being managed.

34. In my enquiries, the Board were asked for evidence of actions taken as a result of this complaint and also asked about reports previously published by the Ombudsman, which dealt with related issues. The Board provided details of the review of nutritional care and management undertaken as a result of report 200600459, published in August 2007. This had been followed up with an action plan and initiatives were being piloted across the Board area. In direct response to the complaint by Mr C, they said that a practice educator nurse had been employed to support staff in the orthopaedic department in south Glasgow and a SEWS audit had been completed with action points, to ensure compliance amongst staff. As a result of report 200402199, published in May 2007, compliance with the discharge policy had been audited in July 2007. Compliance rates were noted to be high for Hospital 1 but full compliance was not achieved and an action plan had been put in place. The Board also provided copies of their new discharge procedures from March 2008.

(b) Conclusion

35. As stated in paragraph 6, the references made in this report to the management of pressure sores and pain relief will undoubtedly be distressing

for Mr C and his family. Adviser 2 has said these were the worst she has seen in her career.

36. I accept it is the case that, in some circumstances, sores and even severe sores cannot be avoided, even with the highest level of care. However, the advice I have received from both Adviser 1 and Adviser 2 is that the care provided to Mr A was inadequate and it is likely this contributed to his deterioration and the extent of the pressure sores. Taking all this into account, I have concluded that, while there is evidence of provision of care, this was simply reactive and Mr A's care was not appropriate or adequate for his needs. In the circumstances, I uphold this complaint.

37. In this report, I have noted the initiatives taken by the Board in response to both this complaint and previous reports published by the Ombudsman's office. This has been reflected in the recommendations made below.

(b) Recommendations[6]

38. The Ombudsman recommends that the Board:

(xii) undertake a root cause analysis or similar tool to examine the reason why the pressure ulcers developed and why there was no proactive treatment once this occurred;

(xiii) provide the policy/guidance for the assessment and treatment of pressure ulcers, with particular reference to the referral to the specialist teams in tissue viability, pain and nutrition; undertake an audit to review the processes; and provide an action plan to address any shortcomings;

(xiv) undertake an audit of documentation to include nursing assessment; pain assessment and evaluation of nursing care of Wards A and B;

(xv) provide evidence of the education and training programme provided to nursing staff in relation to the assessment and care of pressure ulcers;

(xvi) undertake an external peer review of the nursing care in Ward A, to include an examination of the clinical leadership and management, patient experience and quality of care. In undertaking the review, consideration should be given to Improvement Methodology and the Scottish Government initiatives outlined in Leading Better Care;

(xvii) provide details of the action plan created as a result of the above recommendations and provide updates where relevant. Action plans

[6] In accepting these recommendations, the Board noted their intention to ensure that they would take a multi-disciplinary approach and involve the full clinical team involved.

should be specific, measurable, achievable, realistic and timely (SMART) and include robust quality indicators such as the Clinical Quality Indicator for Pressure Ulcer Prevention.

(c) Communication with Mr A and his family, concerning Mr A's care and treatment, was not adequate

39. In his complaint to the Ombudsman, Mr C raised a number of issues about communication with Mr A and his family. While Mr A had been in Hospital 1, Mr C had complained to the Board and attended two multi-disciplinary team meetings. He said that there had been no written information available to Mr A about a bilateral knee operation; communication with the family about Mr A's condition was poor throughout; and they had not been kept informed of his deteriorating condition.

40. In their response to Mr A's complaint, the Board accepted that the written information given to Mr A was inadequate for patients who would be receiving two knee operations. They said they would review the information sheet provided to all patients. In response to my enquiries, the Board said that this was their booklet 'Your Guide to Total Knee replacement'. In the case of bilateral knee replacements, the Board said additional information was normally supplied by staff to such patients, which highlighted the implication of having both knees operated on at the same stage, but did not confirm whether there had been a review or any changes made, despite direct questions on this point.

41. Adviser 1 noted poor communication in his review of Mr A's clinical records. Adviser 2 dealt with this in more detail and said it was clear that the notes showed Mr C was concerned about the lack of information and the lack of any orthopaedic care plan. Entries relating to communication with the family generally related to Mr C's concern about the lack of a care plan. Adviser 2 said there was also evidence that where communication should have occurred, it did not. As an example, she said there was no sign of anything in the notes to indicate when maggot therapy was introduced or how this was communicated to Mr A or his family. The clinical notes record on 26 June 2007 that it was likely Mr A would need long-term care but there are no notes of this being discussed with the family until 20 July 2007 (see also paragraph 30).

42. In response to a previous report (200600345, published in May 2008), the Board accepted detailed recommendations and produced an action plan

relating to communication with patients and their families. This was scheduled for audit in December 2008.

(c) Conclusion

43. Adviser 1 and Adviser 2 both drew attention to evidence of poor communication in the records. Again, it appears to be the case that communication was predominantly reactive which, given the nature of Mr A's condition and deterioration, was not sufficient. In the circumstances, I uphold this complaint. I have also noted that it is still not clear whether the leaflet provided to patients was reviewed, although the Board had told Mr C they would do so.

(c) Recommendations

44. The Ombudsman recommends that the Board:

(xviii) as a priority, review the documentation provided to patients and provide him with the results of this;

(xix) provide details of the audit made in response to report 200600345 and any action taken as a result; and

(xx) if not covered by that audit, undertake a specific audit of communication within Hospital 1, to include communication with families and between staff.

(d) The Board did not respond appropriately to the complaint raised by Mr C

45. Mr A's family formally complained to the Board on 6 August 2007. The Board's response was sent on 20 November 2007. The Board sent letters on 7 September and 8 October 2007 apologising for the delay in responding. From the internal documentation I have seen, the delay appeared to be due to gaining comments from key staff and this may have been linked to problems opening email attachments. However, it is not clear why this took so long to resolve.

46. In the letter of 8 October, the Board said it was expected that a letter would be sent shortly. A draft had been prepared by this date. However, on review by senior staff, this was felt to be too brief and was not issued. The response which was finally sent on 20 November 2007, was three pages long. The letter covered the decision to perform the operation, including the short notice before Mr A's admission, the pre-operative tests and information provided; and then went on to set out details of Mr A's care, including contact

with specialists, the management of his pressure sore, pain relief and weight loss.

47. Mr C said that during the time the Board were considering his complaint, he was contacted by Board staff about the delay and when told there had been a problem with an 'initial report', he said he asked for, and it was agreed he would receive, a copy of this. An MSP wrote asking for this to be sent in January 2008 and Mr C wrote in February 2008 with the same request. This document was sent to Mr C in February 2008. This document was a draft of a first letter of response which the Board had not felt was sufficiently full. In his complaint to this office, Mr C said there was no evidence given for most of the points made in the response and the delay caused the family further upset.

(d) Conclusion

48. In coming to this office, it is clear that Mr C disagreed with the view put forward by the Board in their letter of response and felt that they did not deal with these fully. I have considered the letter carefully and have concluded that the letter is detailed and does seek to link aspects of Mr A's care to the concerns raised. However, there was a considerable delay in issuing that response and I have seen no reasonable explanation for this. There also appears to have been confusion over the way aspects of the delay were explained to Mr C. In the circumstances, I partially uphold this complaint to the extent that, although the response sought to deal with the issues raised, there was a considerable delay with no reasonable explanation given for this.

(d) Recommendations

49. The Ombudsman recommends that the Board reinforce to clinical staff the importance of responding to requests from complaint handling staff timeously.

General recommendation

50. The Ombudsman further recommends that the Board make a full apology to Mr C and his family for the failings identified in this report.

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

Annex 1

Explanation of abbreviations used

Mr A	The aggrieved, Mr C's late father
Hospital 1	Southern General Hospital
Hospital 2	Crosshouse Hospital
Hospital 3	Ayrshire Central Hospital
Mr C	The complainant
Adviser 1	Medical adviser
Adviser 2	Nursing adviser
The Consultant	The consultant who carried out the operation
Ward A	Orthopaedic ward
Ward B	Rehabilitation ward
Ward C	High Dependency Unit
SEWS	Standardised Early Warning System

Annex 2

Glossary of terms

Flexion	In a bent position
Maggot therapy	A therapy that involves the use of live maggots to keep wounds clean and aid healing
Patient Controlled Analgesia	Pain relief where the dosage is controlled directly by the patient
Sacrum/sacral sore	A sore on the sacrum, the broad area at the base of the spine
Waterlow	A standard assessment tool which allows staff to assess the risk of pressure sores in an individual patient