Scottish Parliament Region: Glasgow

Case 201002391: Greater Glasgow and Clyde NHS Board - Acute Services Division

Summary of Investigation

Category

Health: Hospitals; general medical; nursing care

Overview

The complainant (Mrs C) made a complaint that her daughter (Mrs A) had not received reasonable care and treatment from Greater Glasgow and Clyde NHS Board - Acute Services Division (the Board).

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed to care properly for Mrs A at Inverclyde Royal Hospital, Greenock resulting in her developing a pressure ulcer (*upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. The complainant (Mrs C) made a complaint that her daughter (Mrs A) had not received reasonable care and treatment from Greater Glasgow and Clyde NHS Board - Acute Services Division (the Board).

2. The complaint from Mrs C which I have investigated is that the Board failed to care properly for Mrs A at Inverclyde Royal Hospital, Greenock (Hospital 1) resulting in her developing a pressure ulcer.

3. In making her complaint to my office, Mrs C said the Board admitted negligence in their care and treatment of Mrs A. Negligence is a specific term that involves a legal test. My office's role is to look at whether the care and treatment provided was reasonable. I should clarify that, in their letters to Mrs C, the Board did not say they were negligent in their care of Mrs A.

Investigation

4. The investigation of Mrs C's complaint involved reviewing the documentation provided by her, making an enquiry of the Board and reviewing the documentation provided by them. In addition, my complaints reviewer sought the view of a nursing adviser (the Adviser).

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

6. Mrs A, who was 55 at the time of her admission to Hospital 1, was diagnosed with multiple sclerosis (MS) in 1987. In April 2010, she was diagnosed with maturity onset diabetes mellitus. She was admitted to the acute medical assessment ward (J North) at Hospital 1 on 21 January 2010 with a chest infection, sepsis and confusion. Mrs A remained there overnight and was admitted to Ward G North on 22 January 2010. She was transferred to Hospital 1's Physical Disability Rehabilitation Unit (PDRU) on 8 February 2010, with a period from 9 April 2010 to 19 April 2010 in Ward 53 at the Southern General

Hospital, Glasgow (Hospital 2), while PDRU facilities were being upgraded. Mrs A was discharged home from the PDRU on 26 May 2010.

Complaint: The Board failed to care properly for Mrs A at Hospital 1 resulting in her developing a pressure ulcer

7. Mrs C complained to the Board on behalf of Mrs A on 4 June 2010. Mrs C said Mrs A was able to walk before she went into Hospital 1 but was discharged several months later in a hospital bed, which was put into her own home, because of a pressure ulcer. Mrs C also said the pressure ulcer was so bad that the bed had to have a special mattress, which was obtained from outside the Board area. In addition, Mrs A was only allowed up from bed for one hour, twice a day, and could only lie on one side. In Mrs C's view, this was the result of Hospital 1's failings and was not because Mrs A had MS. Mrs C also complained that, while in Hospital 2, Mrs A was told to use an incontinence pad while in bed, rather than being assisted with using the toilet.

8. The Board responded to Mrs C's complaint on 26 July 2010. They said Mrs A's pressure areas were observed and intact from admission until 25 January 2010. On 26 January 2010, a pressure ulcer was noted on her sacral area and nursing staff put Mrs A on a pressure-relieving mattress and started a repositioning chart. The wound was reviewed by a Tissue Viability Nurse (Nurse 1) on 28 January 2010 and 3 February 2010. However, the Board noted there was no record of a Waterlow Pressure Ulcer Risk Assessment (a Waterlow Assessment), which takes account of a number of factors to determine the risk of developing a pressure ulcer, when Mrs A was admitted. They expressed their regret for this not happening and said they would learn from it. They explained that an assessment would have highlighted the need for earlier investigation, and failure to do this led to a longer stay in Hospital 1 and continued difficulties at home.

9. The Board went on to say that PDRU nursing staff obtained advice from Nurse 1 to care for Mrs A's pressure ulcer and their actions following this advice were evidenced in the clinical records. She was changed to a different mattress on 16 February 2010 and then another mattress, which was a trial product from outside the Board area, on 17 March 2010. The Board said the reason for using the trial product was to make it easier for Mrs A to be transferred in and out of bed. However, the Board acknowledged the serious nature of the pressure ulcer.

10. In relation to the use of incontinence pads while in Hospital 2, the Board apologised for this, they said it was not normal practice, and the Senior Charge Nurse on Ward 53 would not knowingly allow this to happen. They said the Senior Charge Nurse had advised her staff that such an incident was unacceptable practice and, if established, would result in action being taken against any staff involved.

11. Mrs C was not entirely satisfied with the Board's response and wrote again on 13 August 2010, saying while they had at least acknowledged failings, Mrs A was still having to spend 22 hours a day in bed. Mrs C wanted to know why Mrs A still had a pressure ulcer nearly three months after discharge, when Nurse 1 had noted its condition as improving on 3 February 2010.

12. The Board responded to Mrs C on 13 September 2010. They said Nurse 1 had reviewed Mrs A's wound on 16 August 2010, was pleased it was progressing, and Mrs A could get out of bed for an hour at lunchtime, teatime and on some evenings. The Board also said they:

> '… were truly sorry that [Mrs A] is undergoing such difficulties in her illness which have been further exacerbated by the development of her pressure ulcer … [Mrs A] will need ongoing care and we are very anxious to do all we can to assist in any way possible.'

They concluded by saying that if Mrs A felt there were areas in her rehabilitation service that were not being fully addressed, she could contact Board staff for assistance.

13. In response to my office's enquiry, the Board said that, despite the failings they identified in Mrs A's care which led to a hospital-acquired pressure ulcer and the contribution this made to her reduced mobility, they did not consider they were fully responsible for Mrs A's bed rest restrictions. The Board explained that Mrs A was transferred to the PDRU because her Consultant in Rehabilitation Medicine (the Consultant) was of the opinion that she would benefit from rehabilitation, which was the standard pathway for patients who have neuromuscular disability such as MS. The aim was to allow multi-disciplinary assessment and treatment of Mrs A's physical disabilities, with a view to exploring avenues for achieving standing transfers. However, their efforts were pre-empted by the extent of neuromuscular impairment caused by Mrs A's MS. Given the diagnosis of diabetes, treatment for this condition was

started which resulted in improvements in Mrs A's general health and body weight.

14. The Board conducted an investigation of Mrs A's case in September 2010. Their investigation referred to problems in finding the location of the pressure ulcer as it was in a crease between the left outer buttock and leg. During the Board's investigation, Nurse 1 was interviewed. She was asked how often nursing staff on the wards would normally do Waterlow Assessments. Nurse 1 said that, although she always recommended that it was done, some wards were better than others and it was 'a bit hit and miss'.

15. The first record of Mrs A having a pressure ulcer was during the day shift on 26 January 2010, when it was written in the nursing notes. The first Waterlow Assessment form on file was dated the same day. The records also noted a poor appetite and, therefore, poor nutritional intake which can be a contributory factor in the development of a pressure ulcer, and so a referral was made to a dietician. A referral was also made to the Tissue Viability Service (TVS) on 28 January 2010. The form noted the referral was for a review of the pressure ulcer wound and that a pressure-relieving mattress was in use. The nursing notes for 28 January 2010 recorded the referral to the TVS and concluded that:

> 'This ulcer is related to time sitting in chair. [Mrs A] needs a strict repositioning regime with no time spent sitting in chair. She must be alternated side to side and only sat up for meals.'

A positioning chart was then put in place and Nurse 1 checked the wound on 30 January 2010 and 3 February 2010.

16. In the Board's complaints file, it was noted they upheld Mrs C's complaint due to evidence of a lapse in clinical care. It was also noted there had been learning from the complaint about Mrs A's care at local, directorate and corporate levels in how to identify and treat pressure ulcers, with a view to reducing their incidence.

17. In terms of the pressure ulcer's condition after discharge, the Board said Hospital 1's medical team were updated by the community team and Mrs A appeared to be progressing as expected. The Consultant intended to review her at home in the near future. In a telephone conversation with Mrs A in

February 2011, the Consultant said Mrs A told him that all appeared to be well[1]. The pressure ulcer was healing and the Consultant would expect Mrs A's General Practitioner to contact him should this change. The Consultant's view was that Mrs A was 'currently in optimum health' for her condition and that, following treatment for diabetes, she had improved her weight to have the required Body Mass Index to help avoid the risk of further skin breakdown. The Board said there were no restrictions at present on Mrs A sitting up, provided the appropriate pressure-relieving cushion was in place, and that, assisted by one person, she could now mobilise with a gutter frame and manage up to 12 steps on a smooth level surface. However, the Consultant noted that Mrs A suffered from a condition that was known to be progressive and her disability had progressed over the long term, despite a period of stable remission for an extended period prior to her admission to Hospital 1.

Advice received

18. The Adviser said that part of the initial assessment of a patient should include examining the skin for integrity and any vulnerable areas, which should be documented in the records. She also said that all nursing staff, including auxiliaries, should be aware of assessing skin condition, although a registered nurse would be accountable for the care of the patient. The Adviser said that nursing staff in G North should have carried out a Waterlow Assessment within six hours of admission, in line with the NHS Quality Improvement Scotland Best Practice Statement from March 2009 on the prevention and management of pressure ulcers. This document also stated that skin assessment should be undertaken regularly thereafter at dressing changes or at least weekly. Given this, the Adviser's view was that the standards in relation to assessments on the ward at the time of Mrs A's admission were not reasonable.

19. The Adviser said that once the pressure ulcer was noted by nursing staff, the care and treatment was of a reasonable standard. This was evidenced in the clinical records by the prompt action of nursing staff in taking appropriate steps to prevent further breakdown of Mrs A's pressure ulcer, such as: using a pressure-relieving mattress; starting a repositioning chart; referrals to a dietician and the TVS; and regular wound care. In terms of the first referral to the TVS,

[1] In commenting on a draft of this report, Mrs C said that the telephone call in February 2011 from the Consultant was the first time Mrs A had heard from him since her discharge from Hospital 1 in May 2010. Mrs C added that Mrs A was so taken aback by the call, that was why she said she 'was fine'.

the Adviser's view was that the timing of this, even though it took two days, was not unreasonable. In addition, the Adviser said that, generally, the standard of record-keeping was good. The Adviser also said that, even if earlier skin condition assessment had been carried out, the pressure ulcer may not have been prevented. This was because Mrs A was at high risk of developing pressure ulcers, taking into account her MS, her poor nutritional status and her impaired mobility.

20. My complaints reviewer specifically asked the Adviser whether the pressure ulcer had resulted in, or contributed to, the apparent deterioration in Mrs A's health and mobility which led to her being restricted to bed for much of the day. The Adviser said it was difficult to make this link due to the complexities of Mrs A's care given her underlying medical conditions. However, there was evidence of the need to restrict Mrs A from sitting in a chair to encourage healing of the pressure ulcer. This specific care required that Mrs A should not be out of bed to sit for more than two hours a day, which had been very restrictive on her mobility.

21. In relation to the use of incontinence pads in Hospital 2, the Adviser said it was unacceptable practice and she noted the Board had acknowledged this and had taken action to address this poor practice.

Conclusion

22. The Board identified lapses in clinical care and, because of this, they upheld Mrs C's complaint. The Board also acknowledged there were problems on wards at that time with the frequency of Waterlow Assessments for patients.

23. The Board noted there was no Waterlow Assessment form in the clinical records until 26 January 2010, the day the pressure ulcer was recorded in the nursing notes, which was five days after Mrs A was admitted to Hospital 1. The Board's records noted that once the pressure ulcer was recorded, appropriate referrals were made and action was taken to put Mrs A on a pressure-relieving mattress and to change her position in bed. However, the Board's records also noted that Nurse 1 was unhappy that nursing staff let Mrs A sit up in a chair for too long, which did not promote healing of the pressure ulcer.

24. The evidence shows that the primary reason Mrs A was transferred to the PDRU, and the main cause of her reduced mobility, was due to her underlying medical conditions and not because of the pressure ulcer. However, the Board

have acknowledged that the pressure ulcer was a contributory factor. As noted by the Adviser, even though earlier intervention may not have prevented the pressure ulcer given the risk factors involved, there was a delay in the assessment of Mrs A's skin and, once the pressure ulcer was noted, a short delay in referral to the TVS.

25. Although the Board have said the pressure ulcer was improving, I understand it has still not healed and requires ongoing treatment from district nursing staff. It is important to note the impact the pressure ulcer had, and still has, on the quality of Mrs A's life. Given the failings identified in relation to the care of Mrs A in Hospital 1 leading to the development of the pressure ulcer, in particular the absence of a Waterlow Assessment form in the clinical records before 26 January 2010, I uphold this complaint.

26. The Board have provided my office with evidence of the steps already taken to learn lessons, develop and monitor an action plan to improve the frequency of Waterlow Assessments and, therefore, reduce the incidence of pressure ulcers. They have also apologised for the failures in care. Taking all this into account, I have no recommendations to make.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The complainant's daughter
The Board	Greater Glasgow and Clyde NHS Board – Acute Services Division
Hospital 1	Inverclyde Royal Hospital, Greenock
The Adviser	A nursing adviser to the Ombudsman
MS	Multiple Sclerosis
PDRU	The Physical Disability Rehabilitation Unit at Hospital 1
Hospital 2	Southern General Hospital, Glasgow
Nurse 1	A tissue viability nurse
Waterlow Assessment	A Waterlow Pressure Ulcer Risk Assessment
The Consultant	A Consultant in Rehabilitation Medicine
TVS	The Board's Tissue Viability Service

Annex 2

Glossary of terms

Body Mass Index	A measure of whether someone is a healthy weight for their height, calculated by dividing an individual's body weight by the square of their height
Incidence	New cases occurring in a specified population over a given period of time
Maturity Onset Diabetes Mellitus	Diabetes is a long-term condition caused by too much glucose, a type of sugar, in the blood. It is also known as diabetes mellitus. Maturity onset diabetes mellitus is one of the two major types of diabetes, peaking in onset between 50 and 60 years of age, characterized by gradual onset
Multiple Sclerosis (MS)	The most common neurological condition in young adults in the UK. It is the result of damage to a protective sheath surrounding nerve fibres of the central nervous system. The central nervous system controls the body's actions and activities, such as movement and balance, and this damage this interferes with messages between the brain and other parts of the body
Neuromuscular	Relating to, or affecting both nerves and muscles
Pressure ulcer	Also called a pressure sore or bed sore, is an area of tissue damage connected to issues of nutrition, mobility, continence, pain and infection control

Sacral	The sacrum is a large triangular bone at the base of the lower spine
Sepsis	A life-threatening illness caused by the body overreacting to an infection
Tissue Viability	The maintenance of skin integrity and the management of patients with acute and chronic wounds, prevention and management of pressure damage

Annex 3

List of legislation and policies considered

NHS Quality Improvement Scotland Best Practice Statement March 2009 – Prevention and management of pressure ulcers