SPSO decision report

Case: **202002913, Fife NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the care and treatment their parent (A) received from district nurses in relation to the management of sores/ulcers on their legs while resident at a care home. In particular, C complained that district nursing staff had failed to adequately monitor and treat A's sores/ulcers to such an extent that dressings would become saturated in exudate (fluid), requiring care home staff to apply further dressings. C stated that this had led to A developing significant infection requiring admission to hospital, where they died a short time later. C further complained that district nursing staff had failed to identify the deterioration in A's legs and had not alerted A's GP nor made a referral to a specialist tissue viability practitioner (a specialist in aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration).

In response to C's complaint, the board stated that A had been reviewed frequently by district nursing staff, who had not identified any signs suggesting that A's legs had become infected. The board concluded that district nursing staff had delivered consistent and appropriate care and that referral to a tissue viability specialist had not been indicated.

We took independent advice from a district nursing adviser. We found that there were a number of failings in relation to how A's sores/ulcers had been managed, specifically that wound assessments carried out were incomplete and not carried out at the required frequency and that the wound dressings used were inappropriate, often contradicting the findings of examinations, and contrary to current guidelines. We noted that district nursing staff had failed to carry out baseline observations and tests to check for the presence of infection or sepsis (blood infection) despite noting that A was as “flat” and “lethargic”. We also found that the district nursing staff's record-keeping was poor and not in accordance with relevant professional standards given there was no documented record of interactions with A on certain dates.

For these reasons, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with reasonable care and treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

- The board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and that learning from complaints is used to drive service development and improvement. The board should comply with their complaint handling guidance when investigating and responding to complaints.

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.