Scottish Parliament Region: Highlands and Islands

Case 201004176: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; general nursing care; pressure sore

Overview

The complainant Ms C raised a complaint that, as a result of substandard care at Raigmore Hospital, she developed a large pressure sore during a period of recuperation following an operation.

Specific complaint and conclusion

The complaint which has been investigated is that Highland NHS Board (the Board) failed to prevent a pressure sore developing following Ms C's operation on 4 October 2010 *(upheld).*

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide the Ombudsman with evidence of current audit and monitoring in relation to pressure sore prevention and treatment. This should include relevant national initiatives, Clinical Quality Indicators and patient safety data;	31 December 2011
(ii) provide the Ombudsman with the current education and training programmes for the prevention and management of pressure sores;	31 December 2011
(iii) draw the report to the attention of nursing staff involved in Ms C's care; and	30 November 2011
(iv) provide a full apology to Ms C for the failures identified within this report.	30 November 2011

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

Main Investigation Report

Introduction

1. Ms C has spina bifida and significantly reduced sensation below the waist. She also has a left below-knee amputation and renal disease for which she has dialysis three times weekly. At the time of the operation she was awaiting a kidney transplant. At present she is still awaiting being placed on the transplant waiting list. She walks with the use of sticks and occasionally uses a wheelchair for mobility.

2. Ms C was admitted to hospital (the Hospital) on 3 October 2010 for an ileo-cystoplasty which was performed on 4 October 2010. She was admitted into Ward 5C (the Ward) on 6 October 2010 following a night in intensive care. The pressure sore was subsequently discovered on 15 October 2010. Ms C received treatment for the sore and was discharged on 18 October 2010, with arrangements for her to receive further treatment for the sore in the community from a district nurse. However, Ms C had to be re-admitted to the Hospital on 21 October 2010 for treatment to the sore as it had become infected. She remained in the Hospital for a further nine days.

3. Ms C complained to Highland NHS Board (the Board) on 22 November 2010 about the fact the pressure sore was able to develop during her stay in the Ward. She described how distressing and painful her experience was. She was also particularly concerned that the development of the sore may have impacted upon her being placed on the kidney transplant waiting list. The Board responded on 23 December 2010, however Ms C remained dissatisfied and complained to the Ombudsman on 28 February 2011.

4. The complaint from Ms C which I have investigated is that the Board failed to prevent a pressure sore developing following Ms C's operation on 4 October 2010.

Investigation

5. My complaints reviewer examined Ms C's medical and nursing records, and a copy of the Board's complaint file. She sought medical advice from a professional nursing adviser (the Adviser) on the nursing aspects of the case. She also considered the NHS Healthcare Improvement Scotland Standards for the Prevention and Management of Pressure Sores (the HIS Standards).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report. 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. The list of polices and standards referred to can be found at Annex 3.

Background

7. Ms C has a number of health difficulties which are detailed at paragraph 1. She was scheduled for an ileo-cystoplasty procedure on 4 October 2010. Following the surgery she spent a night in intensive care. She was thereafter transferred to the Ward on 6 October 2010 to recover and remained there for two weeks following the operation.

8. According to the nursing notes Ms C's pressure areas were checked on 6, 8 and 10 October 2010. The records from 10 October note 'sacrum red but intact'. No preventative measures such as a pressure relieving mattress or a positioning chart were implemented at this time. There were no further observations of the pressure areas noted until 15 October 2010 when a large sacral pressure sore was discovered on Ms C's left buttock. The sore was cleaned and dressed and Ms C was given a pressure relieving mattress on 17 October. She was subsequently discharged home on 18 October. Arrangements were put in place for Ms C to continue to receive treatment in the community from a district nurse who would clean and dress the sore daily.

9. Due to the severity of the sore Ms C was re-admitted back into the Hospital on 21 October into a different ward as the wound site had become infected. She remained in hospital for another nine days. She was examined by a plastic surgery nurse specialist and a treatment plan was implemented.

10. Although the sore has improved, at the current time it is yet to heal fully. Ms C continues to receive treatment in the community from a district nurse.

Complaint: The Board failed to prevent a pressure sore developing following Ms C's operation on 4 October 2010

11. Ms C complained to the Board on 22 November 2010 that the nursing staff at the Ward had failed to provide her with adequate care due to the fact a large sacral pressure sore was allowed to develop during her two week recovery period there. Ms C complained the sore was so severe she had to be re-

admitted to hospital on 21 October 2010 for further treatment, and remained there for nine further days. Subsequently Ms C had to receive treatment from a district nurse attending her home every day to dress the wound. She stated the sore had caused her serious pain and distress. She was also concerned about the delay the development of the sore may have caused in her being placed on the kidney transplant waiting list, given this was a new source of infection and she needed to be of good health to be considered for a transplant.

12. The Board responded to Ms C's complaint on 23 December 2010. They stated that the nursing records documented that her pressure areas were checked on 6, 8 and 10 October 2010, and that appropriate treatment was implemented immediately once the pressure sore was discovered. The Board also went on to say Ms C had shown reluctance to move due to her levels of discomfort, and had spent significant periods lying down in bed. The Board commented that 'it is not always possible to avoid pressure sores developing in every case and it is regrettable that this was the outcome you experienced'. Finally the Board said they had taken steps to ensure it learned from Ms C's experiences and that nursing staff would be updated on the use of risk assessment tools in relation to pressure sores and the use of pressure relieving aids.

13. Ms C was dissatisfied by the Board's response and complained to this office on 28 February 2011. She explained that she disagreed with the Board's comments about her reluctance to move; she felt this was not a true reflection of the situation – she had in fact wanted to move but did not feel there was enough nursing support to assist her in this. She stated she had also been told by the Hospital that due to the fact she was on dialysis and had other health difficulties her skin was soft and prone to breaking down. Ms C felt this was an excuse to explain away the fact the sore had developed to the size it was.

Advice received

14. The Adviser examined Ms C's clinical and nursing records for the duration of her stay in the Ward. She said that a fundamental part of the initial assessment of a patient upon admission is to examine the skin for integrity and any vulnerable areas, which should be documented in the records. The most common assessment tool for this purpose is the Waterlow Assessment which must be carried out within six hours of admission. This tool is also part of the SEWS chart. She noted the assessment had not been carried out at any point during Ms C's stay in the Ward. If it had been used the tool would have

identified whether Ms C was at high or medium risk of sores developing and actions could have been taken accordingly. Particularly taking into account the fact Ms C has spina bifida and significantly reduced sensation below the waist, she described the lack of assessment as a significant failing by the nursing staff.

15. The Adviser went on to consider the pressure area checks as documented within the nursing records and referred to by the Board in their response letter to Ms C. She did not consider these checks to be of adequate frequency or thoroughness. She stated that the HIS Standards were clear about the need to assess within six hours of admission and that there should be regular frequent checks thereafter. She noted there was an entry on 10 October which stated 'sacrum red but intact' yet still no action was taken. The Adviser considered that if preventative measures such as a specialised mattress or a positioning chart had been put in place at this stage then Ms C may not have gone on to develop the pressure sore.

16. The Adviser went on to say that she was highly critical of the nursing care and record-keeping given there were no records of checks between the 10 and 15 October 2010. She said it must be assumed from this that the pressure sore developed between these two dates. The Adviser referred to the Nursing and Midwifery Council Code which states that:

> 'You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been.'

17. My complaints reviewer asked the Adviser to comment on the stance of the Board that Ms C had been reluctant to move around and get out of bed. The Adviser said that even if Ms C had been reluctant to move because of her discomfort, more could have been done to prevent the pressure sore developing in the first place. She also noted that in the Board's response, they stated that 'these factors [spina bifida, renal disease and reduced below waist sensation] have the potential to increase tissue vulnerability'. This indicates the Board knew and have admitted that Ms C was at high risk of developing pressure sores.

18. The Adviser described the pressure sore which developed as 'significant' and suggested that its development may well have delayed the future care and

treatment of Ms C's renal problems, given that it acted as a source of infection and caused severe pain and distress to Ms C.

19. It was noted by the Adviser that once the pressure sore was discovered it was treated appropriately in that a pressure relieving mattress was provided, the sore was cleaned and dressed and a referral was made to the Plastic Surgery Service.

Conclusion

20. My investigation has established that the care Ms C received on admission to the ward fell well below an acceptable standard. The fact that there was no assessment of her pressure areas upon admission and no resultant action taken even when an issue with Ms C's skin was noted by a nurse on 10 October 2010 is unacceptable. As stated previously, if preventative measures had been taken earlier and there had been further checks of the pressure areas between 10 and 15 October 2010 there may have been a different outcome in this case.

21. These significant failings were compounded by the failure to take account of Ms C's other health difficulties which increased her risk of tissue vulnerability. Although the additional risk factors were acknowledged by the Board in their response to Ms C, this was not reflected in the care plan put in place for her. I also consider that the comment by the Board regarding the perceived lack of Ms C's willingness to move concerning given it takes no account of her health difficulties.

22. It is also important to recognise the impact that the pressure sore has had on the quality of Ms C's life. Pictures taken of the pressure sore show that it is of a significant size and severity. Ms C continues to receive treatment for it and she is not currently on the waiting list for a kidney transplant. The advice I have received is that the development of the pressure sore may well have delayed the future care and treatment of Ms C's renal problems and the Board have confirmed to my complaints reviewer that, as well as recurrent urinary infections, the development of the pressure sore has contributed to the delay given the extra risks associated with a large wound site and the effects of immune suppression on wound healing.

23. Given the significant failings identified in relation to the nursing care and standard of record-keeping in this case, I uphold the complaint. It is vital that

the Board takes action to ensure that a similar situation does not occur and I make the following recommendations.

Recommendations

24. The Ombudsman recommends that the Board:	*Completion date*
(i) provide the Ombudsman with evidence of current audit and monitoring in relation to pressure sore prevention and treatment. This should include relevant national initiatives, Clinical Quality Indicators and patient safety data;	31 December 2011
(ii) provide the Ombudsman with the current education and training programmes for the prevention and management of pressure sores;	31 December 2011
(iii) draw the report to the attention of nursing staff involved in Ms C's care; and	30 November 2011
(iv) provide a full apology to Ms C for the failures identified within this report.	30 November 2011

25. 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

Ms C	The complainant
The Hospital	Raigmore Hospital
The Ward	Ward 5C at Raigmore Hospital
The Adviser	The professional nursing adviser to the Ombudsman
HIS Standards	NHS Healthcare Improvement Scotland Standards
SEWS	Scottish Early Warning Scores

Annex 2

Glossary of terms

Dialysis	A medical process used when a person's kidneys are damaged and can no longer filter toxins from the blood; a dialysis machine filters the blood and infuses it back into the body
Ileo-cystoplasy	A bladder augmentation procedure
SEWS chart	Scottish Early Warning Scores chart, a patient observation chart designed to assist in the early detection and initiation of treatment in severe illness

Annex 3

List of policies and standards considered

NHS Healthcare Improvement Scotland Standards for the Prevention and Management of Pressure Sores – Best Practice Statement, March 2009

The Nursing and Midwifery Council Code – Standards of conduct, performance and ethics for nurses and midwives