SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
4 Melville Street
Edinburgh
EH3 7NS

Tel **0800 377 7330**
SPSO Information **www.spso.org.uk**
SPSO Complaints Standards **www.valuingcomplaints.org.uk**

Scottish Parliament Region: Glasgow

Case ref: 201402113, Greater Glasgow and Clyde NHS Board - Acute Services Division
Sector: Health
Subject: Hospitals: clinical treatment; diagnosis

Summary
Mrs C was admitted to Glasgow Royal Infirmary in January 2013 to get treatment for a skin infection in her left leg. Mrs C has spina bifida (a condition where the spine does not develop properly, leaving a gap in the spine) and lymphoedema (a build-up of fluid which causes swelling in an area of the body) which means that she has problems moving around. She developed pressure ulcers on her left heel and calf, which were still there when she was discharged. When she got home, Mrs C also found that a pressure ulcer had developed on her buttock. She was readmitted to the hospital in February 2013 as one of the pressure ulcers was infected, and discharged a few weeks later. She was again admitted in December 2013.

Mrs C felt that, each time she was admitted to the hospital, her risk of pressure ulcers was not properly assessed and that, due to her existing medical conditions, she should have been placed in the 'very high risk' category. She said that the pressure ulcers developed because of the incorrect assessment and due to a lack of appropriate care. She said that she had suffered a great deal of pain and discomfort, as well as scarring, which continued to cause her distress. With the help of an advice worker, Mrs C complained to the board.

The board apologised that Mrs C felt that her pre-existing medical conditions were not taken into account. They set out the timeline of events across her three admissions to hospital, stating that she had been assessed as requiring a low level of support. When she had needed a pressure-relieving mattress when she left hospital on the second occasion, they said that this had been provided.

They said that she was assessed by a district nurse at home and continued to receive treatment for a pressure ulcer at the base of her spine until the end of July 2013. The board said that the readmission notes for Mrs C's third admission to hospital state that her skin was healthy and, although she had previously developed pressure ulcers when she was unwell, she did not require pressure-relieving equipment because she was assessed as being able to

adjust her own weight whilst in bed. The board said it was documented that Mrs C's husband (Mr C) had insisted that a pressure-relieving mattress was ordered for Mrs C, and he had been extremely unhappy that one had not been provided. Finally, they said that staff had carefully considered Mrs C's condition and treatment, and they were sorry that she had been dissatisfied with her care in the hospital.

Mrs C was dissatisfied with the board's response to her complaint and contacted my office, with the help of an advice worker. I took independent advice from a nursing adviser who considered that, as Mrs C has spina bifida, she was at very high risk of developing pressure ulcers during her admissions to hospital. The adviser found no evidence that the nursing staff took Mrs C's pre-existing conditions into account or put steps in place to prevent pressure ulcers occurring. In particular, the Waterlow risk assessment charts (a pressure ulcer risk assessment tool) completed for each hospital admission were not marked properly. The adviser said that, as Mrs C has reduced sensation below the waist (because of spina bifida), she should have had five extra points added to her Waterlow score. This would have put her into the 'high risk' category. During the second hospital admission, the adviser considered that the delay of several days for a tissue viability nurse to provide advice on Mrs C's care, and for a pressure-relieving mattress to be arranged, was unacceptable. The adviser also noted that the nursing staff involved in an incident when Mr C was very angry about Mrs C's treatment and the delays experienced may benefit from education and training in front-line resolution. The adviser also found it 'shocking' that the board had not determined and admitted their failings in Mrs C's care and treatment when they investigated her complaint.

The advice I have received is that nursing staff failed to take into account Mrs C's specific needs due to her spina bifida and, as a result, failed to appropriately assess and manage her pressure areas on each of her admissions to the hospital. There was also a failure by the board to acknowledge these failings while carrying out their investigation of Mrs C's complaint. I am critical of these failings and uphold the complaint.

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review the training for nursing staff on the assessment, prevention and care of pressure	26 October 2015

	ulcers, particularly where a patient has reduced sensation to the limbs;	
(ii)	ensure the tissue viability team review the mechanism for recording patients who are 'special risk', particularly patients with reduced sensation such as spina bifida;	26 October 2015
(iii)	carry out a review of the reasons why there was a delay in the involvement of the tissue viability team in Mrs C's care; and advise this office of the action taken to ensure that lessons are learned from this complaint;	26 October 2015
(iv)	review the education and training in early resolution skills for the nursing staff involved when dealing with patients and their families who have raised concerns about their care and treatment; and	26 October 2015
(v)	apologise to Mrs C for the failings identified in her care and treatment.	28 September 2015

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C, who has spina bifida, complained to the Ombudsman about the care and treatment she received in relation to her pressure care needs on three separate occasions while she was a patient in Glasgow Royal Infirmary (the Hospital) between January and December 2013. Mrs C was assisted in bringing her complaint to my office by the Citizens Advice Bureau. The complaint from Mrs C I have investigated is that Greater Glasgow and Clyde NHS Board (the Board) failed to appropriately assess her pressure care needs (*upheld*).

Investigation

2. In order to investigate Mrs C's complaint, my complaints reviewer examined all information provided on Mrs C's behalf by the Citizens Advice Bureau, a copy of her clinical records and the Board's complaint file. My complaints reviewer also obtained independent advice from a nursing adviser (the Adviser) on the nursing aspects of the complaint. In this case, we have decided to issue a public report on the complaint because the failings I found led to a significant personal injustice to Mrs C, and also because of the failure by the Board to acknowledge these failings while carrying out their investigation of Mrs C's complaint.

3. I have not included in this report every detail investigated but 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: The Board failed to appropriately assess Mrs C's pressure care needs

Background

4. Mrs C has spina bifida and lymphoedema which she said restricts her mobility to a considerable degree. Mrs C considered the Board failed to take these conditions into account and nursing staff were generally disinterested in her care on the three occasions, in particular during her first admission, when she was a patient in the Hospital. Mrs C believed that, due to a lack of care, she developed pressure ulcers. Mrs C said she felt strongly that the Waterlow risk assessment, a pressure ulcers risk assessment tool, was never administered correctly and she was given an incorrect score on each of her admissions. Mrs C was of the view that had her spina bifida been taken into account, she would have been placed in the 'very high risk' category. Mrs C said she had suffered a great deal of pain and discomfort as well as scarring,

which still causes her distress on a daily basis, as a result of developing pressure ulcers and this had also caused her family significant distress and worry.

5. Mrs C was dissatisfied with the Board's response to her complaint. Mrs C said she was seeking an acknowledgement of the errors which she said had occurred during her admissions and for a change in the Board's practices and procedures so that other patients were not subject to the inappropriate treatment she considered she had received.

First admission (21 January 2013)

6. Mrs C explained that she developed cellulitis, a skin infection, in her left leg and she was admitted to the Hospital on 21 January 2013. Mrs C was a patient in Ward 23. Mrs C said she considered that her pre-existing medical conditions, spina bifida and lymphoedema, were not taken into account by nursing staff. In particular, Mrs C said she was not provided with a pressure mattress; she was not monitored for pressure ulcers; and no action was taken to ensure she was regularly moved, even though she had mobility problems. Mrs C also questioned whether a Waterlow risk assessment was carried out correctly.

7. Mrs C said that although nursing staff were aware she struggled to get in and out of bed due to her left leg being very swollen, the height of the bed being too high for her and the bed brakes being faulty, no action was taken to assist her or to deal with the problems with the bed.

8. Mrs C also said that, due to her lack of mobility and lack of sensation caused by her spina bifida, she developed pressure ulcers on her left heel and her left calf. However, according to Mrs C, although nursing staff were aware of this they took no action and as a result she still had the pressure ulcers when she was discharged on 1 February 2013. Mrs C further said she was unaware she had developed a large pressure ulcer on her buttock. It was only when she returned home following her discharge this became apparent.

Second admission (6 February 2013)

9. Mrs C required to be readmitted to the Hospital on 6 February 2013. Mrs C said this was because the pressure ulcer she had developed during her previous admission in January 2013 had become infected. Mrs C remained a patient there until 6 March 2013.

10. Mrs C said that, following her discharge, she required daily treatment at home from district nursing staff, who she said told her the pressure ulcer on her buttock was a 'top end grade 4' and had caused her permanent disfigurement. As a result, Mrs C said she required the use of a hospital bed with a pressure relieving mattress at home for several months thereafter and was advised by district nursing staff she had to stay in bed for 22 hours per day. Mrs C said she believed what happened to her could and should have been avoided and had she been provided with appropriate care during her first admission in January 2013, she would not have required the second admission on 6 February 2013.

11. Mrs C also said that on discharge she was offered a pressure relieving cushion to take home with her. Mrs C explained when in the Ward she was given pressure relieving boots to protect her heels which could only be used while she was in bed. However, Mrs C said she had declined to take the boots home when she was discharged because she had difficulty turning in bed when using the boots and the tissue viability nurse had told her that she did not need to use them at home as long as she lay on her side. Mrs C said this had been explained to the nursing staff prior to her discharge.

Third admission (12 December 2013)

12. Mrs C was admitted to the Hospital again on 12 December 2013. Mrs C said that on this admission she had explained to staff her previous experiences during her first and second admissions and that the tissue viability nurse had previously told her she had to be provided with pressure relieving equipment, including a pressure relieving mattress, when in the Hospital. However, Mrs C said she was initially told by nursing staff that she did not meet the criteria for a pressure relieving mattress and she was only provided with this type of mattress when her husband (Mr C) insisted. Mrs C also said her Waterlow risk assessment was again not carried out appropriately.

The Board's response

13. The Citizens Advice Bureau complained on Mrs C's behalf to the Board in relation to her concerns about her care and treatment on 24 June 2013 and 18 March 2014. Written responses were sent by the Board to the Citizens Advice Bureau on 20 August 2013 and 15 May 2014.

14. In their response, the Board apologised that Mrs C had felt her pre-existing conditions were not taken into account and that staff had generally been disinterested in her care while she was on Ward 23. The Board stated that, following treatment for a left leg cellulitis, Mrs C's leg was much improved although the leg remained inflamed when she was discharged. According to the Board, Mrs C had been assessed as requiring a low level of support to her pressure areas, being able to self-care while in the Ward and was at low risk of falling. The Board said there was no documentation in Mrs C's clinical records that a pressure ulcer was evident during her admission in Ward 23. The Board said the beds used in the Ward were variable height beds and could easily be adjusted. The Board also said that staff did not recall any reported problems with Mrs C's bed and there was no record of a broken bed being reported at the time.

15. The Board explained that the Waterlow assessment system is NHS Scotland's recommended tool for pressure care assessment of patients, which assessment is routinely undertaken within 24 hours of a patient's admission and then repeated, as required, throughout the patient's stay in hospital. The Board said the process is individual to patient requirements and takes into account the gender of the patient, age, body mass index, continence, skin type, mobility, nutritional elements and if there are any special risks. This is then scored into categories of 'at risk', 'high risk' and 'very high risk'. The Board said that the completion of assessments was also subject to review.

16. The Board stated that, on Mrs C's readmission on 6 February 2013, the referral letter for admission from her GP stated she had marked cellulitis surrounding a pressure ulcer. It was documented in her readmission notes that she had 'noticed pain in lower back/buttock area for three days, thought must have bumped into something'. It was also noted Mrs C had a cellulitis to the left buttock, with broken skin at pressure points.

17. According to the Board, staff on Ward 8, where Mrs C was admitted following her second admission, liaised with district nursing staff and arranged for a pressure relieving mattress and pressure relieving boots to be given to Mrs C following her discharge, although she had not accepted the boots. The Board said it was documented in Mrs C's medical records that staff had explained to Mrs C the importance of using a pressure relieving mattress at home and a bed was ordered by the district nurse for her use at home. The Board stated that Mrs C was assessed by the district nurse following her

discharge from Ward 8 on 6 March 2013 and it was noted she had a grade 4 sacral sore, for which she received treatment until the end of July 2013.

18. In respect of Mrs C's third admission on 12 December 2013, the Board said that on her admission to Ward 53 it was noted Mrs C's skin was healthy and intact; she had previously developed pressure ulcers when she was unwell; and she was able to adjust her weight while she was in bed. The Board also stated that, as Mrs C was assessed as being able to adjust her own weight, she did not require pressure relieving equipment at that time. The Board said that when Mrs C was transferred to Ward 4 it was documented in her records that Mr C had spoken with nursing staff on 13 December 2013, as he was extremely unhappy that a pressure relieving mattress had not been provided for Mrs C. According to the Board, although the Ward staff nurse had informed Mr C that Mrs C did not require this type of mattress, a mattress was ordered because Mr C had insisted.

19. The Board also said that Mrs C's Waterlow risk assessment was partially undertaken in Ward 53 and completed while she was in Ward 4. It had been recorded that Mrs C's pressure areas were intact throughout this admission and there was no evidence of the pressure ulcers on Mrs C's heel and calf muscle.

20. The Board concluded that staff had carefully considered Mrs C's condition and treatment and were sorry she had been dissatisfied with her care while a patient in the Hospital.

Advice obtained

21. The Adviser explained to me that because Mrs C has spina bifida, she does not have the usual sensation in the pressure points of her body (her buttocks, heels, elbows) and she requires regular and frequent reduction of pressure on these points. The Adviser, therefore, considered that during each of Mrs C's three admissions to the Hospital she was at very high risk of developing pressure ulcers.

22. The Adviser was of the view, from her review of Mrs C's medical records, that nursing staff had failed to take Mrs C's particular needs into account during her three admissions to the Hospital. In particular, the Adviser could find no evidence that Mrs C having spina bifida had been particularly taken into account by the nursing staff on each of the admissions.

23. The Adviser told my complaints reviewer that, although it appeared Mrs C was able to care for most of her needs while in the Hospital, she considered the nursing staff should have been aware of the importance of assessing Mrs C and putting steps in place to prevent pressure ulcers occurring. The Adviser said that there was no evidence this had happened. The Adviser, therefore, considered the personalised care Mrs C had received on each admission was inadequate.

24. The Adviser also told my complaints reviewer that the Waterlow assessments completed on each of Mrs C's admissions did not appear to be accurate because Mrs C's reduced sensation below the waist did not appear to have been taken into account. Therefore, the Adviser considered Mrs C was given an incorrect score on each of her admissions. As evidence of this, the Adviser referred me to the special risks section of a completed Waterlow pressure area risk assessment chart in Mrs C's records. The Adviser told my complaints reviewer that this had not been marked as it should have been. The Adviser explained to my complaints reviewer that account should have been taken of Mrs C's reduced sensation below the waist. If it had, this would have resulted in another five points being added to Mrs C's Waterlow score and would have put her into the 'high risk' category. The Adviser considered the Board should, therefore, provide evidence of what steps were in place to take account of patients with reduced sensation, including patients such as Mrs C with spina bifida, when carrying out a Waterlow assessment.

25. The Adviser also highlighted that although on Mrs C's second admission in February 2013 she had a pressure ulcer on her buttock, it took days to arrange for a pressure relieving mattress for Mrs C. The Adviser considered this type of mattress should have been provided for Mrs C on her admission. The Adviser was also concerned that when Mrs C's pressure ulcer deteriorated, although nursing staff requested advice from a tissue viability nurse on 11 February 2013, the tissue viability nurse did not become involved with Mrs C's care until 19 February 2013. Although the Adviser noted that once the tissue viability nurse became involved the relevant advice was given and treatment was started, such as charting position changes and pressure relieving measures used, the Adviser was of the view that much of the advice should have been provided sooner. The Adviser considered the delay involved was unacceptable.

26. The Adviser noted that on 18 February 2013, there was an incident when Mr C was very angry with staff concerning Mrs C's treatment and the delay in providing input from the tissue viability team. This had resulted in an escalation of his concerns to the lead nurse. The Adviser considered Mr C's frustration and concern for Mrs C was understandable, given the length of time she had to wait for a pressure relieving mattress and to be seen by the tissue viability nurse. The Adviser told my complaints reviewer that the nursing staff involved may benefit from education and training in front-line resolution to deal with this kind of situation.

27. Overall, the Adviser was of the view Mrs C did not receive the level of monitoring and nursing care she would have expected her to receive, given that she had spina bifida, and there had been a failure in the Waterlow assessments carried out. As a result, the Adviser said Mrs C had required to spend long and protracted periods of time in the Hospital.

28. The Adviser also told my complaints reviewer she found it 'shocking' that the Board had not determined and admitted their failings in Mrs C's care and treatment when they investigated her complaint.

Decision

29. The advice I have received is that nursing staff failed to take into account Mrs C's specific needs due to her spina bifida and, as a result, failed to appropriately assess and manage her pressure areas on each of her admissions to the Hospital. In particular, I acknowledge the failings in relation to the Waterlow risk assessment carried out during each of Mrs C's admissions and the unacceptable delays in obtaining advice from the tissue viability team and providing Mrs C with pressure relieving equipment. I am critical of these failings.

30. I also acknowledge the critical comments of the Adviser concerning the Board's failure to determine and admit these failings when they investigated Mrs C's complaint.

31. For these reasons, I uphold the complaint.

32. I have, therefore, made the following recommendations, which include a recommendation that the Board should apologise to Mrs C.

Recommendations

33. I recommend that the Board:	*Completion date*
(i) review the training for nursing staff on the assessment, prevention and care of pressure ulcers, particularly where a patient has reduced sensation to the limbs;	26 October 2015
(ii) ensure the tissue viability team review the mechanism for recording patients who are 'special risk', particularly patients with reduced sensation such as spina bifida;	26 October 2015
(iii) carry out a review of the reasons why there was a delay in the involvement of the tissue viability team in Mrs C's care; and advise this office of the action taken to ensure that lessons are learned from this complaint;	26 October 2015
(iv) review the education and training in early resolution skills for the nursing staff involved when dealing with patients and their families who have raised concerns about their care and treatment; and	26 October 2015
(v) apologise to Mrs C for the failings identified in her care and treatment.	28 September 2015

34. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
the Hospital	Glasgow Royal Infirmary
the Board	Greater Glasgow and Clyde NHS Board
the Adviser	the Ombudsman's nursing adviser
Mr C	the husband of Mrs C

Annex 2

Glossary of terms

cellulitis	a bacterial skin infection
lymphoedema	a build-up of fluid which causes swelling in an area of the body
pressure ulcer	an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure
sacral	relating to or lying near the sacrum, the large bone at the base of the spine
spina bifida	a condition present at birth where the spine does not develop properly, leaving a gap in the spine

Annex 3

List of legislation and policies considered

Royal College of Nursing - Nursing Standard, Pressure Ulcer treatment in a patient with Spina Bifida 2014, 28 (35): 60-69

Healthcare Improvement Scotland Best Practice Statement – Prevention and management of pressure ulcers