**Scottish Parliament Region: Glasgow**

**Case 201104025: Greater Glasgow and Clyde NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; care of the elderly; clinical treatment; diagnosis

***Overview***

The complainant (Mrs C) together with other members of her family raised a number of concerns with Greater Glasgow and Clyde NHS Board (the Board) concerning the care and treatment their mother (Mrs A) received while a patient in the Victoria Infirmary, Glasgow between September and November 2010. Mrs A died in hospital on 13 November 2010.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) the care and treatment provided to Mrs A, including the management of her pressure ulcer and the use of a Certificate of Incapacity, was inadequate (*upheld*);

(b) the implementation and application of the Liverpool Care Pathway (LCP) was inadequate (*not upheld*); and

(c) communication between board staff and Mrs A's family was unreasonably poor, in particular a meeting with Mrs A's Consultant on 26 October 2010, and a telephone conversation between Mrs A's son and a medical registrar on 1 October 2010 (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Board: | *Completion date* |
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| (i) provide the Ombudsman with evidence that the Board's current policies and procedures regarding the prevention, management, monitoring, education and training of pressure ulcers is in line with national guidance and best practice; | 14 August 2013 |
| (ii) take steps to put in place an action plan to address the shortcomings identified in this report in relation | 14 August 2013 |

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| | to pressure ulcer management and share this action plan with both the Ombudsman and Mrs C; | |
| (iii) | review how in-patient units communicate with each other about the decision making capacity of patients requiring procedures as in-patients, to ensure that a patient who is being managed under the terms of the Adults With Incapacity (Scotland) Act 2000, is known to be so by any other team undertaking a procedure that would normally require written consent; | 14 August 2013 |
| (iv) | consider whether the use of treatment plans (recommended for patients with complex care needs) might support the effective use and validity of Certificates of Incapacity in terms of Section 47 of the Adults With Incapacity (Scotland) Act 2000; | 14 August 2013 |
| (v) | review how clinicians document the fact that capacity may be lacking for one specific intervention but present for other investigations and treatments if they believe this to be the case; | 14 August 2013 |
| (vi) | ensure that family and carers are appropriately involved and informed of the consideration of use of the Adults With Incapacity legislation in the care of a patient and to document this clearly on the Certificate of Incapacity; | 14 August 2013 |
| (vii) | apologise to Mrs C and other members of the family for the failings identified in complaint (a); | 19 June 2013 |
| (viii) | with reference to our adviser's comments under paragraph 84 of this report, consider auditing the precise location of death of their in-patients and whether any system of prioritisation for single rooms across units might minimise this; | 14 August 2013 |
| (ix) | seek to ensure that any discussion that a member of staff has with a patient's family is recorded in the patient's medical records; and | 14 August 2013 |
| (x) | apologise to Mrs C and other members of the family for the failings identified in complaint (c). | 14 August 2013 |

## Main Investigation Report

### Introduction

1. Mrs A, who was aged 78 years at the time, was admitted to the Victoria Infirmary (the Hospital) in September 2010 for investigation of a possible gastrointestinal bleed against the background of a deterioration in her physical and cognitive function. Mrs A was initially admitted to Ward 14 and then transferred the following day to Ward 1 (the Ward). Whilst in the Hospital a pressure ulcer (the pressure ulcer), that was present on Mrs A's admission, deteriorated in association with the development of a bone infection (osteomyelitis).

2. The family of Mrs A believe that poor management of the pressure ulcer led to Mrs A developing osteomyelitis of the spine which ultimately led to her death. Mrs A's daughter (Mrs C) said that whilst Mrs A was in the Ward, she and other members of Mrs A's family raised concerns with hospital staff about Mrs A's care and treatment.

3. Mrs C said that she only learned that a Certificate of Incapacity under Section 47 of the Adults With Incapacity (Scotland) Act 2000 (the Certificate of Incapacity) had been in place when Mrs C requested a copy of Mrs A's medical records following her death. The reason given for the Certificate of Incapacity was because of Mrs A's 'cognitive impairment secondary to dementia'.

4. In November 2010 Mrs A was put on the Liverpool Care Pathway (LCP) and all treatment was stopped including antibiotics and possible surgery for the pressure ulcer. Mrs C said that, whilst Mrs A was on the LCP, her pain relief needs were routinely not met and she was nursed in an open ward until she died.

5. Mrs A's family considered that communication with hospital staff regarding Mrs A's care and treatment was unreasonably poor. In particular, during a telephone conversation between Mrs A's son (Mr B) and a medical registrar (Doctor 2), on 1 October 2010 and also at a meeting that members of Mrs A's family had with Mrs A's consultant (Doctor 1) on 26 October 2010.

6. The complaints from Mrs C which I have investigated are that:

(a) the care and treatment provided to Mrs A, including the management of her pressure ulcer and the use of a Certificate of Incapacity, was inadequate;
(b) the implementation and application of the Liverpool Care Pathway (LCP) was inadequate; and
(c) communication between board staff and Mrs A's family was unreasonably poor, in particular a meeting with Doctor 1 on 26 October 2010, and a telephone conversation between Mr B and Doctor 2 on 1 October 2010.

**Investigation**

7. Investigation of the complaint involved reviewing copies of Mrs A's medical records and the complaints correspondence received from Greater Glasgow and Clyde NHS Board (the Board) and the information supplied by Mrs C. As the complaint included clinical issues my complaints reviewer obtained clinical advice from two of the Ombudsman's medical advisers, a tissue viability nurse (Adviser 1) and a consultant in Acute Medicine for Older People (Adviser 2) who both also reviewed Mrs A's medical records and the complaint correspondence.

8. 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.

**(a) The care and treatment provided to Mrs A, including the management of her pressure ulcer and the use of a Certificate of Incapacity, was inadequate**

9. Mrs A's physical and mental health had deteriorated drastically between June and August 2010 and, therefore, her General Practitioner had referred her to a Care of the Elderly specialist. Mrs A was admitted to the Hospital in September 2010 for investigation of a possible gastrointestinal bleed against the background of her rapidly deteriorating physical and mental health which had caused her to become frail and confused.

10. Mrs C and her family believe that poor management of the pressure ulcer, which Mrs A had prior to her admission, by hospital staff led to Mrs A developing osteomyelitis of the spine. Although many diagnostic tests were carried out, Mrs C said that hospital staff failed to realise for seven weeks that the pressure ulcer and the bone infection were causing the marked deterioration in Mrs A's health which ultimately led to her death. It was not until 3 November 2010 when plastic and orthopaedic surgeons examined Mrs A that

it was discovered that she had a serious bone infection and multiple organ failure. Two days later, on 5 November 2010, it was decided to put Mrs A on the LCP and to stop all treatment including antibiotics and surgery for the pressure ulcer.

11. Mrs C said that she and the other members of Mrs A's family did not accept the assertion of Doctor 1 that the pressure ulcer was secondary to an undiagnosed spinal abscess. They said that they were not supplied with a proper explanation as to why this abscess was not detected for such a lengthy period of time and questioned why the diagnosis of osteomyelitis was identified too late for Mrs A to be treated. They were also concerned that Doctor 1 repeatedly attempted to discharge Mrs A home despite her deteriorating condition and failed to acknowledge that Mrs A was 'shutting down'.

12. Mrs C also considered that the Hospital's Tissue Viability Service was ineffective. An example of this being that a specialised pressure mattress was not requested until 42 days after Mrs A's admission to the Hospital and two days prior to her being put on the LCP. This was despite the fact that Mrs A, prior to her admission to the Hospital, had been receiving treatment for the pressure ulcer from the District Nursing team at home and had been provided at home with a pressure relieving mattress and cushion.

13. Mrs C also questioned the use of the Certificate of Incapacity and the diagnosis of dementia which had been put in place in September 2010. In the view of Mrs A's family the diagnosis did not appear to be justified. Mrs A's family also questioned the validity of a colonoscopy consent form signed by Mrs A on 18 October 2010. The colonoscopy did not proceed on this date and was rescheduled. The consent form was resigned on 25 October 2010 which was the day after the Certificate of Incapacity apparently lapsed.

14. Mrs A's family believe that systematic failures in communication and the care of Mrs A led to her death on 13 November 2010 and were at the root of this 'dreadful' outcome.

15. In response to the concerns raised by Mrs A's family, the Board said that Mrs A had been admitted to the Hospital with a suspected acute gastro-intestinal bleed, increased confusion and poor mobility. Her background medical history included multiple myeloma, spinal stenosis and atrial fibrillation. Mrs A's family also expressed concerns about her weight loss, incontinence and

the rapid deterioration in her condition. A number of tests had been carried out, including a bone scan, an endoscopy, a computerised tomography (CT) scan of the brain, a colonoscopy and cognitive tests but they had revealed no significant problem which could simply explain Mrs A's rapid deterioration in the weeks prior to and during her admission to the Hospital.

16. The Board also said that a patient with osteomyelitis may present with pain in the affected bone and with signs of infection. Mrs A had long standing pain. A magnetic resonance imaging (MRI) scan in 2008 had shown that she was suffering from spinal stenosis. The pain that she suffered with this condition would, therefore, have obscured any pain in the spinal area which was due to a different cause, which may have been an issue in Mrs A's case.

17. The Board explained that the main markers of infection are Pyrexia and an increase in C-reactive protein (CRP) and White Cell Count (WBC). On Mrs A's admission to the Hospital both her CRP and WBC were elevated. However, they had settled to normal levels after a day or so and remained within normal limits until 13 October 2010 when there was a slight rise in the CRP and thereafter a gradual increase up to 2 November 2010. However, a minor rise in the CRP would not initially have caused concern unless there were other associated features. The WBC remained normal until 29 October 2010 when it was elevated and remained elevated on 4 November 2010 when Pyrexia was first noted.

18. The Board advised that, in retrospect, the earliest marker of infection which could have been in any organ of the body was 13 October 2010 but more convincingly on 29 October 2010 when both Mrs A's CRP and WBC were elevated. Mrs A's alkaline phosphatase (AP) was also elevated but was initially fairly mild. Therefore, osteomyelitis would not have been the first consideration, given there could have been other causes for this. Initially, in the early stage of Mrs A's admission the bone scan ordered was looking for myeloma but the scan did not show any area of abnormality in the sacrum (lower part of the back). Therefore, osteomyelitis was not detected and may not have been present in late September 2010 when the scan was carried out. There was also no reported evidence of any abscess around the pelvic area on the CT scan of the chest, abdomen and pelvis when it was carried out on 25 October 2010.

19. The Board outlined that, when Mrs A was admitted to the Ward on 23 September 2010, it was documented in the nursing notes that Mrs A had a

pressure ulcer. The dressing was intact so was initially left. On 25 September 2010 the dressing was removed and a wound assessment chart completed. The wound remained stable until 8 October 2010 when it appeared to have begun to grow under the skin and the Tissue Viability Nurse (TVN) was contacted for advice. A surgical review was also undertaken and the staff were happy with the advice from the TVN which was that appropriate skin care products be started.

20. The Board further stated that the Hospital's clinical team were actively seeking a diagnosis until 29 October 2010 and Mrs A was functioning at a level that was felt compatible with discharge and further out-patient clinic follow-up. There was no evidence at that stage to suggest that Mrs A was dying. The situation changed in the following few days when it was noted that the pressure ulcer had deteriorated dramatically. A surgical and Tissue Viability review was undertaken on 2 November 2010 and the wound was debrided (removal of dead, damaged or infected tissue to improve the healing of the remaining tissue). The TVN and surgical team reviewed Mrs A on 4 November 2010 and an orthopaedic review was obtained on the same day when it was noted that Mrs A had osteomyelitis. It was only the recognition of the major deterioration of the pressure ulcer and the osteomyelitis which changed the prognosis.

21. It was further explained that, in discussion with Mrs A's family, it was felt that Mrs A was not fit for transfer to another hospital for an MRI imaging of the bone to identify the extent of the bone involvement. Major surgical intervention which might have left Mrs A with a major disability was also not considered appropriate. There was, at this stage, a discussion about a palliative approach and the LCP was felt to be the most appropriate course of action. This was in accordance with the wishes of Mrs A's family.

22. Doctor 1 was asked to comment on the concerns raised by Mrs A's family. Doctor 1 said that she first saw Mrs A when she returned from annual leave on 5 October 2010. An examination of Mrs A's rectum and rectal area raised issues as to whether the pressure ulcer was indeed a pressure ulcer. As it looked atypical, and as Mrs A had been described as independent one month previously, the cause was unclear. Therefore, Doctor 1 had requested a surgical review as to whether this was a sinus or an underlying abscess. A referral was made by the nursing team to the TVN on 7 October 2010 and a review carried out the following day. The TVN was aware that a surgical review had been requested by the medical team and advised use of appropriate wound

care products to manage the wound until then. The surgical review was that Mrs A had a pressure ulcer which was consistent with the view of the TVN and both proposed topical treatment to achieve healing. The wound management chart maintained by the nursing staff suggested that the wound was healing until the acute and dramatic deterioration in the wound was reported on 2 November 2010. This was recognised as being extensive and as there was further deterioration over the next twenty four hours, further opinions were requested from the surgical and plastic surgery teams.

23. Doctor 1 said that there might have been on-going tissue destruction and erosion into the bone but this was not apparent from any investigations or blood tests that had been carried out. In retrospect it was accepted that some changes in Mrs A's blood tests were apparent in the week of 22 October 2010 but in the context at the time were not immediately attributed to the pressure ulcer as this had appeared to be healing.

*Clinical Advice Obtained*

24. Adviser 1 told my complaints reviewer that there is a lack of clearly documented evidence of the condition of the pressure ulcer on Mrs A's admission to the Hospital on 22 September 2010 and that a full assessment was not completed until three days later. Adviser 1 noted that not only was no grading of the pressure ulcer carried out at that point but there was a clear lack of grading of the pressure ulcer throughout the documentation in Mrs A's medical records. According to Adviser 1 this is against the NHS Quality Improvement Scotland Tissue Viability-Best Practice Statement March 2009 Prevention and Management of Pressure Ulcers (the Best Practice Statement) which states that all patients identified with existing pressure ulcers have their ulcers assessed to determine the level of tissue damage. This is a four system grading tool with grade 1 being the least severe and grade 4 being the most severe pressure ulcer.

25. The only evidence that Adviser 1 could find of the pressure ulcer being graded was the initial assessment carried out by the TVN on 8 October 2010 when the ulcer was first given a grade of 3. In accordance with the Best Practice Statement all grade 3 or 4 pressure ulcers should be referred to the Hospital's Tissue Viability Service. Therefore, in Adviser 1's view, the failure to grade the pressure ulcer earlier thus potentially delayed the referral of Mrs A to the Tissue Viability Service.

26. Adviser 1 also told my complaints reviewer that the Waterlow risk assessment tool was initially wrongly calculated. If it had been calculated correctly this would have raised Mrs A's risk to high.

27. Adviser 1 also noted there was no communication documented with regard to seeking information from the district nursing services about the history of the pressure ulcer.

28. Adviser 1 accepted there had been an improvement in the pressure ulcer over the initial period of admission and clinically there was no evidence to suggest that the wound was infected at that point.

29. Adviser 1 also considered there was good evidence with regard to Mrs A's nutritional intake, the use of speech and language therapy and recording of the MUST nutritional screening. There was also good evidence to demonstrate on the wound care chart that the pressure ulcer was improving between 7 October 2010 and 28 October 2010.

30. In addition, there was also a reasonable focus on the pressure ulcer wound management. Although there were gaps when the wound care chart was not completed there was documentation in the nursing notes elsewhere that the dressing had been changed although it did not record a full assessment. In terms of the topical preparation used for the management of the pressure ulcer, Adviser 1 was concerned that the manuka honey which was being used to treat the pressure ulcer was discontinued. Although Adviser 1 accepted that management of the pressure ulcer would be dependent on the local wound management guidelines, there did not appear to be evidence that consideration had been given to using any other antimicrobial dressing to reduce the bacterial load such as a silver product. Furthermore, Adviser 1 told my complaints reviewer that wound dressing will only manage the symptoms of the pressure ulcer and promote the appropriate environment for healing.

31. Adviser 1 said that although initially there were good reassessments of the pressure ulcer taking place, there was a gap in the reassessments carried out between 23 September and 9 October 2010. It was also not clear that the pressure ulcer was reassessed as Mrs A's condition deteriorated.

32. Adviser 1 also considered there was poor documentation regarding Mrs A's skin integrity in general on a daily basis despite her being at high risk on

the Waterlow risk assessment tool and as recommended in the Best Practice Statement. Although there was improved documentation from 3 November 2010 with a turn chart being introduced as Mrs A was in bed, it was not fully completed and Adviser 1 considered that such a chart should have been introduced earlier.

33. There was also, in the opinion of Adviser 1, a clear lack of preventative strategies in place to reduce the risk of further pressure damage and to prevent a deterioration of Mrs A's existing pressure ulcer.

34. Adviser 1 considered there was a lack of clear advice from the TVN in terms of preventative strategies. For instance, there was no mention in Mrs A's records about what equipment should be used or about pressure relief and skin inspection. There was also no review planned and, therefore, Mrs A was not seen by the TVN between 8 October 2010 and 2 November 2010. Adviser 1 was also of the opinion that when a full septic screen was carried out following the deterioration in Mrs A on 29 October 2010, there was possibly a missed opportunity at that time to have swabbed the pressure ulcer and for it to have been examined by the medical team as part of this screening.

35. Adviser 1 further noted there was no documentation relating to pressure relieving devices being used until 4 November 2010 when there was significant deterioration in the pressure ulcer. There was no record of what level of mattress Mrs A was nursed on up until this point. While there is some evidence about a cushion being brought in from Mrs A's home but then lost, it is unclear what further provision for providing a pressure reducing/relieving cushion was provided, particularly as it appeared that Mrs A was quite independent initially and, therefore, sat out of bed in her chair. There was also no documented evidence, that pressure relief was given or that information was given to her on how she could provide her own pressure relief with assistance if required. This was despite Mrs A being at high risk of pressure ulcer damage and that she had an existing pressure ulcer.

36. Adviser 1 also told my complaints reviewer that it was not documented whether or not a clinical incident had been recorded with regard to the pressure ulcer as there had been a deterioration of the pressure ulcer whilst Mrs A was under the care of the Hospital.

37. Adviser 1 further expressed concern about what she regarded as the lack of acknowledgement by the Board about any preventative care having been put into place, especially following the full sceptic screen on 29 October 2010 when there was a deterioration in Mrs A's general condition.

38. Adviser 1 also considered there to be very little evidence in Mrs A's medical notes concerning communication with Mrs A's family, specifically regard to the pressure ulcer. While there was evidence about discussion with Mrs A's family about Mrs A's general deterioration and after the plastic surgeon assessment, there was very little other evidence that Mrs A's family were kept informed about the progress of the pressure ulcer.

*Adviser 2*

39. Adviser 2 considered the clinical issues of this case to be complex and difficult. Adviser 2 highlighted several specific observations about the care Mrs A received at the Hospital which he regarded to be of importance. These were as follows:

- Mrs A had deteriorated physically and cognitively to a significant degree for a period of between one and five months before her admission.
- Mrs A's nutritional status which was assessed on admission to hospital may have reflected a period of recent poor health.
- Mrs A had multi-morbidity (multiple diseases). Specifically, myeloma, anaemia, atrial fibrillation, multiple cerebral infarcts (small strokes), cognitive impairment, spinal stenosis, haemorrhagic gastritis (found on endoscopy after admission). She also had dilated biliary ducts (the duct that transports bile from the liver to the duodenum) of uncertain cause and significance, and an elevated blood test that may have been a marker for cancer, for which no cause was found.
- The pressure ulcer was present on admission to the Hospital. This is likely, in Adviser 2's opinion, to reflect, in part, her condition as set out above.
- Mrs A was also immunosuppressed (that is her immune system, which defends the body from infection, was less effective than normal), and had to be taken into account in association with her age, the myeloma, her multi-morbidity, her nutritional status and her frailty. Adviser 2 noted from Mrs A's medical records that although the myeloma was described as 'smouldering' and not in need of any treatment, this could not in Adviser 2's opinion be taken to mean that it had no effect on Mrs A's well-being,

and specifically her capacity to resist infection. As a result of such immunosuppression, infection would be a common occurrence, could be rapid and overwhelming and could present atypically.

- In Adviser 2's clinical opinion, Mrs A's documented cognitive impairment would most likely be due to a combination of 'delirium', perhaps relating to recurring infection, and a 'multi-infarct' type of dementia. Adviser 2 considered that the precise contribution of each of these to Mrs A's cognitive status could not be ascertained. However, Adviser 2 noted Mrs A's family's comments regarding the relatively short duration of the problem, which may have suggested that delirium was more prominent. Alternatively, it is known that multi-infarct dementia can progress rapidly, and the CT scan of Mrs A's brain undertaken whilst in the Hospital would be compatible with that disease, although it was not diagnostic of it.
- There may have been an additional element of 'dysphasia' (defect of language production or processing) relating to cerebrovascular disease and previous strokes. If present, this would have complicated the assessment of Mrs A's cognition. However, in view of the speech and language therapists' detailed assessments of Mrs A, Adviser 2 was of the opinion that this was not the primary or dominant problem with Mrs A's communication.

40. Adviser 2 was of the view that Mrs A had appropriate investigations for the problem for which she had been admitted to the Hospital, that is, possible gastrointestinal bleeding. Adviser 2 also considered the Hospital had carried out appropriate screening and further investigation for the common coincidental problems of frail older people. For example, cognitive impairment was screened for, assessed and investigated. In addition, appropriate specialist input was requested, for example, haematology was asked to comment on the cause of Mrs A's anaemia.

41. Adviser 2 noted the comments of Adviser 1 and her criticism of the assessment of the pressure ulcer and the associated documentation of the status and progression of the pressure ulcer. However, Adviser 2 said it did appear that the pressure ulcer initially improved and that medical staff did review it and requested and obtained a general surgical review specifically because of uncertainty regarding the nature of the wound, and whether it was indeed a pressure ulcer.

42. When Mrs A deteriorated abruptly and generally in early November 2010, the pressure ulcer was not immediately considered as a possible source of deterioration. However, as soon as the change in the condition of the pressure ulcer was appreciated by medical staff, appropriate specialist (general, orthopaedic and plastic surgery) opinion was sought and obtained quickly. Surgical staff did record that although investigation of the pressure ulcer was reasonable (by MRI scanning) that surgical treatment may not have been appropriate in the light of Mrs A's overall condition.

43. Adviser 2 considered the pre-terminal decision to start antibiotics and the choice of specific antibiotics were both reasonable. However, faced with a rapidly deteriorating patient, and with the involvement of Mrs A's family, a medical decision was then made that continued use of these drugs was futile. Adviser 2 did not believe that this can be said to have been an unreasonable decision even though the duration of antibiotic use was short.

44. Adviser 2 considered that it was entirely understandable that Mrs A's family had questioned whether the sudden and significant deterioration of the pressure ulcer and the development of the osteomyelitis could have been prevented or detected earlier. Adviser 2 had noted the comments regarding care of the pressure ulcer made by Adviser 1 and, in particular, her comments regarding the provision of pressure relieving equipment and some aspects of documentation in Mrs A's medical records.

45. From a medical perspective, Adviser 2 did not feel that it could definitely be said that anything different could have been done to anticipate the breakdown of the pressure ulcer or prevent establishment of the osteomyelitis. Several specific areas regarding care around the time Mrs A deteriorated in late October 2010 were, in the view of Adviser 2, however, worthy of comment.

46. A change in the level of the enzyme alkaline phosphatase (AP) in the blood occurred in the last week of October 2010. This is an enzyme that can rise in association with a number of medical problems including diseases of bone, such as osteomyelitis. Adviser 2 noted that the Board had openly noted this in their complaints response. However, when reviewed in the context of the overall condition of Mrs A and the existence of other competing co-morbidities, some of which could cause a similar change, Adviser 2 did not believe that it could definitely be said that there was any specific failure by medical staff to act differently on the basis of this single result at that time.

47. Adviser 2 explained that the CRP (a sensitive but non-specific marker of inflammation, including that caused by infection) was measured frequently and when it rose a variety of causes were considered. On 27 October 2010 the overall clinical condition of Mrs A as documented by the medical staff, did not significantly change, with the exception of some symptoms suggesting possible urinary infection. A 'septic screen' to seek possible causes of infection was suggested but this did not include a wound swab. It was, however, noted that the elevated CRP had fallen (but not normalised) before antibiotics for a possible urinary infection (which could cause the elevated CRP) had been started, and this may have reassured the clinicians at this point.

48. Mrs A did, however, deteriorate clinically on 30 October 2010 with hypotension (low blood pressure). The need to swab the ulcer was suggested by a doctor on 1 November 2010 and the wound was reviewed by the TVN on 2 November 2010. A surgeon then reviewed the wound later that day. In most medical units, in Adviser 2's experience, medical staff do not routinely review the condition of all pressure ulcers on a regular or routine basis after the diagnosis is made and treatment started. Adviser 2 was aware of no mandatory guidance to that effect. Primary responsibility for care and monitoring of the wound lies with the nursing staff supported by the specialist TVN. Liaison between medical staff and nursing, and specialist tissue viability nursing staff was, however, important and medical staff should review such a wound at any time they are requested by nursing staff. It did not, however, appear that a request for review was made at any point in late October 2010. Adviser 2 also noted, in this regard, the comments of Adviser 1 regarding nursing documentation of the wound over that time.

49. Adviser 2 told my complaints reviewer that it may be argued that medical staff should independently review the wound at any time there is a suggestion of clinical deterioration of a patient or suspicion of infection (for example a rising CRP). Alternatively, they should at such times discuss the status of the wound with nursing staff to ascertain whether it could be the source of the change in a patient's condition. When Mrs A did have a rise in CRP in late October 2010 Adviser 2 could see no medical documentation to suggest that the status of the pressure ulcer was considered as a possible cause. When the clinical condition of Mrs A did change more clearly in early November 2010 there did not appear to have been any consideration that the wound may have been the source of the change until 48 hours after Mrs A deteriorated. Adviser 2 told my

complaints reviewer that, with hindsight, it is likely that the wound was breaking down and osteomyelitis developing over this period.

50. My complaints reviewer asked Adviser 2 whether he considered osteomyelitis had occurred as a result of the pressure ulcer and if he considered this was the main contributory factor leading to Mrs A's death. Adviser 2 said that on the balance of the evidence available and on the basis of his review of Mrs A's medical records, it was his opinion that Mrs A developed osteomyelitis at some point during her stay in the Hospital but it was not possible to state with certainty when this occurred. However, Adviser 2 did not believe that it could be said that the development of osteomyelitis in Mrs A could necessarily in itself be said to have indicated care of a poor standard or to have been preventable in all circumstances.

51. According to Adviser 2 the rapid deterioration in the pressure ulcer in early November 2010 could have related, as had been suggested by the Board, to a period of poor blood circulation to the damaged skin during a period of severe hypotension (low blood pressure), but could also suggest overwhelming infection in an immunocompromised individual, or breakdown of superficial tissues due to indolent and perhaps unrecognised deeper infection in bone or subcutaneous (below the skin) tissues. The deterioration in the pressure ulcer in late October 2010 appeared to have been concurrent with the deterioration of Mrs A in general. Adviser 2 was of the view that Mrs A was septic at that point, that the source of sepsis was the skin and bone adjacent to the pressure ulcer, and that sepsis did cause death. This was the working diagnosis of the clinicians treating Mrs A, and as such, in the view of Adviser 2, a perfectly reasonable diagnosis to enter onto the death certificate.

52. Adviser 2 also told my complaints reviewer that it is not at all uncommon, in day-to-day clinical practice in the care of older people, to be faced with a situation where a patient had deteriorated over weeks or months and to find multiple health issues, some chronic and some new, but no absolutely specific or single cause of the deterioration. Adviser 2 considered that the medical team treating Mrs A, after investigating thoroughly, concluded that this was the situation with Mrs A.

53. Adviser 2 believed that Mrs A dramatically and unpredictably deteriorated at the end of October 2010 and this was due to the development of sepsis secondary to breakdown of the pressure ulcer and osteomyelitis. As such,

Adviser 2 did not feel that the treating team could be criticised for considering the possibility of a return home before Mrs A became critically unwell in late October 2010.

54. However, whilst Adviser 2 did not believe that it can be said there was any failure of the medical staff to review the pressure ulcer at any specific point, Adviser 2 felt that the documented communication between nursing and medical staff and vice versa regarding the status of the pressure ulcer and its possible relationship to Mrs A's clinical condition, as evidenced by the clinical records alone, was below a standard that should be expected.

55. Adviser 2 was also asked by my complaints reviewer to comment on the appropriateness of the Certificate of Incapacity and whether there was evidence to support consultation with Mrs A's family in this respect.

56. A treating clinician judged that Mrs A lacked the capacity to fully participate in decision-making regarding the need to have an upper endoscopy shortly following her admission. Based on the review of Mrs A's case notes, Adviser 2 believed this was an appropriate judgement that could not be said to be incorrect or unreasonable.

57. Adviser 2 noted Mrs A's family appeared to accept that Mrs A was confused and/or had communication difficulties. They, however, questioned whether they should have been told that a Certificate of Incapacity had been completed and whether the justification for incapacity (a diagnosis of dementia) was correct. Adviser 2 told my complaints reviewer he would expect objective cognitive screening to form part of the basis of assessment of capacity, although it cannot be used in isolation to determine capacity. In this regard, Adviser 2 noted several screening tests of cognitive function were undertaken. Adviser 2 also explained that no single test or assessment or investigation can conclusively make a diagnosis of dementia or delirium.

58. Adviser 2 also noted the concerns of Mrs A's family that the reason given for Mrs A's lack of capacity was dementia. Adviser 2's view of the likely cause of Mrs A's confusion was her documented cognitive impairment which would be most likely, in his clinical opinion, to relate to a combination of 'delirium', perhaps relating to recurring infection, and a 'multi-infarct' type of dementia. However, the precise contribution of each of these to Mrs A's cognitive status could not be ascertained. However, as Mrs A's family had said that her

confusion had been of relatively short duration this suggested that delirium was more prominent. Alternatively, as it is known that multi-infarct dementia can progress rapidly, and the CT scan of Mrs A's brain undertaken during her stay would be compatible with that disease, although it was not diagnostic of it. Accordingly, Adviser 2 did not feel it was unreasonable to enter 'dementia' as a justification for use of the Certificate of Incapacity.

59. Given the belief of the treating team that Mrs A had confusion that may compromise capacity, Adviser 2 considered it had been good practice to have considered the need for and completed the Certificate of Incapacity to cover the proposed upper endoscopy procedure. Adviser 2 noted that a consultant had completed the form which was to cover this procedure only and not other aspects of investigation or treatment.

60. However, Adviser 2 said that one specific issue regarding completion of the Certificate of Incapacity could be criticised. Adviser 2 explained that one of the five general principles that must be applied by those authorised to make decisions on behalf of an individual with impaired capacity was that there should be consultation with relevant others. It should, therefore, be standard practice to consult with family or carers about the patient's possible treatment preferences and to ascertain the legal decision making status of any family and specifically establish whether or not a power of attorney was in place. Adviser 2 could find no evidence of such communication with Mrs A's family. The Certificate of Incapacity includes a section for the documentation of the next of kin and whether they have any formal decision-making status. However, in the case of Mrs A, a patient identification label had been placed over that section of the Certificate and was, therefore, apparently incomplete.

61. Adviser 2 commented that the lack of communication with Mrs A's family at this point about this issue was, in the opinion of Adviser 2, below a standard that should be expected.

62. The Certificate of Incapacity was completed solely to cover the upper endoscopy, which took place on 24 September 2010. It did not cover the colonoscopy or any other aspect of Mrs A's care. As such, according to Adviser 2, either another certificate should have been completed around the time of the colonoscopy, if the treating team felt Mrs A lacked capacity to consent to that procedure, or a standard consent form should have been

completed for the colonoscopy if the doctor undertaking the procedure felt that Mrs A did have capacity.

63. A colonoscopy consent form was completed initially on 18 October 2010 when the procedure was first scheduled, but then apparently countersigned by Mrs A on 25 October 2010, the day the procedure actually took place. Although the circumstantial evidence in the case notes would suggest that Mrs A may have lacked capacity at this point, there was no definite evidence to prove that she did. Capacity is also regarded as task specific – if the doctor responsible for undertaking the colonoscopy felt that Mrs A, on the day of the procedure, understood the need for and implications of the colonoscopy then the consent form as completed could not be said to be invalid.

64. As already stated, it was good practice that the need to consider capacity was considered when the upper endoscopy was planned. There did not, however, appear to have been on-going consideration of capacity for other aspects of investigation and treatment that – by the nature of the information entered onto the Certificate of Incapacity – were not actually covered by the form that had been completed. If clinicians did consider capacity again, Adviser 2 saw no clear documentation of it.

65. Overall, it is the opinion of Adviser 2 that although no specific issue other than the lack of communication with Mrs A's family could be directly criticised, the Board should consider:

- how in-patient units communicate with each other about the decision making capacity of patients requiring procedures as in-patients, to ensure that, for example, a patient who is being managed under the terms of The Adults With Incapacity (Scotland) Act 2000, is known to be so by any other team undertaking a procedure that would normally require written consent.
- whether the use of treatment plans (recommended for patients with complex care needs) might support the effective use and validity of Certificates of Incapacity in terms of Section 47 of The Adults With Incapacity (Scotland) Act 2000.
- how clinicians document the fact that capacity may be lacking for one specific intervention (in this case upper endoscopy) but present for other investigations and treatments (in this case CT scanning, multiple blood tests etcetera) if they believe this to be the case.

- that the Board ensure that family and carers are appropriately involved and informed of the consideration of use of the Adults With Incapacity legislation in the care of a patient and to document this clearly on a Section 47 Certificate of Incapacity.

*(a) Conclusion*

66. The clinical advice I have received from Adviser 2 is that this was a complex and difficult clinical case and that Mrs A, when she was admitted to the Hospital, had existing multiple health problems and had already deteriorated physically and cognitively to a significant degree. Adviser 2 considered the Hospital had carried out appropriate investigations and screening both for the problem for which Mrs A had been admitted to the Hospital, possible gastrointestinal bleeding, and for the common interrelated problems of frail older people. Furthermore, Adviser 2 considered that, from a medical perspective, it could not definitely be said that anything different could have been done to anticipate the breakdown of the pressure ulcer or prevent establishment of the osteomyelitis. Adviser 2 also told my complaints reviewer that as Mrs A had dramatically and unpredictably deteriorated in late October 2010 he considered, therefore, the medical staff treating Mrs A could not be criticised for considering the possibility of Mrs A return home prior to this. I acknowledge and accept this advice.

67. Nevertheless, the clinical advice that I have also received from Adviser 1, in particular, and also Adviser 2, which I also accept, is that there were clear and unacceptable failings by hospital staff in relation to the management of Mrs A's pressure ulcer mainly from a nursing perspective and in communicating with Mrs A's family.

68. Despite Mrs A having the pressure ulcer on admission and being at high risk of pressure ulcer damage, there were failures to initially grade and document the pressure ulcer and thereafter on occasions to reassess the condition of the pressure ulcer, contrary to the Best Practice Statement. There was also poor documentation regarding the condition of Mrs A's skin integrity in general on a daily basis and there was a long period of time from early October 2010 until the beginning of November 2010 when Mrs A was not seen by the TVN.

69. Although the pressure ulcer seemed to be improving during October 2010 and there was a reasonable focus on the wound management of the pressure

ulcer, it is concerning that there appears to have been a clear lack of preventative strategies in place to prevent a deterioration of the pressure ulcer and to reduce the risk of further pressure damage. I have also noted the concerns expressed by Adviser 1 about what she regards as the absence of the Board to acknowledge the lack of preventative care by the Hospital in relation to the pressure ulcer and the risk of further pressure damage.

70. Furthermore, based on the clinical advice received from Adviser 1 and Adviser 2, there were also failings in communication. Adviser 2 considered that the documented communication between nursing and medical staff and vice versa regarding the status of the pressure ulcer and its possible relationship to Mrs A's clinical condition, as evidenced by the clinical records alone, was below a standard that should be expected. Adviser 1 also was of the view that there seemed to be very little evidence in Mrs A's medical notes concerning communication with her family specifically with regard to the pressure ulcer.

71. In addition, there is no evidence that hospital staff consulted Mrs A's family about the Certificate of Incapacity or enquired as to the legal decision making status of any family member, specifically, whether or not a power of attorney was in place. I note the opinion of Adviser 2 that this was below a standard that should be expected.

72. In view of these reasons, I uphold the complaint.

*(a) Recommendations*

| 73. I recommend that the Board: | *Completion date* |
|---|---|
| (i) provide the Ombudsman with evidence that the Board's current policies and procedures regarding prevention, management, monitoring, education and training of pressure ulcers is in line with national guidance and best practice; | 14 August 2013 |
| (ii) take steps to put in place an action plan to address the shortcomings identified in this report in relation to pressure ulcer management and share this action plan with both the Ombudsman and Mrs C; | 14 August 2013 |
| (iii) review how in-patient units communicate with each other about the decision making capacity of patients requiring procedures as in-patients, to | 14 August 2013 |

| | Recommendation | Date |
|---|---|---|
| | ensure that a patient who is being managed under the terms of the Adults With Incapacity (Scotland) Act 2000, is known to be so by any other team undertaking a procedure that would normally require written consent; | |
| (iv) | consider whether the use of treatment plans (recommended for patients with complex care needs) might support the effective use and validity of Certificates of Incapacity in terms of Section 47 of the Adults With Incapacity (Scotland) Act 2000; | 14 August 2013 |
| (v) | review how clinicians document the fact that capacity may be lacking for one specific intervention but present for other investigations and treatments if they believe this to be the case; | 14 August 2013 |
| (vi) | ensure that family and carers are appropriately involved and informed of the consideration of use of the Adults With Incapacity legislation in the care of a patient and to document this clearly on the Certificate of Incapacity; and | 14 August 2013 |
| (vii) | issue Mrs C and her family with an appropriate apology for the failings identified in the complaint. | 19 June 2013 |

**(b) The implementation and application of the Liverpool Care Pathway (LCP) was inadequate**

74. Mrs C raised concerns regarding the administration of the LCP. Mrs C said that whilst Mrs A was on the LCP she was frequently agitated. Mrs A's pain relief needs were routinely not met resulting in members of the family who were visiting having to approach medical staff for increased sedation. The family also considered that Mrs A should have had her regular medication needs reviewed by senior medical staff on a daily basis.

75. Mrs C said when Mrs A died on the Ward after eight days on the LCP the smell from the infection in her pressure ulcer was 'awful'. If medical staff had identified that Mrs A was 'shutting down' then the family could have arranged for hospice care or taken her home to die. They felt her passing was extremely disturbing, she required six injections of morphine in six hours, and could not be described in any way as peaceful.

76. Mrs A was nursed in an open ward until she died which was stressful for Mrs A's family who were in constant attendance with her in the days before she died.

77. In their response, the Board said that the decision to use the LCP had been agreed with Mrs A's family. In Doctor 1's opinion, the LCP was in keeping with Mrs A's rapid deterioration over the period between 3 and 5 November 2010. It offered a robust process to ensure that appropriate medication was prescribed for symptomatic relief, particularly as the weekend was approaching. Doctor 1 had regretted that this approach did not reduce some of the distressing symptoms of agitation and discomfort that Mrs A was perceived as experiencing by her family and that Mrs A's family did not feel that she died peacefully. The Board said that it is often the case that family members who spend a great deal of time with a patient are the first to identify any distress being suffered by the patient and would be the first to alert nursing staff to its occurrence. A review of a patient's medication is undertaken by nursing staff and the ward team supported where necessary by a consultant. In Mrs A's case, a daily review by a senior doctor was not required and her charts demonstrate that her medication was regularly adjusted in response to identified symptoms.

78. Following representations from Mrs A's family about Mrs A's care and treatment after her death, the Board asked a consultant geriatrician (Doctor 3), to carry out a review. Doctor 3 supported the Board's response to the concerns raised by Mrs A's family although she was of the opinion that if Mrs A's medication had been increased prior to her death, then her symptoms would perhaps have been better controlled. The Board had sincerely apologised to Mrs A's family that this did not happen and advised them that Doctor 3's findings had been relayed to the Ward team and also to Doctor 1.

*Clinical Advice Obtained*

79. Adviser 2 told my complaints reviewer that the decision to manage Mrs A using the LCP appeared to have been made by a consultant with the knowledge and understanding of Mrs A's family. It marked a change in care strategy from a curative to a palliative approach. In Adviser 2's opinion, in the context of the overall course and condition of Mrs A, this was a reasonable decision to make.

80. Adviser 2 said that the management of a dying patient is a responsibility shared by all members of the healthcare team, whether or not the patient is

managed within the LCP. Both nursing and medical staff should assess the patient frequently and make judgements about changes in care, particularly changes in drug treatment, according to the patient's condition, symptoms and needs. There is, however, considerable variation between individual patients and symptom control may not be smooth or without difficulty, irrespective of whether the LCP is used or not.

81. Adviser 2 explained to my complaints reviewer that ideally a patient will have their symptoms managed in a manner that means they experience no pain or distress whatsoever in the days and hours before death. Adviser 2 noted that the Board have already apologised for the fact that the dose of morphine in the continuous infusion could have been increased more rapidly in the day before Mrs A died, and that, had this occurred, this may have led to the need for fewer additional 'as required' doses of morphine before her death. Adviser 2 concurred with this. However, provided medical reviews of Mrs A were taking place, (Adviser 2 told my complaints reviewer that it appears they were) he did not feel that failure to judge the correct dose of morphine in the infusion in Mrs A could be said to be below a standard that could reasonably be expected.

82. Adviser 2 said that, preferably, terminal care should be delivered in a single room where the appropriate level of privacy and dignity can be afforded to the patient and their family. However, given the number of single rooms in the majority of Scottish NHS hospitals at present it can be difficult or even impossible to provide a single room for terminal care. In addition, single rooms are also required for patients with specific infections or suspected infection or disturbed or agitated behaviour, all of which are common in hospitals.

83. Therefore, although it was clearly not ideal and was understandably distressing to Mrs A's family that Mrs A was not in a single room, Adviser 2 saw no reason to dispute the Board's explanation that this was because an appropriate single room was not available at the time. However, Adviser 2 considered that it may be useful for the Board to consider how frequently such an occurrence happens in their hospitals at present, for example by auditing the precise location of death of their in-patients and whether any system of prioritisation for single rooms across units might minimise this.

*(b) Conclusion*

84. Adviser 2 agreed with the findings of the Board, following the review by Doctor 3, that the failure to judge the correct dose of morphine in the infusion

leading up to Mrs A's death, may have led to the need for fewer additional 'as required' doses of morphine before she died. I accept that advice and note that the Board have already issued an apology to Mrs A's family for this. However, overall, the clinical advice I have received from Adviser 2 is that the implementation and application of the LCP was appropriate.

85. Furthermore, I note the views of Adviser 2 that ideally terminal care of a patient in hospital should be delivered in a single room where the appropriate level of privacy and dignity can be afforded to the patient and their family. However, I accept the advice from Adviser 2, for the reasons set out above, that this is unfortunately at present not always possible.

86. For these reasons, I do not uphold the complaint.

87. However, following the advice received from Adviser 2, I am recommending the following.

*(b) Recommendation*

| 88. | I recommend that the Board: | *Completion date* |
|---|---|---|
| (i) | with reference to Adviser 2's comments under paragraph 83 of this report, consider auditing the precise location of death of their in-patients and whether any system of prioritisation for single rooms across units might minimise this. | 14 August 2013 |

**(c) Communication between board staff and Mrs A's family was unreasonably poor, in particular a meeting with Doctor 1 on 26 October 2010, and a telephone conversation between Mr B and Doctor 2 on 1 October 2010**

89. Mrs C said that communication between her and other members of Mrs A's family and Board staff was poor during Mrs A's time in the ward. Mrs C and the family also considered that members of staff had adopted an adversarial tone towards them from the date Mrs A was admitted to the Hospital.

90. Mrs C said that Mr B had spoken on the telephone to Doctor 2 on 1 October 2010. On this occasion, Mr B had been seeking information about how the decision to discharge Mrs A home had been made, given her clinical deterioration, and lack of a diagnosis for her condition. According to Mr B,

Doctor 2 made it clear that he was unhappy talking to Mr B and had answered his questions in a curt and dismissive manner.

91. Mrs C also said that Doctor 1 had been unpleasant towards her, her sister (Mrs D), and Mr B, during a prearranged meeting on 26 October 2010. At the meeting Doctor 1 had been unable to answer basic questions regarding Mrs A's care and had no access to Mrs A's case notes or clinical portal. Mrs C also said that Doctor 1 was also defensive when Mr B asked to see one of Mrs A's test results. Doctor 1 seemed only interested in getting them to accept that Mrs A should be discharged home.

*Clinical Advice Obtained*

92. Adviser 2 has told my complaints reviewer there is evidence in Mrs A's medical records of medical staff communicating with Mrs A's family. However, there did not appear to have been any specific communication by staff with Mrs A's family regarding the management of her incapacity. In addition, Adviser 2 had also noted Adviser 1's comments about the lack of specific communication with Mrs A's family regarding the pressure ulcer.

93. Adviser 2 had considered Mrs A's family's detailed comments regarding their communication with medical staff. In particular, their specific concerns about two conversations, that is with Doctor 2 by telephone, and a meeting with Doctor 1. However, Adviser 2 can find no documentation in relation to either of these specific conversations in Mrs A's case notes. Adviser 2 told my complaints reviewer that it would be regarded as good practice for medical staff to document any discussion with family members of a patient in their medical records.

*(c) Conclusion*

94. I consider it unsatisfactory that there does not appear to have been any record made of the discussions which members of Mrs A's family had with Doctor 1 and Doctor 2 on 1 and 26 October 2010. Furthermore, the Board have not responded to these two specific issues of concern in their response to the complaint. The Board said the reason for this is because they were raised by Mr B 'for consideration only'.

95. Given the lack of documentary evidence in the medical records and the failure by the Board to respond to these concerns, I am, therefore, unable with certainty to draw any conclusions about the content and tone of these

discussions and to make a finding about what occurred on these two occasions. I appreciate this will be disappointing and frustrating for Mrs A's family. Given the serious nature of the concerns against two named members of staff I consider that the Board should have addressed these issues in their response to the complaint. The advice received from Adviser 2 is that it would be regarded as good practice for medical staff to do so. I concur with this advice.

96. However, I am satisfied, based on the clinical advice received from both Adviser 1 and Adviser 2, as set out in complaint (a) that there was unreasonably poor communication with Mrs A's family both with regard to the treatment and management of the pressure ulcer and the management of Mrs A's incapacity. Therefore, for this reason I uphold the complaint.

*(c) Recommendations*

| 97. | I recommend that the Board: | *Completion date* |
|---|---|---|
| (i) | seek to ensure that any discussion that a member of staff has with a patient's family is recorded in the patient's medical records; and | 14 August 2013 |
| (ii) | issue Mrs C and her family with an appropriate apology for the failings identified in the complaint. | 19 June 2013 |

**Annex 1**

## Explanation of abbreviations used

| | |
|---|---|
| Mrs A | The deceased mother of Mrs C and the subject of the complaint |
| The Hospital | Victoria Infirmary, Glasgow |
| The Ward | Ward 1, Victoria Infirmary, Glasgow |
| Mrs C | The complainant and daughter of Mrs A |
| The Certificate of Incapacity | A Certificate of Incapacity under Section 47 The Adults With Incapacity (Scotland) Act 2000 |
| LCP | The Liverpool Care Pathway |
| Mr B | Mrs A's son |
| Doctor 2 | A medical registrar at the Victoria Infirmary, Glasgow |
| Doctor 1 | Mrs A's consultant at the Victoria Infirmary, Glasgow |
| The Board | Greater Glasgow and Clyde Health Board |
| Adviser 1 | A clinical adviser to the Ombudsman |
| Adviser 2 | A clinical adviser to the Ombudsman |
| CT scan | Computerised tomography scan |
| TVN | A Tissue Viability Nurse |

| | |
|---|---|
| Best Practice Statement | NHS Quality Improvement Scotland Tissue Viability - Best Practice Statement March 2009 Prevention and management of pressure ulcers |
| Doctor 3 | A consultant geriatrician |
| Mrs D | Mrs A's daughter and the sister of Mrs C |

**Annex 2**

## Glossary of terms

| | |
|---|---|
| Alkaline phosphatase | A protein found in all body tissues |
| Atrial fibrillation | An abnormal heart rhythm |
| Colonoscopy | A procedure where the large intestine is examined |
| C-reactive protein (CRP) | A blood test that measures for inflammation and infection |
| Endoscopy | a procedure where the inside of the body is examined internally using an endoscope |
| MRI imaging | Magnetic resonance imaging, a medical imaging technique used in radiology to visualise internal structures of the body in detail |
| MUST nutritional screening | A screening tool to identify adults, who are malnourished |
| Myeloma | the presence of an abnormality of the production of immunuglobulins |
| Osteomyelitis | An infection of a bone |
| Pyrexia | A fever |
| Spinal stenosis | A narrowing of the spinal column |
| Waterlow risk assessment | A pressure ulcer risk assessment scoring system |
| White Cell Count (WBC) | A blood test to measure the number of white blood cells |

**Annex 3**

**List of legislation and policies considered**

NHS Quality Improvement Scotland Tissue Viability - Best Practice Statement March 2009 Prevention and Management of Pressure Ulcers

The Adults With Incapacity (Scotland) Act 2000 (Section 47)

The Liverpool Care Pathway for the Dying Patient (LCP)