SPSO decision report

Case: **201801116, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C, a support and advocacy worker, raised a complaint on behalf of her client (Mr B) about the clinical and nursing care and treatment his late wife (Mrs A) received when she was admitted to University Hospital Monklands.

We took independent advice from a consultant physician and a nursing adviser. In relation to the clinical care and treatment given to Mrs A, we found that the physiotherapy support had been reasonable. We also found that the administration of medicines and the clinical input at the time of Mrs A's death had been reasonable. However, we found that she should have been referred to the diabetes in-patient team early in her admission to the hospital and, had this happened, it was likely that insulin would have been started which may have avoided the development of a necrotic heel. We also found that there should have been better control of Mrs A's blood sugar which might have reduced her propensity to infection. We noted that communication or documentation of communication with the family could have been better. Given the failings identified, we upheld this aspect of the complaint.

In relation to the nursing care and treatment given to Mrs A, we found a number of failings. In particular, that Mrs A did not receive the required interventions to prevent pressure damage and that there had been a delay in obtaining equipment to help prevent pressure damage. We also found there had been confusion over the diagnosis of a sacral wound and that Mrs A's food, fluid and nutrition needs were not met. Furthermore, we found that there was a failure to refer Mrs A to podiatry (medical treatment of the feet and their ailments) and that there were omissions in patient-centred care planning and incomplete documentation. Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr B and his family for the failings this investigation has identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Ensure that there is appropriate and documented communication with patients and/or their families during a patient's stay in hospital.
- Where a diabetic patient has consistent elevation of blood sugars there should be a thorough evaluation of their diabetes medication and an early referral to the diabetes review team.
- Nursing staff should ensure Healthcare Improvement Scotland (HIS) standards for prevention and management of pressure ulcers is followed.
- When a patient with diabetes shows a decreased appetite, a patient-centred care plan should be

developed in line with HIS Standards for Food, Fluid and Nutrition and HIS Standards for Care of Older People in Hospital.
- Accurate records should be maintained in line with the Nursing and Midwifery Council Code of record-keeping and the HIS Scottish Wound Assessment and Action Guide.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.