SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: North East Scotland

Case ref: 201800964, Grampian NHS Board
Sector: Health
Subject: Hospitals / Clinical treatment / diagnosis

Summary
Mrs C complained about the care and treatment given by Grampian NHS Board (the Board) to her late mother (Mrs A) during the period after she had a coronary artery bypass graft (a surgical procedure to treat coronary heart disease) and an aortic (heart) valve replacement in December 2016, until her death in March 2017.

Mrs A had a history of type 2 diabetes and after her operation she experienced significant delirium and a stroke. Her leg wound also broke down and became infected. Because of her changing and deteriorating symptoms, Mrs A moved on a number of occasions between Aberdeen Royal Infirmary (ARI) and Woodend Hospital. Regrettably, Mrs A's condition deteriorated and she died in March 2017.

Mrs C was unhappy with Mrs A's care and treatment and complained to the Board. They said that her case had been a complex one and that although her outcome had been poor, Mrs A had been treated by appropriate specialists and that management decisions made at each stage of her illness appeared to have been reasonable.

We took independent advice from a consultant geriatrician and from a registered nurse specialising in tissue viability. We found that while she was in ARI some of Mrs A's post-operative problems could have been expected in someone with her complex health and overall frailty. However, insufficient attention had been paid to her symptoms of delirium in relation to her more surgical complications despite them causing Mrs A significant distress. We also found that the Board's own pressure ulcer prevention and management pathway had not been followed; there were delays in referring Mrs A to the tissue viability team, her wounds were not attended to frequently enough and inappropriate dressings were used.

While we found that Mrs A's medical care improved when she was initially transferred from ARI to Woodend Hospital for rehabilitation and more attention

was paid to her delirium, the nursing care of her leg wound remained extremely poor and caused Mrs A pain and distress which were all avoidable.

Finally, we found that there had been a lack of information given to the family by ARI about Mrs A's delirium and little to no evidence of discussion between nursing staff and the family. This was an extremely distressing time for Mrs A which was compounded by a lack of information.

We upheld Mrs C's complaints and made a number of recommendations to address the failings identified.

Redress and Recommendations

The Ombudsman's recommendations are set out below:

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	Mrs A's post -operative care in ARI fell below a level she and her family could have expected; there was a lack of attention to her delirium management and her wounds and pressure ulcer were not treated appropriately	Apologise to Mrs C for the failure of ARI to give proper care and attention to the symptoms of Mrs A's delirium and to her wounds	A copy or record of the apology made By: 17 May 2019.
(b)	While she was a patient in Woodend Hospital, the attention paid to Mrs A's leg wound and sacral pressure sore remained poor: no referral was made to Tissue Viability; her leg wound was not dressed with appropriate products; a review did not take place until 16 February 2017; important documentation (the Applied Wound Management Chart) was not completed. Similarly, her sacral pressure sore did not receive appropriate and reasonable attention	Apologise to Mrs C for the failure of Woodend Hospital to give Mrs A's leg wound and sacral pressure sore the required care and treatment	A copy or record of the apology made By: 17 May 2017.
(c)	The level of communication with Mrs A's family was not what they could have reasonably expected	Apologise to Mrs C for the failure of Board staff to communicate reasonably and appropriately	A copy or record of the apology made By: 17 May 2019.

We are asking The Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	Mrs A's post-operative care in ARI fell below a level she and her family could have expected; there was a lack of attention to her delirium management and her wounds and pressure ulcer were not treated appropriately	Proper care and attention should be given to the symptoms of delirium. The Board should follow the Health Improvement Scotland (HIS) Standards for the prevention and management of pressure ulcers; staff should have wound knowledge of how to assess and dress a wound appropriately and be aware when to refer to the Tissue Viability Service	Evidence that the Board are improving the care of patients with delirium. Also evidence that they have taken measures to improve the clinical knowledge of the staff concerned in relation to pressure ulcers, wound management and referrals to the Tissue Viability team By: 17 July 2019
(b)	While she was a patient in Woodend Hospital, the attention paid to Mrs A's leg wound and sacral pressure sore remained poor: no referral was made to Tissue Viability; her leg wound was not dressed with appropriate products; a review did not take place until 16 February 2017; important documentation (the Applied Wound Management Chart) was not completed. Similarly, her sacral	Proper care and attention should be given to the symptoms of delirium in line with HIS Scotland Standards for the management of delirium. The Board should follow the HIS Standards for the prevention and management of pressure ulcers; staff should have wound knowledge of how to assess and dress a wound	Evidence that the Board are improving the care of patients with delirium. Also evidence that they have taken measures to improve the clinical knowledge of the staff concerned in relation to pressure ulcers, wound management and referrals to the Tissue Viability team By: 17 July 2019

Complaint number	What we found	Outcome needed	What we need to see
	pressure sore did not receive appropriate and reasonable attention	appropriately and be aware when to refer to the Tissue Viability Service	
(c)	The level of communication with Mrs A's family was not what they could have reasonably expected	Particularly where there are capacity issues, staff should communicate with family members in a reasonable and appropriate manner	All staff who were involved in Mrs A's care and treatment were made aware of the outcome of this report and were reminded of their obligations to communicate clearly with family members By: 17 May 2019

We are asking The Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a) and (b)	The Board's investigation failed to identify the significant failures in Mrs A's care, in particular, in relation to the management of her delirium and her wound/pressure ulcer	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and learning from complaints are used to drive service development and improvement	Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in investigating Mrs C's complaints and that they have reflected on the findings of this investigation. (For instance, a copy of a meeting note or summary of a discussion) By: 17 July 2019

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 and her late mother is Mrs A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. Mrs C complained to me about Grampian NHS Board (the Board) and the care and treatment given to her late mother (Mrs A) during the period after she had a coronary artery bypass graft (a surgical procedure to treat coronary heart disease) and an aortic (a heart) valve replacement in December 2016, until her death in March 2017. The complaints I investigated were that:

a) the care and treatment given to Mrs A in Aberdeen Royal Infirmary were unreasonable (upheld);

b) the care and treatment given to Mrs A in Woodend Hospital were unreasonable (upheld); and

c) communication with Mrs A's family was unreasonable (upheld).

Investigation

2. With my complaints reviewer, I have considered carefully all the information provided by Mrs C and the Board including:

the complaints correspondence; and

Mrs A's relevant clinical records and photographs;

3. I obtained independent advice from a consultant geriatrician (Adviser 1) and from a registered nurse specialising in tissue viability (Adviser 2). This was also taken into account.

4. I have decided to issue a public report into Mrs C's complaint due to the significant personal injustice suffered by Mrs C and Mrs A and because of the wider learning that may be available to other health boards who are treating elderly patients after surgery like Mrs A. My report highlights significant failures in the management of Mrs A's delirium and pressure ulcer care. In particular I have found that, had Mrs A received reasonable care, she and her family would have been spared a distressing and painful final few weeks. Mrs A was entitled to die in a dignified way and sadly this did not happen.

5. This is not the first time I have made findings similar to those set out in this report: I made similar findings in respect of this Board in another recently published report (ref: 201701938). As I also consider there to be potential learning for all Boards I will bring this report to the attention of the Chief Medical Officer for Scotland.

6. This report includes the information required for me to explain the reasons for my decision on this case. Please note that I have not included every detail of the information considered but I confirm that all the information available during the investigation has been reviewed. Mrs C and the Board were both given an opportunity to comment on a draft of this report.

Background

7. Mrs A, who had a history of type 2 diabetes, was admitted to Aberdeen Royal Infirmary (ARI) on 29 November 2016 with chest pain. However, she was discovered to have severe aortic stenosis and ischaemic heart disease (coronary arteries become narrowed by a gradual build-up of fatty material within their walls). She remained in hospital and had a coronary artery bypass graft and aortic valve replacement surgery on 22 December 2016.

8. Afterwards, Mrs A experienced significant delirium and an occipital (referring primarily to the part of the brain concerned with vision) stroke. Her leg wound also broke down and became infected.

9. In the meantime, Mrs A moved between ARI and Woodend Hospital, Aberdeen. She was transferred to Woodend Hospital on 19 January 2017 for rehabilitation but was readmitted back to ARI on 4 February 2017.

10. Mrs A went back to Woodend Hospital on 27 February 2017 but, because her condition had seriously deteriorated with worsening infection, she was returned to ARI on 10 March 2017.

11. Mrs A developed abdominal pain, gastro intestinal bleeding and evidence of colitis (inflammation of the inner lining of the colon/bowel). The Board said that, latterly, as it became clear she was dying, she was treated palliatively (a procedure to reduce the severity of a disease or condition without curing it). Mrs A died on 20 March 2017 and, as her family had concerns about her death, a hospital post mortem was carried out.

12. Mrs C made a formal complaint to the Board and, in attempt to address her concerns, four meetings (on 8, 17 and 31 August 2017 and 2 February 2018) were held with her and other members of her family.

13. A formal response to Mrs C was sent on 3 May 2018. Essentially, the Board said that Mrs A's case had been a complex one and that while her outcome had been

very poor, Mrs A had been reviewed and treated by appropriate specialists; management decisions made at each stage of her illness appeared to have been reasonable.

14. Mrs C remained unhappy and complained to us.

(a) The care and treatment given to Mrs A in Aberdeen Royal Infirmary were unreasonable

What happened

15. On 29 November 2016, Mrs A was admitted as an emergency to ARI with a heart attack. During her subsequent care she was noted to have an abnormal valve (the aortic valve) in her heart. The severity of this was such that an operation was needed to replace the valve and to bypass the blocked blood vessels that had caused her heart attack. The operation was performed on 22 December 2016.

16. Mrs C said that the operation itself appeared to go well but then Mrs A began to experience episodes of delirium. She questioned the care Mrs A was given after her operation.

Advice received

First admission to ARI, 29 November 2016-19 January 2017

17. Adviser 1 said that after her operation, Mrs A's care was initially in the intensive care unit and her initial recovery appeared uneventful. However, on 24 December 2016, staff noted that she had a 'confused episode this pm'. The next day they thought she had a chest infection, and she was started on antibiotics. By 26 December 2016, although she was noted to be drowsy, she was easily rousable and able to follow commands. She was cooperative and communicative.

18. On 28 December 2016, Adviser 1 said that a swab (a test for infection) was taken from her sternal/breastbone wound presumably because of concern about infection. However, staff noted that she had fluctuating cognitive function (ability to think as normal) being confused overnight but orientated during a ward round on 29 December 2016.

19. Adviser 1 noted that Mrs A's care was also reviewed by the diabetes team to help control her blood sugar levels by adjusting her medication and insulin.

20. On 30 December 2016, Mrs A was seen by a consultant geriatrician (the Consultant Geriatrician) who noted her progress since the operation and recorded that she was experiencing symptoms of 'delirium', rather than confusion. Adviser 1

said there was a discussion with Mrs A which suggested that she was anxious about returning home, and it was suggested that she might need a period of ongoing care in a rehabilitation setting if she did not improve over the weekend.

21. At this point, Adviser 1 said that Mrs A seemed to stop improving. She developed diarrhoea and vomiting and found walking more difficult. Staff recorded their concern about her leg wound on 6 January 2017, as a swab from this had grown a bacteria (called pseudomonas). They explained that the leg wound was related to the removal of a vein that had been used as part of Mrs A's heart operation; the vein was removed from her leg and then used as a blood vessel to supply the heart muscle (bypass). Evidence of infection was also found in Mrs A's urine and she was given antibiotics.

22. Adviser 1 said that on 9 January 2017, Mrs A was reviewed again by the Consultant Geriatrician. It was noted that she had infection(s) which were being treated, and that she was not well enough to transfer from the ward at the time.

23. While her antibiotics were changed the next day, Adviser 1 said that the reasons for this were not clear but seemed to relate to concern that the initial antibiotic given was causing her blood sugars to fall to levels that were thought to be too low, and unsafe.

24. On the evening of 10 January 2017, Adviser 1 said that medical staff were asked to see Mrs A at 21:00 as she had 'increasing agitation' and 'hallucinations'. The cause of this was thought to be an opiate based painkiller that she had received. Her family were contacted, and she was prescribed a sedative (diazepam). By the morning of 11 January 2017, these symptoms had improved. The possibility of performing a Computerised Tomography (CT) scan of her brain was considered, but it was determined that she did not need this.

25. Adviser 1 said that Mrs A seemed to stabilise slightly, but remained frail over the next few days. On 16 January 2017, she was reviewed by the same Consultant Geriatrician who had seen her before who considered that her delirium and infection were both resolving slowly.

26. The Consultant Geriatrician took the view that Mrs A was fit to transfer to a rehabilitation ward and asked the ward to stop using sedatives to treat her agitation (Adviser 1 commented that these sedatives could prolong the state of delirium, despite their apparent short term relief of symptoms).

27. Adviser 1 noted that the last entry of this aspect of Mrs A's care was on 19 January 2017.

28. Adviser 2 also reviewed Mrs A's care and treatment for this period of time. They said that in their view it had not always been reasonable and appropriate and cited examples. They observed that although Mrs A was noted to have a pressure ulcer on 29 December 2016, the Board's Pressure Ulcer Prevention and Management Pathway was not followed and Mrs C and her family were not made aware of this hospital acquired pressure ulcer.

29. In connection with this, Adviser 2 said that staff appeared to have lacked knowledge about the products that should have been used to treat Mrs A's wounds (leg and sternal wounds) and that they had been dressed with gauze. It was Adviser 2's view that there was no place in wound management for gauze as it could adhere to the wound bed, was non-absorbent and had no healing properties.

30. Adviser 2 said that the clinical record showed that Mrs A was prescribed Inadine for her leg wound but, again, said this was inappropriate because her leg wounds were leaking. They commented that when there was a high level of wound fluid, the therapeutic properties of Inadine were washed away with it.

31. On 6 January 2017, after a swab was taken, the bacteria pseudomonas was identified (see paragraph 21) and Adviser 2 said that at this time, a referral should have been sent to the Tissue Viability team for review. Such a referral was not made until some days later (on 10 January 2017) and at that point the Tissue Viability Nurse provided a detailed plan for Mrs A's wound based on the photographs and accompanying wound description they had been given. Adviser 2 said that the plan provided was appropriate and instructed clinical staff to re-refer Mrs A should they have any concerns.

32. During this period, Adviser 2 also commented that Mrs A's sacral wound had been treated with four different products, two of which had not been appropriate.

Second admission to ARI, 4 February – 27 February 2017

33. Mrs A was transferred to Woodend Hospital on 19 January 2017 for rehabilitation but after some time there (see complaint (b) below) required to be returned to ARI on 4 February 2017. Adviser 1 said that at that time, staff had concerns about her condition, particularly the duration and severity of her delirium, and her infection(s). They said that she needed a level of care, including investigations such as CT scanning, which could not be met in Woodend Hospital.

Given the concern of staff, and her family, Adviser 1 said that her transfer back to ARI was reasonable.

34. Mrs A was seen by the Consultant Geriatrician (see paragraph 25), so Adviser 1 said that they would have been in a good position to judge the change in her condition as they had seen her before, and in particular to the changes in her wounds. Mrs A's situation was brought to the attention of the Cardio-thoracic team (who had created the wounds during her operation) and also to the Plastic Surgery team (who often repaired wounds that would not heal) and the advice received was to discuss the wound with the Tissue Viability team. This was actioned immediately (on 4 February 2017).

35. At this time, Mrs A's leg wound was noted to be necrotic (had some dead tissue) and deep to the extent that fat under the skin, and the stitches from the operation present in the deep tissue of the leg, had become visible. A detailed eight point care plan was agreed including investigation and discussion with the consultant surgeon.

36. A CT scan of Mrs A's brain also showed evidence of a new stroke, which staff thought might have occurred during, or after her operation. Adviser 1 said that this could have explained some of her delirium and slow recovery and this was discussed with her family.

37. On 7 February 2017, the Plastic Surgery team saw Mrs A and Adviser 1 noted that they did not think her wound was sufficiently compromised or infected to need their surgical input at this time.

38. Afterwards, Adviser 1 said that Mrs A appeared to improve again, and her delirium reduced. However, they said that staff were still concerned about her wound and infection(s). Medical staff were also concerned about the possibility of infection below her sternum and Mrs A was discussed and reviewed by surgeons. She was given another CT scan on 10 February 2017.

39. On 11 February 2017, Adviser 1 said that medical staff noted that the Tissue Viability team had not reviewed Mrs A. They remained concerned about her infections and on 14 February 2017 discussed her case with the infectious disease medical staff to make sure that her treatment and antibiotics were appropriate, and to clarify the duration of these. Adviser 1 said that this led to further discussion with the surgeons who organised drainage of the fluid below her sternum on 15 February 2018.

40. A Tissue Viability review took place on 16 February 2017, and Adviser 1 said that medical staff noted that specific dressings had been recommended to help Mrs A's tissue healing. Also, it was confirmed that the fluid samples from below her sternum had not suggested significant evidence of infection. Accordingly, staff proposed a more prolonged period of antibiotics to treat Mrs A's leg wound infection.

41. Adviser 1 said that once again, over the next few days, Mrs A appeared to stabilise and she received reviews from the infectious diseases team on 20 February 2018 as well as regular and detailed reviews from the ward doctors.

42. As her condition had stabilised, Adviser 1 went on to say that no further scans were needed and staff were noted to be happy that she did not need an operation to her wounds. Adviser 1 added that it was clear that Mrs A would still require a long period of in-patient care which would be available at Woodend Hospital and she was transferred back there on 27 February 2017.

43. Adviser 2 also commented on Mrs A's treatment during her return to ARI between 4 and 27 February 2017. They noted that on 6 February 2017, an acting consultant geriatrician had e-mailed Tissue Viability saying that they were 'significantly concerned' about Mrs A's leg wound but it appeared that this was not acted upon.

44. Furthermore, Adviser 2 said that Mrs A again did not receive appropriate care for her wound. Amongst other things, they said that a tissue viability care plan wound prescription previously agreed (paragraph 35) was not followed; clinical staff were indecisive as to who should review the wound and referred Mrs A inappropriately to Plastic Surgery; there was delay in referring Mrs A to Tissue Viability despite instructions to re-refer her if any concerns arose (she was not referred until 16 February 2017); there was a delay in establishing why this did not happen; dressings were applied that did not contain the moisture leaking from Mrs A's leg wound and a topical cream was incorrectly prescribed, which was generally used in burns.

45. Adviser 2 observed that at times during this admission, caring for Mrs A was challenging due to violent and aggressive behaviour which was as a result of her compromised cognition. Nevertheless, they said that were shortcomings in her basic core nursing which were to Mrs A's detriment, for instance she had a sacral pressure ulcer which developed during her first admission to ARI (paragraph 28) but the Board's Pressure Ulcer Prevention and Management Pathway was not followed and the family were not made aware of this; her Applied Wound Management Chart was

not updated; there was delay in getting wounds reviewed by Tissue Viability; and Mrs A's dressings were not changed frequently enough nor was the secondary dressing absorbent enough as Mrs A's outer bandages were frequently soiled.

Third admission to ARI, 10-20 March 2017

46. On 10 March 2017, after a further period in Woodend Hospital, Mrs A was returned to ARI for a repeat CT scan but this showed no change. Her inflammatory markers were still raised and the cause of Mrs A's infection was felt to be her leg wound. Adviser 2 indicated that again Mrs A's care and treatment was problematic, for instance, dressings prescribed for Mrs A on 11 March 2017 were not available and her legs were dressed with a simple dressing which had no therapeutic effect; her Applied Wound Management Chart was not updated until 18 March 2017 which Adviser 2 said led them to conclude that no appropriate dressing was applied for several days; although Mrs A already had a pressure ulcer which developed on 29 December 2016, the nursing records showed there were gaps of up to seven hours in her being seen when she should have been seen every two hours.

47. Regrettably, Mrs A's condition failed to improve and she became more unwell. She showed little response to antibiotics and, after 17 March 2017, her treatment was palliative only. Mrs A died on 20 March 2017. Adviser 1 said that ultimately Mrs A died from clots in her lungs, which were caused by immobility and other conditions such as the infections and stroke she developed.

48. Adviser 1 went on to say that even with perfect care, they were of the opinion that Mrs A would probably still have died. They said that her stroke seemed to have occurred around the time of her operation, and this caused her delirium and poor initial progress. This was further compromised by her wound infection. Adviser 1 explained that each of these factors would have played a role in making Mrs A more frail, and less likely to survive.

49. Adviser 1 explained that if Mrs A had not suffered a stroke, then her condition may not have deteriorated so much, but as this was a common, recognised complication of this type of operation, they did not think that the development of this complication itself could be said to be unreasonable. They added that they could not think of any specific intervention(s) or treatment(s) of sufficient effectiveness, that medical staff could have made that would have given them the confidence to say that Mrs A would have survived if she had received it/them.

(a) Decision

50. Adviser 1 expressed the view that, in general, some of Mrs A's problems seemed to have been identified in keeping with usual ward levels of care; she had some post-operative problems, but these would have been expected in someone with her complex health, and overall level of 'frailty'.

51. They said that some of her medical care was good, for example, the attention from the diabetes team. However, they would have expected to have seen a more detailed approach to her delirium, and an approach that sought to avoid sedative medication. They said that the delirium caused significant distress to Mrs A, and also caused a significant delay in her improvement.

52. Adviser 1 said that at the time concerned, they did not think the matter of Mrs A's delirium received as much attention from the ward team as her more 'surgical' complications, such as her wounds and their infection(s). They commented that the treatment of delirium was a national priority for NHS Scotland, and had been for several years. They added that there was a Health Improvement Scotland (HIS) Delirium Management tool/recommendation (HIS National Workstream –Think Delirium- Improving Care for Older People) which included the use of a ward based assessment called '4AT'. They said that this allowed the progress of delirium to be assessed in a more structured and standardised way. The HIS delirium toolkit also described how to engage families in this process, and alter, as much as possible, the ward environment to try to minimise the impact of delirium.

53. Adviser 1 further stated that there was no evidence in the clinical record to show that ward staff had diagnosed or monitored Mrs A's delirium in this way, despite some prompting from the Consultant Geriatrician (paragraph 20). They went on to say that this type of assessment was within the capability of ward staff, as evidenced by a form from 30 November 2016 which had been completed appropriately. Consequently, in their view, better care for Mrs A would have been to use this assessment and process it during her post-operative period. Because it was not, Adviser 1 considered that Mrs A's care fell below a level she could have expected and it was unreasonable as a result.

54. Adviser 2 was also critical of Mrs A's care and treatment and identified aspects that were not appropriate: the Board's own Pressure Ulcer Prevention and Management Pathway was not followed, Inadine was inappropriately prescribed; there were delays in referring Mrs A to the Tissue Viability team; her wounds were not attended to frequently enough and inappropriate dressings that had no therapeutic effect were used.

55. I accept this advice. Given this criticism from both advisers, I uphold the complaint that the care and treatment given to Mrs A in Aberdeen Royal Infirmary were unreasonable. I have made a number of recommendations in relation to my findings which can be found at the end of this report.

(b) The care and treatment given to Mrs A in Woodend Hospital were unreasonable

56. On 19 January 2017, Mrs A was transferred to Woodend Hospital although Mrs C considered that she was not medically fit and that her leg wound did not appear to be improving. She also considered that once Mrs A was transferred, staff in Woodend Hospital failed to contact the Tissue Viability Service as quickly as they should and as a consequence, her condition further deteriorated.

What the Board said

57. The Board said that Mrs A, unlike the majority of patients, was transferred from ARI to Woodend Hospital because staff felt that she needed some extra time in hospital for rehabilitation prior to going home. It was noted that ward staff requested a care plan from ARI but that Mrs A was not initially seen by the Tissue Viability Service. However, there was a Tissue Viability recommendation that Mrs A's wound be re-dressed every three to four days and it appeared that the leg dressings had been redressed as required. However, it appeared that Mrs A's leg wound was incorrectly documented as a skin graft and accordingly was not automatically picked up by the Tissue Viability team. Mrs A was not seen by them until 16 February 2017 for which the Board apologised.

Advice received

First admission to Woodend Hospital, 19 January-4 February 2017

58. Adviser 1 said that despite initially appearing to recover well, overall, Mrs A made a poor recovery from her surgery. While most people with this type of surgery were able to return home with a week or so of their operation, she was not. In connection with this, they noted that Mrs A's surgery had been as an emergency and that before this, she had several existing chronic conditions.

59. Adviser 1 noted that before she was deemed well enough to be transferred to Woodend Hospital on 19 January 2017, Mrs A had had several reviews by the Consultant Geriatrician. At the time, her infection appeared to have settled, and there were no specific issues that meant her medical care could not be provided elsewhere. When she was transferred, Adviser 1 said that she did not need ongoing

specialist Cardio-thoracic ward care and the decision to transfer her was a reasonable one.

60. Adviser 1 commented that the admission documents for Woodend Hospital clearly detailed an assessment of Mrs A's infection(s) and swab results and there was no undue concern about her health at the time. Staff thought that with more time to recover and rehabilitate, she would be able to return home.

61. The issue of her delirium was noted, and was discussed with Mrs A's family on 24 January 2017. There was also a formal assessment of Mrs A's cognitive function which showed that she scored slightly low.

62. On 25 January 2017, Mrs A's ongoing delirium and fluid retention was noted in her clinical records, and a detailed plan was made to address these. However, by 30 January 2017, her leg wound was giving more concern, particularly as the bacteria grown seemed resistant to several antibiotics. Adviser 1 said that this prompted a discussion with the microbiology team on 31 January 2017 to help guide the most appropriate antibiotic choice for her.

63. Adviser 1 said that Mrs A continued to receive regular and detailed medical reviews – for instance on 2 February 2017 when it was discussed which medication should be used to try and treat the hallucinations caused by her delirium. A specific, less sedative drug called Quetiapine was proposed and was discussed with Mrs A's family, because she now lacked the decision-making capacity to decide this for herself. Adviser 1 commented that this was an example of good care, and in keeping with the standards described in the HIS Delirium guidance.

64. Adviser 1 observed that this was a difficult period in Mrs A's care as her symptoms of delirium had worsened. However, they said that they thought this was due to the development of infection (or the recurrence of the previous infection treated in ARI) rather than to poor medical care.

65. In this admission, Adviser 1 said that Mrs A's medical records showed more care and attention than she had received previously in ARI, particularly with regard to the issues of delirium and infection. They added that there were clear records, showing detailed assessment and planning for her problems.

66. However, Adviser 2 did not think that Mrs A's leg wound had been treated in a reasonable and appropriate way. They explained that although a deterioration in her wound was noted on 2 February 2017 with a diagram demonstrating an open wound

with accompanying positive microbiology swab, no referral was made to Tissue Viability even although her family requested such a review the next day. Meanwhile, Adviser 2 said that Mrs A's wound was not being dressed with appropriate products and a review did not take place until 16 February 2017. Adviser 2 also commented that important documentation (the Applied Wound Management Chart) was not completed.

Second admission to Woodend Hospital, 27 February-10 March 2017

67. On 21 February 2017, Adviser 1 said that a potential move for Mrs A from ARI to Woodend Hospital was discussed with her family. They said that the doctor concerned noted no specific concerns but it was clear that Mrs A was going to need a long period of in-patient care to aid her rehabilitation (paragraph 42).

68. Adviser 1 added that at the time of her transfer, the assessment made was detailed and clear. Staff were, however, concerned about her poor progress which Adviser 1 said seemed to be caused by persisting infection, delirium, and immobility.

69. On 1 March 2017, Mrs A was seen by a consultant, there were discussions with her family, and reviews by the old age psychiatry team and dieticians.

70. On 7 March 2017, staff also became concerned about the possible development of another chest infection and the next day there was a specific and detailed review of her care, including plans for senior medical review if needed.

71. During this admission, Mrs A developed a new symptom of chest pain, and staff considered the possibility of infection (in the form of mediastinitis). Adviser 1 said that it was reasonable to assume this, particularly as some of her blood tests had deteriorated. They said that there was a need to discuss this possibility further, despite previous scans and investigations in ARI indicating this was unlikely, as Mrs A had now developed chest pain. This prompted discussion about the need for further scans, and transfer back to ARI again.

72. Adviser 1 was of the view that Mrs A's care at this time was good, there were frequent and detailed medical reviews, and clear plans for her care were made, and adjusted, when her condition changed.

73. However, Adviser 2's view was that Mrs A's sacral pressure ulcer (which had developed on 29 December 2016) had still not been treated in accordance with the Board's Pressure Ulcer Prevention and Management Pathway and her family had still

not been informed of this; two hourly pressure relieving interventions (and associated documentation) were not carried out as they should have been.

74. Adviser 2 went on to say that Mrs A's last few weeks should have been dignified, pain free and comfortable, however, delays in appropriate wound treatment and the failure to prevent pressure damage meant that Mrs A died with more than one pressure ulcer and a leg wound that had broken down on which the dressings were regularly 'soaked through'.

(b) Decision

75. Overall, Adviser 1 was satisfied that Mrs A's medical care improved when she was in Woodend Hospital. In particular, they said that greater attention had been given to the causes of her delirium. Doctors became more concerned about further infection and drew up a plan to address this. Subsequently, Mrs A developed chest pain which prompted discussion and her transfer back to ARI.

76. However, Adviser 2's view was that the attention paid to Mrs A's leg wound and sacral pressure sore remained extremely poor: no referral was made to Tissue Viability; the wound was not being dressed with appropriate products; a review did not take place until 16 February 2017; important documentation (the Applied Wound Management Chart) was not completed. Similarly, her sacral pressure sore did not receive appropriate and reasonable attention. As a consequence, they said that Mrs A did not have a dignified death.

77. I accept this advice. While I am satisfied with the clinical care and treatment Mrs A received in Woodend Hospital, I cannot be satisfied with her nursing care, the failings of which obviously caused Mrs A pain and distress. This should have been avoidable as specialist Tissue Viability expertise was available to support nursing staff but they appeared unaware how to access this. Mrs A's last few weeks should have been pain free and comfortable. She was entitled to die in a dignified way and she did not. This statement and report must be extremely distressing for Mrs C and her family to read and they have my sympathy.

78. I uphold this complaint and I have made recommendations which can be found at the end of this report.

(c) Communication with Mrs A's family was unreasonable

79. Mrs C complained that the Board's communication with her was at times atrocious and her family felt very strongly that there had been a lack of communication throughout Mrs A's admission but particularly concerning her leg

wound. The Board acknowledged this in their complaint decision letter of 3 May 2018 and confirmed that communication had not been ideal. They said that earlier and more honest discussions may have been helpful in relieving Mrs C's anxieties and in proving clarity.

80. Both advisers reviewed Mrs A's clinical records and Adviser 1 said that with regard to Mrs A's delirium in particular, they would have expected more significant interaction between staff and Mrs A's family. They added that medical staff seemed to consider that she had 'early signs of dementia' before her operation but Adviser 1 commented that this had not been documented in Mrs A's admission notes, nor had it been suggested by observations of staff. They said that the comment about dementia was important but needed to be accurate and justified. Notwithstanding, they said that the situation had not been checked or discussed with her family.

81. Adviser 1 said that while Mrs A was a patient in ARI, there was evidence that the surgical options for treatment, and their potential complications were explained to Mrs A as part of the consent process. At that time she was deemed to have capacity to decide for herself. However, after the operation, when Mrs A started to have symptoms of delirium, her family should have been more involved in her care.

82. Adviser 1 explained that the HIS toolkit (paragraph 52) noted that:-

> 'Families and carers can give you a history of change. Always speak to them to obtain history and baseline function. Families and friends can help re-orientate. Always document delirium diagnosis. Reassure families and carers.'

83. Adviser 1 said that this level of care was not provided to Mrs A and her family in ARI.

84. Similarly, Adviser 2 said there was no documented record of discussion with Mrs A and her family regarding her nursing care and treatment. They said that they would have expected communication regarding future treatment plans, goals for her leg wound and pressure ulcer, and goals for her cognitive impairment.

85. Once Mrs A transferred to Woodend Hospital on 19 January 2017, Adviser 1 said that the clinical records showed that senior medical staff spoke with Mrs A's family (on 1 February 2017) and explained her condition and care. Staff also shared their concern about her poor health in their reassessment of her condition at this time.

The next day, Adviser 1 said that Mrs A received a detailed medical review which included discussion about which medication to use in attempt to treat the hallucinations caused by her delirium. The decision to use the less sedative drug, Quetiapine (paragraph 63), was discussed with the family, as by this time Mrs A lacked decision-making capacity. Adviser 1 commented that this was an example of good care, and in keeping with the standards described in the HIS Delirium guidance (paragraph 52).

86. Adviser 1 further noted that there was a longer and more detailed discussion with the family on 3 February 2017, as it was felt that Mrs A's condition had deteriorated since transfer. Staff discussed her care with the family in detail, including the potential need to transfer Mrs A back to ARI. Adviser 1 observed that this was a difficult period in Mrs A's care, as her symptoms of delirium had worsened. They went on to say that this was due to the development of infection (or recurrence of the previous infection treated in ARI) rather than due to poor medical care.

87. Adviser 1 noted that while she was in Woodend Hospital, Mrs A was shown more medical care and attention than she had received previously in ARI, particularly with regard to the issues of delirium and infection. They commented that there was also evidence in the clinical records of more detailed discussions with her family.

88. However, on nursing matters including about her leg wound and pressure sore, Adviser 2 said that they could only find one record of discussion (on 8 March 2017) between nursing staff at Woodend Hospital and Mrs A's family. They expressed the view that this was unreasonable given the complexity and deterioration of the issues Mrs A was experiencing.

(c) Decision

89. When there are issues of capacity as in Mrs A's case, who was suffering delirium and extreme pain, families are entitled to be advised of the care and treatment being given to their loved ones. They are entitled to be updated and where appropriate to be part of the discussions involving these issues.

90. Adviser 1 was critical of the lack of information given to Mrs A's family about her delirium while she was a patient in ARI and Adviser 2 commented that there was little to no record of discussion between nursing staff and the family. As already confirmed (see complaints (a) and (b)), this was a very distressing time for Mrs A and her family which was compounded by the lack of information provided by staff. The level of communication was not what Mrs A's family could reasonably have expected. I uphold the complaint.

91. While I recognise the Board have acknowledged failings in communication during their investigation of the complaint, I am disappointed that, given the extent of the failings I have identified in relation to care and treatment under complaints (a) and (b) they were not identified by the Board's own investigation. I consider this was a missed opportunity for learning and improvement at an earlier stage and may have helped alleviate the distress for Mrs A's family. As noted in my introduction to this report, I have previously expressed similar concerns about pressure ulcer care and communication issues with the Board in another case (ref: 201701938). Given this, I expect the Board to urgently address the failings highlighted in this report.

92. I have made my recommendations at the end of this report.

93. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on the recommendations and the Board are asked to inform us of the steps taken to implement them 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.

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for Mrs C:

Complaint number	What we found	What the organisation should do	What we need to see
(a)	Mrs A's post-operative care in ARI fell below a level she and her family could have expected; there was a lack of attention to her delirium management and her wounds and pressure ulcer were not treated appropriately	Apologise to Mrs C for the failure of ARI to give proper care and attention to the symptoms of Mrs A's delirium and to her wounds	A copy or record of the apology made. By: 17 May 2019
(b)	While she was a patient in Woodend Hospital, the attention paid to Mrs A's leg wound and sacral pressure sore remained poor: no referral was made to Tissue Viability; her leg wound was not dressed with appropriate products; a review did not take place until 16 February 2017; important documentation (the Applied Wound Management Chart) was not completed. Similarly, her sacral pressure sore did not receive appropriate and reasonable attention	Apologise to Mrs C for the failure of Woodend Hospital to give Mrs A leg wound and sacral pressure sore the required care and treatment	A copy or record of the apology made By: 17 May 2019

Complaint number	What we found	What the organisation should do	What we need to see
(c)	The level of communication with Mrs A's family was not what they could have reasonably expected	Apologise to Mrs C for the failure of Board staff to communicate reasonably and appropriately	A copy or record of the apology made By: 17 May 2019

We are asking The Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(a)	Mrs A's post-operative care in ARI fell below a level she and her family could have expected; there was a lack of attention to her delirium management and her wounds and pressure ulcer were not treated appropriately	Proper care and attention should be given to the symptoms of delirium. The Board should follow the HIS Standards for the prevention and management of pressure ulcers; staff should have wound knowledge of how to assess and dress a wound appropriately and be aware when to refer to the Tissue Viability Service	Evidence that the Board are improving the care of patients with delirium. Also evidence that they have taken measures to improve the clinical knowledge of the staff concerned in relation to pressure ulcers, wound management and referrals to the Tissue Viability Team By: 17 July 2019

Complaint number	What we found	Outcome needed	What we need to see
(b)	While she was a patient in Woodend Hospital, the attention paid to Mrs A's leg wound and sacral pressure sore remained poor: no referral was made to Tissue Viability; her leg wound was not dressed with appropriate products; a review did not take place until 16 February 2017; important documentation (the Applied Wound Management Chart) was not completed. Similarly, her sacral pressure sore did not receive appropriate and reasonable attention	Proper care and attention should be given to the symptoms of delirium in line with HIS Standards for the management of delirium. The Board should follow the HIS Standards for the prevention and management of pressure ulcers; staff should have wound knowledge of how to assess and dress a wound appropriately and be aware when to refer to the Tissue Viability Service	Evidence that the Board are improving the care of patients with delirium. Also evidence that they have taken measures to improve the clinical knowledge of the staff concerned in relation to pressure ulcers, wound management and referrals to the Tissue Viability Team By: 17 July 2019
(c)	The level of communication with Mrs A's family was not what they could have reasonably expected	Particularly where there are capacity issues, staff should communicate with family members in a reasonable and appropriate manner	All staff who were involved in Mrs A's care and treatment were made aware of the outcome of this report and were reminded of their obligations to communicate clearly with family members By: 17 May 2019

We are asking The Board to improve their complaints handling:

Complaint number	What we found	Outcome needed	What we need to see
(a) and (b)	The Board's investigation failed to identify the significant failures in Mrs A's care, in particular, in relation to the management of her delirium and her wound/pressure ulcer	The Board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and learning from complaints are used to drive service development and improvement	Evidence that SPSO's findings on this complaint have been fed back in a supportive manner to the staff involved in investigating Mrs C's complaints and that they have reflected on the findings of this investigation. (For instance, a copy of a meeting note or summary of a discussion) By: 17 May 2019

Terms used in the report **Annex 1**

Adviser 1	an independent consultant geriatrician
Adviser 2	an independent registered nurse specialising in tissue viability
Aortic valve	a heart valve
Aortic stenosis	a narrowing of the aortic valve opening
Cardio-thoracic	concerning the organs within the chest, principally the heart, lungs and oesophagus
Colitis	to inflammation of the inner lining of the colon/bowel
Coronary artery bypass graft	a surgical procedure used to treat coronary heart disease. It diverts blood around narrowed or clogged parts of the major arteries to improve blood flow and oxygen supply to the heart
Computerised Tomography (CT) scan	a scan that uses x-rays and a computer to create detailed images of the inside of the body
Delirium	an acute, fluctuating syndrome of inattention, impaired level of consciousness
Inadine	a non-adherent surgical dressing
Ischaemic heart disease	when the coronary arteries become narrowed by a gradual build-up of fatty material within their walls

Mrs A	the complainant's late mother
Mrs C	the complainant
Occipital	refers to that part of the brain primarily concerned with vision
Palliatively	a procedure/something to reduce the severity of a disease or condition without curing it
Quetiapine	a drug used to treat certain mental/mood conditions
Sacral	area at the bottom of the spine
Tissue viability	a speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure sores and all forms of leg ulceration
Type 2 diabetes	a condition when the body does not use or produce insulin properly

List of legislation and policies considered **Annex 2**

National Institute for Health and Care Excellence (NICE) – Investigation and Management of Heart Valve Diseases in Adults

Aortic Diseases European Society of Cardiology Clinical Practice Guidelines

Healthcare Improvement Scotland (HIS) Delirium Management

Best Practice Statement Prevention and Management of Pressure Ulcers (2009) Health Improvement Scotland

Scottish Adaptation of the European Pressure Ulcer Advisory Panel (EPUAP) Pressure Ulcer Classification Tool Scottish Government (2015) Scottish Patient Safety Programme. In June 2015, the Scottish Government announced an expansion of the existing aim, to reduce acquired grade 2–4 pressure ulcers in hospitals and care homes in Scotland by 50% by 2017

Standards for prevention and management of pressure ulcers (2016) HIS

Nursing and Midwifery Council Code of Conduct (2014)