SPSO decision report

Case: **202208120, An NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (A). A had undergone breast surgery to remove nodes and C complained that the board did not adequately assess and manage A's wound when it showed signs of infection. The wound deteriorated and A became critically unwell with sepsis.

The board carried out a Significant Adverse Event Review (SAER), in which A expected greater involvement. C also complained that the SAER failed to identify that the incident met the Duty of Candour threshold and did not address the key issue, which was the inadequate care provided. The board stated the staff involved used their clinical judgement to assess the wound, which did not show signs of infection. However, it was difficult to investigate the adequacy of the wound assessment due to the omission of notes they made. The board acknowledged communication between health care professionals was impeded by a reliance on a paper-based system and the clinical record keeping was inadequate.

The board further advised the SAER was a formal process, which did not allow for A's inclusion and maintained the incident did not meet the Duty of Candour threshold. They considered the SAER to be adequate, as an investigation had taken place that had identified a number of learning points and recommendations.

We took independent clinical advice from a registered nurse specialising in tissue viability. We found the wound assessment to be inadequate, leading to a missed opportunity for appropriate wound management and that those involved in A's care lacked knowledge of current best practice in terms of wound assessment, wound management and antimicrobial stewardship. We also found the SAER to be inadequate as it failed to address the key issues of wound assessment, wound management and antimicrobial stewardship and failed to identify the incident met the Duty of Candour threshold.

As such, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failings 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:

- A person centred approach should be adopted.
- For all patients with a wound to have an adequate wound assessment undertaken and documented in a formal wound assessment chart. This should be in line with the following guidance Vale of Leven Inquiry Scottish Government Recommendations 2015NMC: The Code 201Scottish Ropper Ladder for Infected Wounds 2020 and HIS Scottish Wound Assessment and Action Guide 2021.

- A Duty of Candour Investigation to be undertaken, unless there is definitive evidence that the UTI caused the sepsis as wound deterioration is still a strong possibility.
- All staff involved in wound management are competent in appropriate management and familiar with the relevant guidance.
- Pathway to be developed to ensure timely referral to tissue viability specialist for deteriorating or non-healing wounds.
- Recommendations added to the SAER to address learning and improvement around wound assessment, management and antimicrobial stewardship.
- Staff to be reminded of Stage 3 of the Scottish Ropper Ladder for Infected Wounds, and consideration of antibiotics.

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.