Scottish Parliament Region: North East Scotland

Case 200601565: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; General medical; Hygiene, cleanliness and infection control

Overview

Mrs C was concerned that her mother, Mrs A, had developed a pressure sore while in Ninewells Hospital (Hospital 1) and this prevented her from accessing stroke rehabilitation services.

Specific complaint and conclusion

The complaint which has been investigated is that the care and treatment received by Mrs A from Hospital 1 was inadequate and reduced her ability to access rehabilitation services (*partially upheld to the extent that the Board did not fully respond to concerns raised by Mrs C*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) apologise to Mrs C for failing to respond clearly to her concerns about the effect on Mrs A of the problems in the care she had received; and

(ii) use this case as a learning tool for staff to demonstrate the importance of good documentation and the effect that failing to complete documentation can have on patient care.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mrs A, aged 69, was admitted to Ninewells Hospital (Hospital 1) on 3 March 2006 following a stroke. She had had a stroke the year before but had recovered and been able to return home.

2. On 14 March 2006 she was transferred to Stracathro Hospital (Hospital 2) for specialised stroke rehabilitation. On admission, she was found to have a grade 3 pressure sore on her sacrum and a grade 1 sore on her right elbow. The grade 3 sore was subsequently found to contain MRSA and Mrs A developed septicaemia. This infection required prolonged antibiotic treatment. On 23 May 2005, having been unable to access the rehabilitation services because of her conditions, Mrs A was transferred again for continuing care at a third hospital. Following this, she returned home with a care package.

3. Mrs A's daughter, Mrs C, complained that the sores had developed because of failures in her care at Hospital 1. She said she felt that her mother's ability to access rehabilitation had been directly affected as a result. In two letters, Tayside NHS Board (the Board) accepted there had been a number of failings and said that their policy on pressure area management had not been followed. They also said that the information given to Hospital 2 on discharge was written without the aid of nursing notes, which was unacceptable. In their second letter, the Board said Mrs A's consultant at Hospital 2 (the Consultant) had been asked to comment and 'clearly the issue of the sacral sore she has suffered has impacted on this process'. Mrs C said that, despite the response, she remained concerned that the care given had been so inadequate.

4. The complaint from Mrs C which I have investigated is that the care and treatment received by Mrs A from Hospital 1 was inadequate and reduced her ability to access rehabilitation services.

Investigation

5. The investigation of this complaint involved obtaining all the background documentation relating to the complaint and Mrs A's medical records. Advice was also obtained from medical and nursing advisers (Adviser 1 and Adviser 2, respectively) to the Ombudsman. As a result of the advice, further enquiries were made of the Board. The abbreviations used in the report are explained in Annex 1 and the medical terms used in the report are explained in Annex 2.

6. 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.

Complaint: The care and treatment received by Mrs A from Hospital 1 was inadequate and reduced her ability to access rehabilitation services

7. Mrs A spent time in three different wards in Hospital 1. She was in Ward A for only one day before she was transferred to Ward B, where she remained for most of her stay. She was transferred to Ward C for one night prior to her discharge and move to Hospital 2. Mrs C wrote twice to the Board about her concerns.

8. In their responses to Mrs C's first letter, the Board accepted there had been a number of failings in the care of Mrs A. They said that information in the verbal handover from Ward A to Ward B had not been recorded; they accepted that Mrs A was not immobile, as had been indicated in this handover; no assessment was made of Mrs A's risk of developing pressure sores until 6 March 2006; there was a delay in providing Mrs A with a special mattress; and the transfer letter to Hospital 2 was written without nursing records, following the move to Ward C and vital information was not included.

9. In her second letter, Mrs C asked that the Board contact the Consultant and asked them to address the outcome of the failings on Mrs A's ability to access rehabilitation services at Hospital 2. In their response, the Board said that the nursing records relating to skin changes were inadequate and not sufficiently detailed. The Board said that action was being taken forward with the nursing team as a matter of urgency. They said they had contacted the Consultant and that 'clearly the issue of the sacral sore she has suffered has impacted on this process'.

10. In response to my enquiries, the Board provided me with a copy of the letter from the Consultant to them. This described in detail the effect of the sore and the infections that resulted. In concluding, the Consultant said:

> 'How [Mrs A] would have fared with stroke rehabilitation given that this was her second event within one year, had she not had the pressure sore, is of course difficult to predict but certainly the restrictions imposed upon her by the severe tissue viability issues made stroke rehabilitation for her essentially a non-starter from the outset.'

11. Adviser 1 reviewed the records and the Board's responses. He said that on admission Mrs A had obvious risk factors: she had type 2 diabetes, was overweight and incontinent, which made pressure sores and infection more likely. He said that when this was combined with the poor pressure area management at Hospital 1 this led to a debilitating pressure sore which, combined with infection, weakened the patient and, in his view, probably irretrievably prevented active rehabilitation. Adviser 1 noted that the Consultant had correctly stated that, given Mrs A had only recently suffered a stroke and along with her other conditions, rehabilitation would have been more problematic than following her first stroke. The Consultant had, though, unequivocally stated that the complication of a severe pressure sore rendered Mrs A bedbound and unable to undertake any therapy. Adviser 1 concluded that the unlikelihood of significant improvement, even without the pressure sore, did not mitigate the poor quality of nursing care at Hospital 1.

12. I asked the Board to provide details of the policies that should have been followed and action taken in response to the failings identified. They said they used the 'Waterlow' pressure ulcer risk assessment system[1] and this was re-assessed daily. They were introducing a new pressure ulcer classification tool to improve consistency in the issue of pressure relieving devices. Staff in Ward B had attended a wound care study afternoon and a wound care group had been set up in Ward B to support the nursing team. They would also monitor documentation. They also provided a copy of their wound management formulary which set out up-to-date guidance on wound assessment. This information and the nursing records were reviewed by Adviser 2.

13. Adviser 2 noted that, in general, the nursing staff did not make a full assessment and that this extended beyond pressure area management. She said the nursing records were generally inadequate.

14. The Board provided more detailed information about their Safer Patient Initiative. This had been introduced to improve patient care and they were now using more structured audits of documentation. They provided details of audits for Ward B from 30 September 2005 to 10 August 2007. This did show that there had clearly been issues with the completion of documentation at times in Ward B but there was also evidence of demonstrable and sustained

[1] The Waterlow system is standard practice.

improvement, as evidenced by compliance rates which had reached a low in February 2006 but had not gone below 60 percent since April 2006. The figures for 2007 were almost all above 80 percent and 100 percent compliance was now being regularly achieved.

(a) Conclusion

15. Before the complaint was made to the Ombudsman's office, the Board had accepted that Mrs A did not receive appropriate and adequate care. In their response to Mrs C they did apologise but did not fully explain the Consultant's position to her. Given the details of the Consultant's opinion, the Board's response should have been clearer. Therefore, although the Board apologised and did undertake action to prevent recurrence, they did not fully acknowledge the extent to which their failure to care for Mrs A had affected her recovery and her ability to access and benefit from rehabilitation services despite the detail being available to them from the Consultant. In the circumstances, I partially uphold the complaint to the extent that this was not communicated clearly to Mrs C. However, I would commend the Board for the action taken to prevent a recurrence. Work is ongoing in the area of pressure sore management and the significant improvement in the audits of key documentation in Ward B, as part of the Safer Patient Initiative, is encouraging.[2] Therefore, while I am recommending that the Board apologise to Mrs C for not responding as fully as they could have done to her concerns about the treatment given to Mrs A and that this case be used to demonstrate to staff the importance of good documentation, the Ombudsman is making no further recommendation for process review and change.

(a) Recommendation

16. The Ombudsman recommends that the Board:

(i) apologise to Mrs C for failing to respond clearly to her concerns about the effect on Mrs A of the problems in the care she had received; and

(ii) use this case as a learning tool for staff to demonstrate the importance of good documentation and the effect that failing to complete documentation can have on patient care.

[2] On this point, see report 200601247 which also related to failures which occurred in Hospital 1 in Spring 2006. That report sets out further actions taken by the Board on documentation and nursing care many of which were rolled out across the organisation.

17. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs A	The aggrieved, Mrs C's mother
Hospital 1	Ninewells Hospital
Hospital 2	Stracathro Hospital
Mrs C	The complainant
The Board	Tayside NHS Board
The Consultant	Consultant who treated Mrs A at Hospital 2
Adviser 1	Medical adviser to the Ombudsman
Adviser 2	Nursing adviser to the Ombudsman
Wards A, B and C	The three wards at Ninewells Hospital where Mrs A stayed during her period of admission

Annex 2

Glossary of terms

MRSA	Methicillin-resistant staphylococcus aureus: an organism which causes an infection resistant to a broad range of antibiotics
Pressure sore	Compression of tissue blood vessels due to body weight causing poor skin and deeper tissue perfusion, resulting in cumulative damage and ulceration. Pressure sores are graded 1-4 according to depth of tissue damage, grade 1 being a skin 'break', grade 4 being ulceration to the bone
Sacrum	Lower back
Septicaemia	Blood poisoning that occurs when bacteria enters the blood
Type 2 diabetes	A form of diabetes, more common from middle age onwards, where insulin production is insufficient to control blood sugar levels and dietary restriction and/or oral medication is prescribed