Scottish Parliament Region: North East Scotland

Case 201101660: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; nursing care

Overview

The complainant (Mr C) complained about a significant pressure ulcer he developed after being admitted to Perth Royal Infirmary (the Hospital). Mr C said that the pressure ulcer affected his quality of life because he had to endure an extended period of bed rest.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C was provided with inadequate care and treatment which allowed him to develop a pressure ulcer (*upheld*); and

(b) there was a failure to deal with his complaint appropriately (*upheld*).

Redress and recommendation

The Ombudsman recommends that Tayside NHS Board:	*Completion date*
(i) ensure their tissue viability training programme provides education and training for the assessment, grading and treatment of pressure ulcers in line with national guidance;	14 November 2012
(ii) undertake an audit of wards within the Hospital to ensure pressure ulcer care and management is in line with national guidance and best practice; and	14 November 2012
(iii) provide details of the outcome of their review of their complaints procedure to ensure investigations are evidence based and undertaken without undue delay.	14 November 2012

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

Main Investigation Report

Introduction

1. On 1 February 2011, Mr C complained to Tayside NHS Board (the Board) about the care and treatment he received from Perth Royal Infirmary (the Hospital). The Board responded to the complaint on 26 July 2011. Mr C then complained to the Ombudsman's office on 2 August 2011 as he remained dissatisfied with the Board's response to the issues concerned.

2. Mr C has been tetraplegic for many years following a spinal cord injury. As a result, he is wheelchair-bound with some limited arm movement. Mr C was admitted to the Hospital on 7 November 2010 after falling from his wheelchair and causing fractures to just below both knees. Mr C was dependent on healthcare staff for the majority of his daily living needs, in particular for positioning, and transferring in and out of bed.

3. A pressure ulcer was first identified by staff at the Hospital on 10 November 2010 which was treated with a dressing and barrier cream. Mr C was discharged 12 days later and continued to be treated in the community by district nursing teams who identified that Mr C had a very significant pressure ulcer at the base of his spine. Photographs taken by the district nurse on 24 November 2010 clearly demonstrated a grade 3 (serious) pressure ulcer. Mr C was thereafter referred to a plastic surgeon on 22 December 2010 by his GP when the severity of the pressure ulcer further deteriorated.

4. The complaints from Mr C which I have investigated are that:

(a) Mr C was provided with inadequate care and treatment which allowed him to develop a pressure ulcer; and

(b) there was a failure to deal with his complaint appropriately.

Investigation

5. Investigation of this complaint involved obtaining and reviewing the Board's complaint correspondence alongside Mr C's correspondence and his clinical records. My complaints reviewer then sought the views of a specialist nursing adviser (the Adviser) who reviewed the clinical records in relation to the national guidelines in place at this time, including Quality Improvement Scotland, Royal College of Nursing, and the National Institute for Health and Clinical Excellence.

6. 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. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the terms used can be found at Annex 2 and a list of the legislation considered are in Annex 3.

(a) Mr C was provided with inadequate care and treatment which allowed him to develop a pressure ulcer

7. In response to Mr C's complaint, the Board outlined that Mr C was assessed as being at risk of developing a pressure ulcer and that a treatment plan was initiated. The Board referred to nursing staff having regularly repositioned Mr C but that at times he was uncooperative. The Board also commented on issues affecting the fragility of his skin such as wetness caused by perspiration and problems with the urinary sheath occasionally falling off.

8. The Board also advised Mr C that there were aspects of record-keeping that could be improved and this had been taken forward as a point of learning with the clinical teams who were involved in his care. The Board explained further to my complaints reviewer that the frequency of how regularly skin care checks should be undertaken was not recorded.

9. The Adviser advised my complaints reviewer that Mr C had a number of risk factors which placed him at high risk of skin damage. This included Mr C's limited ability to move himself or to feel any pain or discomfort in the lower half of his body. In addition, Mr C had episodes of illness whilst in the Hospital which would further compromise his pressure areas due to reduced oxygen supply to the tissues. Mr C also suffered occasional and prolonged sweating which can damage the skin in its most vulnerable areas. Furthermore, he experienced urinary problems when the sheath he used kept falling off and this led to further moisture on his skin.

10. The Adviser said that an appropriate risk assessment was carried out within six hours of Mr C's admission to the Hospital using a recognised assessment tool in line with national best practice guidance[1]. The Adviser

[1] Quality Improvement Scotland – Best Practice Statement, Prevention and Management of Pressure Ulcers 2009; and Royal College of Nursing – Pressure Ulcers Prevention and Treatment

explained that the assessment correctly placed Mr C at high risk of developing a pressure ulcer and noted that there was no evidence of any skin damage at this time. The assessment was also reviewed at appropriate regular intervals in line with the national guidance. Therefore, according to the Adviser, an initial care plan was appropriately implemented on admission to the Hospital to prevent a pressure ulcer. This included the use of a bed with a specialised air mattress, regular repositioning and timed skin inspections. Staff also appropriately carried out a moving and handling assessment.

11. The Adviser said that up until 9 November 2010, there was evidence that Mr C's pressure areas were inspected at regular intervals, his position altered and his nutrition assessed. However, on 9 and 10 November 2010, there appeared to be gaps of 16 to 18 hours of these checks and altered positioning being carried out and this was not in accordance with either the Board's care plan or the national guidance.

12. The clinical records documented that Mr C's pressure areas were intact until 10 November 2010 when he was in the High Dependency Unit (HDU). At this time, four small broken areas and two small blisters were documented and noted to be superficial at the base of the spine. The Adviser commented that although there was further evidence of good nursing practice when staff discussed Mr C's skin discolouration with his carer and that they needed to turn him regularly, the pressure ulcer should have been fully assessed and categorised according to the national guidance.

13. The national guidance categorises pressure ulcers into four levels of injury, with grade 1 being the least serious and 4 being the most serious. According to the Adviser, the description of Mr C's pressure ulcer on 10 November 2010 suggested a grade 2 pressure ulcer but no grade was noted in the clinical records. The Adviser highlighted that there was evidence of deterioration in Mr C's skin when it was described as dusky on 12 November 2010, which can be a sign of deep tissue damage. The Adviser further commented that there was little evidence to support any proper description of the pressure ulcer between 10 and 15 November 2010 when a wound chart was started. The pressure ulcer was described as measuring five inches in diameter which suggested a significant lesion but again no grading was recorded. There was no record of it having being graded to assess the level of tissue damage until 21 November 2010 when a grade 2 was noted.

14. The Adviser was unable to clearly identify the precise condition of Mr C's pressure ulcer until he provided photographs that the district nurse had taken on 24 November 2010 which showed a significant grade 3 ulcer. Entries in the clinical records on 18 and 21 November 2010 indicated that the area appeared to be improving but, according to the Adviser, this in no way matched the photographs taken three days later. Therefore, the Adviser considered that the grade 2 ulcer referred to on 21 November 2010 was inaccurate as it did not correspond with the description of the wound being five inches in diameter nor the photographs taken by the district nurse.

15. The Adviser considered that the nursing staff underestimated the deterioration in Mr C's pressure ulcer and did not appreciate the seriousness of the wound.

16. The Royal College of Nursing guidance states that all pressure ulcers of grade 2 and above should be reported as a local clinical incident but this did not happen in Mr C's case. In addition, the Adviser could not find evidence of any discharge handover information regarding Mr C's pressure ulcer to the community nursing teams.

17. The Adviser commented that the clinical records reflected that staff were challenged at times in managing Mr C, in that he sometimes refused to be repositioned and declined a urinary catheter when incontinence became a problem. The Adviser said that both of these factors would have impacted on the fragility of his skin.

18. Therefore, the Adviser considered whether alternative management would have prevented the pressure ulcer deteriorating to the level it did. Although staff made attempts to alter Mr C's position in bed, it is possible that had contact been made with a specialist tissue viability nurse, additional interventions may have been implemented. The national guidance[2] states:

> 'Patients/clients with extensive superficial pressure ulcers, grade 3 or 4 pressure ulcers or those that are deteriorating are referred to a specialist service such as a tissue viability service'

[2] Quality Improvement Scotland, Section 7

19. The Adviser is in no doubt that the pressure ulcer was at a grade 3 prior to discharge on 22 November 2010 and that referral to a tissue viability nurse should have happened in line with the national guidance.

20. Whilst the Adviser also said that using incontinence pads carry the risk of skin damage if they are not replaced regularly or checked for creases, there was no documented plan of care to manage Mr C's urinary incontinence. Furthermore, while there was evidence to support that staff were monitoring Mr C's fluid and food intake, the National Institute for Health and Clinical Excellence guidance refers to the need to consider additional nutritional support for vulnerable patients. Therefore, food charts would have been helpful for staff to know exactly what Mr C was eating as there were times when he ate a limited diet and the reason for this was unclear. It may have also helped Mr C and supported staff if a discussion with a dietician had taken place to explore the possibility of adding nutritional supplements to his diet.

21. The Adviser concluded that the standard of pressure ulcer management after 10 November 2010 fell below the national standards due to a knowledge-skills gap in terms of the assessment of the pressure ulcer.

22. Although the Board provided evidence to my complaints reviewer in relation to improvement work around pressure ulcer prevention for critical care services, the Adviser said that there was no other information about any monitoring systems in place to measure standards of pressure ulcer cases across the Board.

(a) Conclusion

23. Whilst the nursing staff properly recognised Mr C's risk of developing a pressure ulcer, and made efforts to minimise further skin injury when an ulcer developed, there is clear evidence to support that they did not identify and grade the seriousness of the wound and take the most appropriate action in line with national guidance. As a consequence, Mr C endured many months of prolonged care from the community nurses and had to be referred to a plastic surgeon for further treatment.

24. In view of all the above, I uphold the complaint.

(a) Recommendations

25. I recommend that the Board:	*Completion date*
(i) ensure their tissue viability training programme provides education and training for the assessment, grading and treatment of pressure ulcers in line with national guidance; and	14 November 2012
(ii) undertake an audit of wards within the Hospital to ensure pressure ulcer care and management is in line with national guidance and best practice.	14 November 2012

(b) There was a failure to deal with his complaint appropriately

26. Mr C complained that the complaint response from the Board made no mention of any creams applied to the pressure ulcer, the type of dressing applied, or the condition of his skin when the dressing was removed.

27. Although the Board's complaint response accurately reflected what was in the clinical record, the Adviser commented that it did not provide the rationale for some of the actions taken by ward staff. In particular Mr C was informed that the nurse who discovered the broken areas and blisters on 10 November 2010 did not feel that the condition of the skin met a grade 1 pressure ulcer. The Adviser is of the opinion that the Board should have recognised that this assessment was flawed as the nurse clearly described the pressure ulcer as a grade 2.

28. In addition, the Board's response did not acknowledge that Mr C was discharged with a significant pressure ulcer which had not been graded nor did they give him sufficient information about the actual treatment of the pressure ulcer, its progression or whether staff considered consulting a specialist tissue viability nurse. The Adviser considered that this was because the staff did not recognise the severity of the pressure ulcer.

29. My complaints reviewer also noted that the Board took around five months to respond to Mr C's complaint. In various letters updating Mr C on the progress of his complaint between March and July 2010, the Board apologised and explained that the delay was a result of waiting to receive information from one of the clinical areas, staff shortages and the complexity of the complaint.

30. Guidance on the NHS Complaints Procedure issued by the Scottish Parliament at this time stated:

'The investigation of a complaint should be completed wherever possible within 20 working days following the date of receipt of the complaint. Where it appears the 20 day target will not be met, the complainant must be informed of the reason for the delay with an indication of when a response can be expected. The investigation should not normally be extended by more than a further 20 working days.'

31. My complaints reviewer asked the Adviser whether the clinical nature of the complaint was complex in anyway to have impacted on the length of time the Board took to respond to the complaint. The Adviser commented that the issues relating to pressure ulcer prevention and management are straightforward and that Mr C did not have a long hospital admission.

32. The Board have since advised my complaints reviewer that the delay in providing a response to Mr C's complaint was unacceptable and provided detailed information on areas of their complaints procedure they planned to review.

(b) Conclusion

33. Our Statement of Complaints Handling Principles (the Principles) sets out various elements for an effective complaints handling procedure. In particular, it sets out that conclusions should be based on the facts and circumstances established and this should be clearly demonstrated. I consider that the Board's response did not take full account of the evidence Mr C provided of his pressure ulcer along with the information documented in his clinical records.

34. In addition, an effective complaints procedure should aim to resolve complaints at the earliest opportunity. Although Mr C was updated on several occasions about the progress of his complaint and given an explanation for the delay, I consider five months to be an inappropriate length of time to investigate this complaint. Therefore, I uphold the complaint.

(b) Recommendation

35. I recommend that the Board:	*Completion date*
(i) provide details of the outcome of their review of their complaints procedure to ensure investigations are evidence based and undertaken without undue delay.	14 November 2012

36. 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 C	The complainant
The Board	Tayside NHS Board
The Hospital	Perth Royal Infirmary
The Adviser	A specialist nursing adviser to the Ombudsman
The Principles	The Scottish Public Services Ombudsman Statement of Complaints Handling Principles, 2011

Annex 2

Glossary of terms

Tetraplegic	also referred to as quadriplegic or paraplegic. It describes somebody who as damaged the spinal-cord in the neck region resulting in complete or semi-paralysis to all four limbs

Annex 3

List of legislation and policies considered

Quality Improvement Scotland, Prevention and Management of Pressure Ulcers 2009

Royal College of Nursing, Pressure Ulcers Prevention and Treatment

National Institute for Health and Clinical Excellence Nutrition Support in adults, 2006

The Scottish Public Services Ombudsman Statement of Complaints Handling Principles, 2011