Scottish Parliament Region: Lothian

Case 201300690: Lothian NHS Board

Summary of Investigation

Category

Health: Hospitals – care of the elderly; clinical treatment; diagnosis

Overview

The complainant (Mr C) raised concerns about the care and treatment of his late mother (Mrs A) during a 12 week stay in three of Lothian NHS Board (the Board)'s hospitals. During this period, Mrs A developed pressure ulcers[1] on the heels of both her feet and at the base of her spine. One of these pressure ulcers became very severe, and eventually became infected. This infection spread to Mrs A's bone, and ultimately led to her death, six weeks after discharge. Mr C has complained that, had she not developed pressure ulcers, she would have lived longer.

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed to take reasonable steps to prevent Mrs A developing pressure ulcers and they failed to adequately manage these (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide an update on the action that has been taken to implement recent recommendations from Health Improvement Scotland and my office on the care and treatment of patients in relation to the risk and treatment of pressure ulcers;	30 May 2014
(ii) conduct a peer review of the prevention, care and management of pressure ulcers in the ward in Hospital 2 where Mrs A stayed;	30 July 2014
(iii) develop an action plan for improvements identified through the peer review, including education and	30 July 2014

[1] Pressure ulcers can also be known as pressure sores. For consistency I have referred to them as pressure ulcers throughout this report, except where direct quotes require otherwise.

	training, and share this with my office; and	
(iv)	apologise to Mr C for the failures identified in this report in relation to Mrs A's care and treatment, for the pain and suffering experienced by Mrs A and for the inaccurate information provided to Mr C in the Board's initial response to his complaint.	14 May 2014

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

Main Investigation Report

Introduction

1. This complaint relates to the care and treatment of an elderly woman, (Mrs A), who was admitted to hospital following a fall at home. After a period of assessment, she was initially found to have a fractured left hip and was subsequently found to also have a fracture of her sacrum (part of her pelvis). She was unable to move without assistance. She also had reduced sensation in her feet. Mrs A went on to spend three months in three different hospitals, before she was discharged to a nursing home. During this period in hospital she developed severe pressure ulcers on the skin at the heels of her feet and another on her sacrum (at the base of the spine).

2. Mrs A died six weeks after she was discharged from Lothian NHS Board (the Board)'s care. Her death certificate documented osteomyelitis (infection of the bone) as the primary cause of death, and listed the pressure ulcer on her left heel as contributing to her death.

3. The complaint has been brought to us by Mrs A's son (Mr C), who expressed particular concern at the lack of action in relation to Mrs A's pressure ulcers. He questioned whether staff had taken sufficient account of Mrs A's vulnerability to pressure ulcers from her initial admission to the Royal Infirmary of Edinburgh (Hospital 1); and been sufficiently vigilant in checking for and preventing them when she was transferred to Liberton Hospital (Hospital 2). He was concerned that not enough was done to treat the pressure ulcers that developed on Mrs A's heels and at the base of her spine. He also questioned whether intravenous antibiotics had ever been given to Mrs A, as the Board stated in their response to his complaint that she had received these to treat an infection. None of Mrs A's family had been aware of any intravenous medication at the time.

4. Mr C noted that, once Mrs A was transferred to Corstorphine Hospital (Hospital 3), positive action was taken to heal the pressure ulcer on her left heel. He has not expressed any concerns about the care and treatment Mrs A was given by staff at Hospital 3.

5. The complaint from Mr C which I have investigated is that the Board failed to take reasonable steps to prevent Mrs A developing pressures ulcers and they failed to adequately manage these.

Investigation

6. In order to investigate this complaint, my complaints reviewer reviewed Mrs A's clinical records and correspondence with the Board. She also obtained further information from the Board and sought the opinion of two professional medical advisers: A consultant geriatrician (Adviser 1) and a nursing adviser (Adviser 2). I have also taken into account the findings of a previous report I published in May 2013 relating to the treatment of pressure ulcers by the Board; and the findings of an Unannounced Inspection Report on the care of older people in acute hospitals at one of the hospitals in this case, by Healthcare Improvement Scotland.

7. In addition, my complaints reviewer took account of the content of guidance from Health Improvement Scotland (HIS) (2009) on the Treatment/ Management of Pressure Ulcers, and local guidance given in the Lothian NHS Pressure Area Care Pathway.

8. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board failed to take reasonable steps to prevent Mrs A developing pressure ulcers and they failed to adequately manage these

9. Mrs A was admitted to the Hospital 1 following a fall on 28 September 2012. She was transferred to the Combined Assessment Unit, from Accident and Emergency. X-rays taken when Mrs A was admitted did not show any fractures. However, because she continued to experience pain, she had a computerised tomography (CT) scan which was able to identify a small fracture in the left hip. No surgical intervention was required, due to the nature of the injury. However, she was unable to mobilise without assistance as a result of this fracture.

10. On 29 September 2012, Mrs A's skin condition was assessed on two different occasions. In one assessment she was given a score of 16 on the Waterlow Scale (an assessment of the patient's level of risk to pressure areas, included assessments of her skin type, build, age, sex, nutritional status, continence and mobility). This indicated that Mrs A was at 'high risk' of developing skin problems such as pressure ulcers. The other assessment gave her a Waterlow Score of 12, reflecting differences in the assessment of her

weight, height and mobility. This score indicated that she was at lower risk of developing skin problems.

11. No preventative action was taken by staff at Hospital 1 to reduce the risk of pressure ulcers or similar skin problems.

12. Mrs A was transferred to Hospital 2 on 5 October 2012 for rehabilitation. No handover notes were provided by the staff at Hospital 1 to inform staff at Hospital 2 of the care Mrs A was receiving or to raise any specific concerns. She continued to have pain from her hip and to require assistance with all forms of mobilisation but no concerns were raised by staff in relation to skin care or potential pressure ulcers.

13. On 18 October 2012 a nurse noted that Mrs A had bruised areas on both heels. Shortly after this, on 20 October 2012, a review of her Waterlow Score gave a score of 20, which indicates a very high risk of pressure ulcers. At that time she was encouraged to elevate her heels off the bed when lying down. It also became apparent that she had reduced sensation and was unable to feel her feet. By 25 October 2012 staff noted that these bruises had turned to 'boggy blisters' and she was again encouraged to elevate her heels.

14. On 26 October 2012 Mrs A had an Magnetic Resonance Imaging (MRI) scan of her lower spine, as she was suffering from on-going lower back pain. This found that she had a small fracture in her sacrum (the bone at the bottom of the spine).

15. On 1 November 2012 nursing staff noted that there was no change in relation to the blisters on Mrs A's heels, but identified that skin on her sacrum was slightly red.

16. On 2 November 2012 nursing staff emailed a referral to a Tissue Viability Nurse specialist (the TVN), asking for advice regarding the blisters on Mrs A's feet. The following day staff started using a 'skincare bundle' known as 'SSKIN', an assessment tool which included a chart to prompt and record repositioning of Mrs A and skin inspection. However, the skin care/ evaluation element of this chart was never completed.

17. On 12 November the consultant involved in Mrs A's care (Doctor 1) noted that the blister on the left heel had deteriorated significantly and the skin was broken.

18. On 17 November 2012 a nurse identified a small ulcer at the base of Mrs A's spine. This was treated with a dressing, and the notes included a comment: 'chase TVN'.

19. The possibility of infection in Mrs A's left heel was first noted on 26 November 2012, when Doctor 1 noted it was 'becoming smelly/ discharging', and that they were awaiting a review by the TVN.

20. The TVN reviewed Mrs A four weeks after the initial referral, on 30 November 2012. The TVN's notes identified a 'necrotic' area on the right heel (an area of dead tissue) but stated 'no dressings required at present'. The TVN also noted that on the left heel there was a necrotic area which was difficult to assess, but was probably a Grade 4 ulcer (on a four-point scale; this relates to an ulcer with extensive tissue damage, including muscle, bone or supporting structures). However, the TVN found there were no signs of clinical infection and advised that the wound should be covered with a non-absorbent dressing. The TVN went on to advise staff to leave the wound dry, but if it became 'boggy or infected' then to consider 'debridement' (the removal of any dead tissue from the ulcer). The TVN also instructed staff to put regular pressure area care in place.

21. On 3 December 2012 Doctor 1 reviewed Mrs A's heels. She noted that Mrs A's right heel was necrotic (there was dead tissue in it) and that the left heel was also necrotic but worse than the right and, based on the recommendations of the TVN, a dry dressing was required.

22. On 6 December 2012 a nurse noted that Mrs A's left heel was now leaking fluid and had a bad odour. They noted that swabs (samples taken with a sterile gauze and sent to the laboratory to assess the presence of bacteria) had been taken the previous week and they were awaiting the results. The notes indicated that at that time the wound was to be redressed every two days.

23. From 5 October 2012 to 8 December 2012 Mrs A's pressure ulcer risk assessment was reviewed on a weekly basis (with one exception). However, the risk of Mrs A developing pressure ulcers was never identified as greater

than 20 and throughout November, as her wounds deteriorated, the risk was consistently found to be 17. In particular, the score relating to a visual assessment of Mrs A's skin indicated that her skin was thin/fragile and dry. The box for 'broken [skin] (established ulcer)' was ticked on 5 October 2012 but not in any of the later assessments.

24. The Waterlow scoring system is used for identifying the risk of developing pressure ulcers. It allows for a score of up to 22 against some standard criteria including weight, skin, mobility and appetite. There are a further 24 points relating to 'special risks'. These include risks such as major surgery/ trauma, with 'orthopaedic – below waist spinal', which is allocated five points.

25. On 10 December 2012 Doctor 1 noted that left heel was 'smelly – wet'. The swab results showed that there were two different bacteria in the wound, which could be treated by two different forms of antibiotics. The notes went on to say 'treat heel infection with [antibiotics], discuss with microbiology'.

26. Later that day a trainee doctor (Doctor 2) phoned a microbiologist (a specialist in the treatment of infections) to discuss possible treatment. The notes from this call indicated that they discussed potential antibiotic treatments. They also noted that Mrs A had recently had norovirus (a stomach bug that causes vomiting and diarrhoea). The microbiologist concluded that antibiotics would be unlikely to help Mrs A as antibiotics were unlikely to remove the bacteria or help with the odour and advised that good ulcer care should be the first-line treatment. On this basis, the microbiologist 'advised only to use antibiotics in the event of infection'.

27. The notes did not refer to any further action being taken in relation to the care or treatment of Mrs A's pressure ulcers before her transfer, the following day, to Hospital 3.

28. Shortly after Mrs A's admission to Hospital 3, the ulcer on her left heel was treated with a 'honey bandage'. She was discharged from Hospital 3 on 22 December 2012, and went to a nursing home in Perth. There she developed osteomyelitis in her left foot. Mrs A died on 3 February 2013, and osteomyelitis was given as the primary cause of death (with an onset period of 14 days). The secondary cause of death was given as 'frailty of old age' (with an onset of two years) and 'pressure sore left heel' as the third cause (with an onset of six months).

29. Mr C first complained to the Board on 9 January 2013. In their response to Mr C's complaints about Mrs A's skin care, the Board reported that Mrs A had been given a Waterlow score of 12 on the day she was admitted to Hospital 1 (this was the lower of the two scores that had been calculated that day). They reported that Mrs A was put on a 'Huntleigh' bed, which is an appropriate mattress for this level of pressure risk. The Board noted, however, that there were no notes to state how often staff should have checked Mrs A's skin or notes of what other measures were taken to ensure that pressure care was given. They apologised for this, and informed Mr C that this had been brought to the attention of the staff involved.

30. The Board went on to provide an account of the care and treatment given to Mrs A in relation to her pressure ulcers at Hospital 2. They reported that blisters were noted on Mrs A's heels on 18 October 2012 and that she was referred to the TVN. They reported that the TVN 'introduced two-hourly checks of Mrs A's skin', and that staff elevated her heels from the mattress while she was in bed and 'encouraged her to use a footstool when out of bed'. They reported that Mrs A was seen 'again' by the TVN on 30 November 2012, by which time she had open pressure ulcers on both heels. They reported that the left heel continued to deteriorate and that, on the advice of the microbiologist, Mrs A was put on a course of intravenous antibiotics.

31. The Board also reviewed the problems Mrs A had with mobilising and reported that her level of mobility deteriorated during her stay in hospital. They noted that she was unable to walk unaided and that she had considerable hip and back pain.

32. Following receipt of the Board's response, Mr C was not satisfied that he had received answers to all of his questions, so he wrote another letter clarifying the points which he felt had not been addressed by the Board. In the Board's response, they suggested Mr C meet with staff to discuss his ongoing concerns. Mr C decided to bring his complaint to my office instead.

33. During my investigation, my complaints reviewer asked the Board specifically if they could comment on whether or not Mrs A was given any intravenous antibiotics while she was at Hospital 2, as indicated in their letter of 20 February 2013. They have confirmed that intravenous antibiotics were not given, and that a conversation with the microbiologist provided information

about which antibiotics should be used if they were required to treat an infection. Doctor 1 considered their use and, following discussion between Doctor 2 and the microbiologist, it was decided that, as there was no current evidence of an active infection, antibiotics were unlikely to be of benefit. The Board passed on the unreserved apologies of the clinical team that Mr C was given this inaccurate information in response to his complaint.

34. There is a range of guidance available in relation to the prevention and treatment of pressure ulcers. The HIS (2009) Best Practice Statement on the prevention and management of pressure ulcers (the Guidance) was utilised by the Board at the time of Mrs A's hospital stay. This provides guidance as to how patients should be monitored for the development of pressure ulcers and what steps should be taken to prevent their development, should signs arise. The patient's care plan should reflect any concerns relating to the risk or evidence of pressure ulcers, particularly where there are specific risk factors including lack of mobility, poor nutrition and pain.

35. The Guidance also requires staff to assess the risk of pressure ulcers using a formal risk assessment tool (such as the Waterlow score) and their own clinical judgement. This should be reviewed regularly and again if the patient's condition or treatment changes. Where skin redness is identified, the Guidance promotes increased monitoring of the skin with written documentation of what is observed and the use of non-perfumed moisturisers. Patients at risk of developing pressure ulcers should be suitably positioned to minimise pressure and friction. Staff should help to reposition the patient and they should also be encouraged to reposition themselves if possible.

36. If a pressure ulcer is found, the Guidance states that a careful assessment of the wound should be documented, with instructions for treatment and regular review. Patients with pressure ulcers which are deteriorating should be referred to a specialist service such as a tissue viability service.

37. In relation to the treatment of pressure ulcers, the Guidance promotes the use of the principles of moist wound healing, unless the patient's condition dictates otherwise. Where local infection is suspected, the Guidance promotes the use of topical treatment and dressings. Antibiotics are not recommended for the routine treatment of pressure ulcers unless microbiology advice indicates that this would be appropriate.

38. The Board's Pressure Area Care Pathway (the Pathway) provides specific guidance in relation to what steps staff should take in response to potential or actual pressure ulcers. It states that after pressure damage has been noted, the following instructions should be followed:

(i) complete pressure ulcer recording chart;
(ii) initiate repositioning and skin inspection chart or SSKIN Bundle; and
(iii) if skin is broken initiate a 'wound assessment & treatment chart'.

39. The Pathway uses a standard grading for pressure ulcers. They are graded from one to four: with one being similar to a bruise; two relates to a blister; three relates to the loss of the full thickness of the skin; and four relates to ulcers where there is extensive tissue damage, including muscle, bone or supporting structures.

40. The Pathway also specifies the need for complete nursing care plans to include an ongoing evaluation of appropriate pressure ulcer prevention interventions, such as the use of correct moving and handling techniques. It goes on to instruct staff to complete a DATIX (the Board's data base) incident form for ulcers that are graded two to four. Ulcers graded three or four should have a formal incident investigation.

41. The Pathway refers to an adapted Waterlow assessment criteria and SSKIN care bundle. The SSKIN care bundle consists of a sheet for recording frequent care delivery, such as positioning, skin inspection and nutrition. It also has a sheet for the evaluation of each of the elements relating to pressure area care. This includes the surface of the skin and inspection of it, the patient's movement, continence and nutrition.

42. My complaints reviewer asked Adviser 1 and Adviser 2 to review Mrs A's clinical records and comment on the steps taken to prevent and treat Mrs A's pressure ulcers. Adviser 1 raised a number of specific concerns. He noted that Mrs A's Waterlow Scores on admission varied significantly. They varied in their assessment of Mrs A's condition, and risk of pressure ulcers. One that gave an overall score of 16 did not give her sufficient points for her lack of mobility, while the other assessment gave her a score of just 12. This assessment took greater account of her reduced mobility, but lower scores for her bodyweight and height. Adviser 1 noted that it was also not clear why two assessments had been undertaken separately.

43. When he considered the scoring system for Mrs A, Adviser 1 considered that she should have been given a score of over 20, which would have put her in the 'very high risk' category. He noted that, even with a score of 16, Mrs A should have been positioned on a pressure mattress, had pressure care every two hours and any vulnerable areas should have been charted and observed. If the Waterlow score had been 20 or over, Mrs A should also have been referred to a tissue viability service for further advice. She might also have been given an air mattress.

44. Adviser 1 was critical that the assessments varied so widely and that very little, if any, action was taken by staff at Hospital 1 to prevent the deterioration of Mrs A's skin. In particular, he was critical that no intervention was taken to reduce the impact of her immobility on her skin.

45. Furthermore, Adviser 1 was critical of the Board's response to Mr C in relation to this assessment. They provided Mr C with the lower of the two scores that they had recorded, without any assessment as to why there was any variation in scores or checks for accuracy. He also noted that he could find no evidence that a specific bed or mattress was provided for Mrs A.

46. In relation to the care given at Hospital 1, Adviser 1 concluded that Mrs A's pressure care should have been more accurately assessed, and more specific and detailed interventions should have been considered at the time of admission. This process should also have been clearly documented for continuation after her transfer to Hospital 2.

47. Once Mrs A was at Hospital 2, Advisers 1 and 2 both found that Mrs A's clinical and nursing notes indicated that Mrs A's pressure area care was poor. Assessments were limited and were at times contradictory.

48. Adviser 1 noted that the SSKIN care bundle was not completed on admission, as it should have been. He was critical that it was not started until 2 November 2012 and that, even then, it was not completed in full. He noted that while some elements of Mrs A's care were well documented, such as the risk of falls, her skin care was not well documented. He noted that the element of the SSKIN care bundle relating to a full evaluation of each of the contributory elements was never completed while Mrs A was in Hospital 2.

49. Adviser 2 was critical that nursing staff did not follow guidance in relation to the prevention of pressure ulcers. She found that nursing staff did not act on the high Waterlow score when they should have. She also considered the care plan to be poor; it did not have any specific information relating to the care and treatment of pressure ulcers.

50. Adviser 1 was critical of inconsistencies in Mrs A's care and treatment. On 18 October 2012 bruises were noted on both heels. He identified that, following this, on 20 October staff were aware that Mrs A could not feel her feet, and on 26 October 2012 her notes indicated she needed a glide sheet and two members of staff to move her up the bed. However, on 4 November 2012 staff noted that Mrs A could 'relieve pressure areas independently in chair and in bed'. Adviser 1 noted that Mrs A was suffering from two fractures, in her hip and her sacrum (pelvis), which would have made it difficult for her to move her legs. He also noted that Mrs A required significant amounts of analgesia, including opiates, to manage her pain. This, along with the reduced sensation in her feet, should have triggered greater assistance from staff in preventing the further deterioration of Mrs A's heels.

51. Adviser 1 was also critical that from 18 October 2012, when bruises were first identified on Mrs A's heels, her clinical notes referred to further deterioration to the skin of her heels on an almost weekly basis, but no action was taken to prevent further deterioration or improve their condition. This is contrary to the Guidance and the Board's pressure area care pathway.

52. An email was sent to the TVN, referring Mrs A for review on 2 November 2012. However, Adviser 1 was critical that the TVN did not review Mrs A until 30 November 2012 and that there was no evidence in the clinical file that this referral was chased up. The Adviser was also critical that, during this period, very little action was taken to treat the ulcers or prevent them from further deterioration. While he was critical that there was a long delay between the referral to the TVN and review, he also noted that staff should have been able to provide preventative care without the need for specialist TVN advice.

53. In reviewing whether further action should have been taken in relation to a potential infection of the left heel in early December, Adviser 1 was satisfied that, in this respect, staff took appropriate action once they suspected the wound could be infected. Staff became concerned about an infection because of the appearance of the ulcer, but systematic signs of infection were not noted

at that time. The TVN had not thought that the wound was infected on 30 November 2012. It was not until after the TVN review that Mrs A's heel was found to be 'boggy' and odorous.

54. Adviser 1 noted that bacteria (of two different types) were identified in the wound from the swab test. However, this alone did not provide evidence of a deeper infection. He explained that other signs of infection, which would also have provided evidence of a definite deeper wound infection, would have included warmth, redness or discolouration of the surrounding skin or pus leaking from the ulcer. Other, more general signs of infection could have included fever, malaise (a general feeling of discomfort or illness), swollen lymph nodes and confusion.

55. Adviser 1 considered that, as there was no supporting evidence of a definite infection from these supporting factors, the medical staff were reasonable in their decision to consider the situation further, rather than administering antibiotics immediately. He noted that the main aspect of Mrs A's treatment should have been better care to prevent the heel deteriorating in the first place and then specific treatment to heal the ulcer as fast as possible.

56. In addition to his criticism of Mrs A's pressure care, Adviser 1 was also critical of some other aspects of the care of her heel ulcer. He noted that she had been dehydrated, had suffered norovirus and her appetite was reduced. However, she was not reviewed by a dietician and no action was taken to improve her nutrition. Given the reference in the Guidance to nutrition as a significant contributory factor to pressure ulcers, Adviser 1 was critical that this was not given greater attention.

57. Furthermore, he was critical that no DATIX incident form was completed when the ulcer deteriorated to a Grade 4, and no formal incident investigation was undertaken, as required by the Board's pressure area care pathway. He noted that in the Board's response to Mr C there was no attempt to learn any lessons from Mrs A's case, and there were no assurances that this would be less likely to happen again in the future.

58. Adviser 1 noted that staff had been diligent and thoughtful in their pursuit of diagnoses for Mrs A's fractured hip and, subsequently, her fractured sacrum. However, he was slightly critical that the same level of care and thought about her pain was not given to her heels.

59. Adviser 2 noted that Mrs A was already in pain, and that the pressure ulcers would have added to her distress. She stated that requirements to ensure a pressure relieving mattress, regular change of position and good nutrition were not carried out to the standard expected. She agreed with the findings of Adviser 1, and was critical of the nursing care given to Mrs A.

60. Mrs A was admitted to hospital following a fall and injury, typical of many older adults presenting to hospital. Adviser 1 expressed concern that the frequency of people like Mrs A presenting to hospital means that staff should, in his opinion, be competent to care for patients like her without the need for specialist TVN advice in the majority of cases. He considered that it should have been clear to staff that she was at high risk of developing pressure ulcers. He determined that they failed to prevent the ulcers from forming and then also failed to treat them adequately.

61. Adviser 1 was clear in his final conclusions. Assuming Mrs A's death certificate was correct that the cause of death was infection in the bone underlying this ulcer (osteomyelitis), and Mrs A died two months after her discharge from Hospital 2, he concluded that:

> 'the poor care in Hospitals 1 and 2 resulting in the development of the pressure ulcer resulted in her subsequent death from osteomyelitis.'

He confirmed that this level of certainty was appropriate, as he found that if she had not developed this pressure ulcer, she would not have subsequently contracted osteomyelitis in the underlying bone.

Conclusion

62. Mrs A was admitted to hospital following a fall; a common occurrence for older people. She was appropriately assessed and the source of pain in her hip was appropriately investigated. However, her pressure area care was poorly assessed and insufficient action was taken to reduce the risks that were identified.

63. When Mrs A transferred to Hospital 2 there was insufficient information on transfer for staff to know what care and assessment had taken place in relation to her skin. However, Hospital 2 did not take appropriate action to review the risks for Mrs A. They identified the need for Waterlow risk assessments, and carried these out, but did not review them appropriately and did not act on the

risks that were identified. They failed to take full consideration of critical issues, such as Mrs A's decreasing mobility, the potential impact of pain in her hip and lower back on her willingness to change position, and her lack of sensation in her feet. All these would have contributed to her high risk of developing pressure ulcers, but this was not appropriately identified and recorded.

64. When Mrs A's skin started to break down, the Pathway indicates that prompt action should have been taken, by using a SSKIN care bundle, ensuring that her mobility was appropriately assessed and that her nutrition was maintained. A DATIX incident should also have been logged and, subsequently, a formal incident investigation should have been completed. From the evidence that has been provided, this did not happen.

65. There was also an excessive delay in the review of Mrs A's pressure ulcers by a specialist nurse, the TVN. Mrs A waited 28 days for this review and during this time her skin deteriorated significantly.

66. Due to the failures in the Board's care and treatment of Mrs A's skin, she developed an infection in the pressure ulcer on her left heel. This eventually led to osteomyelitis, which was a primary contributory factor in her death. I am drawing on Adviser 1's assessment when I say that, while recovery from her fractures would have been difficult, if she had not developed the pressure ulcer on her heel, she would have had a better chance of learning to walk again, and enjoyed a longer period of better health. Ultimately, the poor care that Mrs A received led to the development of a pressure ulcer that caused her death.

67. With these failures in mind, I uphold this complaint.

68. In developing recommendations based on my findings, I am conscious of recommendations that are being taken forward by the Board following previous reports from HIS and from a previous report of mine. These include the provision of training for staff on the proper implementation of their pressure ulcer policies (across the Board area); that patients are appropriately assessed for the risk of developing pressure ulcers; and that following this assessment, personalised care plans are put in place and followed, clearly documenting the action required to reduce pressure ulcers (in Hospital 1).

Recommendations

69.	I recommend that the Board:	*Completion date*
(i)	provide an update on the action that has been taken to implement recent recommendations from Health Improvement Scotland and my office on the care and treatment of patients in relation to the risk and treatment of pressure ulcers;	30 May 2014
(ii)	conduct a peer review of the prevention, care and management of pressure ulcers in the ward in Hospital 2 where Mrs A stayed;	30 July 2014
(iii)	develop an action plan for improvements identified through the peer review, including education and training, and share this with my office; and	30 July 2014
(iv)	apologise to Mr C for the failures identified in this report in relation to Mrs A's care and treatment, for the pain and suffering experienced by Mrs A and for the inaccurate information provided to Mr C in the Board's initial response to his complaint.	14 May 2014

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

Annex 1

Explanation of abbreviations used

Mrs A	the complainant's late mother
The Board	Lothian NHS Board
Mr C	the complainant
Hospital 1	Edinburgh Royal Infirmary
Hospital 2	Liberton Hospital
Hospital 3	Corstorphine Hospital
Adviser 1	consultant geriatrician
Adviser 2	nursing adviser
HIS	Health Improvement Scotland
TVN	Tissue Viability Nurse; a specialist nurse with expertise in skin care
Doctor 1	Mrs A's consultant
Doctor 2	Trainee doctor
the Guidance	Health Improvement Scotland (2009) Best Practice Statement on the prevention and management of pressure ulcers
the Pathway	Lothian NHS Board's Pressure Area Care Pathway provides guidance on what steps staff should take in response to potential or actual pressure ulcers.

Annex 2

Glossary of terms

DATIX	the Board's data base
Debridement	removal of dead tissue
Malaise	a general feeling of discomfort or illness
Microbiologist	a specialist in the treatment of infections
Necrotic tissue	an area of dead skin and other tissue
Norovirus	a stomach bug that causes vomiting and diarrhoea
Osteomyelitis	infection of the bone
Sacrum	Pelvis
SSKIN care bundle	an assessment tool, which included a repositioning and skin inspection chart and an evaluation record
Swab	samples taken with a sterile gauze and sent to the laboratory to assess the presence of bacteria
Waterlow Score	a scoring system to identify the risk of developing pressure ulcers. 22 points can be allocated against standard criteria, with a further 24 points allocated for 'special risks'.

Annex 3

List of legislation and policies considered

Health Improvement Scotland (2009), Best Practice Statement on the Prevention and Management of Pressure Ulcers

Lothian NHS Pressure Area Care Pathway