SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

# Investigation Report

UNDER SECTION 15(1)(a)

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**Scottish Parliament Region: Central Scotland**

**Case ref: 201601342, Lanarkshire NHS Board**
**Sector:** Health
**Subject:** Hospitals / Nurses / Nursing Care

## Summary


Mr C complained to the Ombudsman about the care and treatment he received during a three-week admission to Wishaw General Hospital, when he developed a pressure ulcer which required district nursing care for five months after his discharge. Mr C said that nursing staff did not take sufficient action to monitor his risk of developing a pressure ulcer.

My complaints reviewer took independent medical advice on Mr C's case from a nurse. The adviser said that the nursing staff unreasonably failed to recognise that Mr C was at high risk of developing a pressure ulcer and, therefore, failed to provide care/assess Mr C using the SSKIN care bundle (a five-step care plan for pressure ulcer prevention). The adviser said the Malnutrition Universal Screening Tool or MUST (a way to screen patients to identify and treat adults at risk of malnutrition) was completed inaccurately on all three occasions it was completed. Had concern about Mr C's weight loss been noted in the MUST and the correct score applied, this would have resulted in Mr C being deemed at high risk of developing a pressure ulcer and a high risk care plan being used. If the nursing staff had assessed Mr C correctly and used the SSKIN care bundle, it is likely that he would not have developed a pressure ulcer. The board have acknowledged that they did not carry out visual inspections of Mr C's pressure areas and I am critical of them in this regard.

The adviser said that the fact that Mr C developed a pressure ulcer in the hospital which appeared to require district nursing care for five months after Mr C's discharge, suggested that the nursing staff failed to provide Mr C with appropriate pressure area care and they considered the board's failing to be significant. I, therefore, upheld Mr C's complaint. I am also concerned that during their own investigation of Mr C's complaint, the board did not recognise the failings in Mr C's care and take appropriate remedial action.


## Redress and Recommendations

The Ombudsman recommends that the Board: *Completion date*

| | | |
|---|---|---|
| (i) | feed back my decision on this complaint to the staff involved; | 7 June 2017 |
| (ii) | ensure that in future nursing staff carry out appropriate assessment and monitoring of patients at risk of developing pressure ulcers; | 24 July 2017 |
| (iii) | ensure that in future, staff carry out a full and proper investigation of patients' complaints and recognise failings where they exist; and | 24 July 2017 |
| (iv) | provide Mr C with a written apology for the failings identified and offer to meet with him to discuss their learning and actions as a result of his complaint. | 23 June 2017 |

**Who we are**

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mr C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

**Introduction**

1. Mr C complained to my office about the care and treatment he received from Lanarkshire NHS Board (the Board) during a three-week admission to Wishaw General Hospital (the Hospital) from 8 to 30 March 2016. The complaint from Mr C which I have investigated is that nursing staff at the Hospital failed to provide Mr C with appropriate pressure ulcer area care (*upheld*).

2. Mr C said the outcome he was seeking, in bringing his complaint to us, was to receive an apology and an acknowledgement from the Board for the poor care he received.

**Investigation**

3. In order to investigate Mr C's complaint, my complaints reviewer considered Mr C's submission to my office and made an enquiry of the Board and reviewed their response. We also took independent medical advice on Mr C's case from a nursing adviser (the Adviser) and obtained clarification from the Adviser on their advice. In this case, we have decided to issue a public report on Mr C's complaint because of the significant nursing failings identified, the significant personal injustice Mr C suffered and to draw the failings identified to the attention of all health boards.

4. 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.

*Background*

5. Mr C's complaint concerned the care and treatment he received during a three-week admission to the Hospital from 8 to 30 March 2016. During this time, Mr C developed a pressure ulcer on his sacral area (bottom). Mr C said that nursing staff did not take sufficient action to monitor his risk of developing a pressure ulcer during his admission.

6. Mr C stayed in four different wards during his time in the Hospital. He was initially admitted to the Acute Care Unit (ACU), where he stayed until 10 March 2016, when he was transferred to Ward 5. He remained there until 23 March 2016, when he had a laparoscopic subtotal colectomy and end-to-end anastomosis (removal of most of his colon and the formation of a stoma to drain faeces into a bag). Mr C was then transferred to Ward 18 for two days and then

on 25 March 2016, he moved to Ward 16, where he remained until 30 March 2016, when he was discharged home.

7. Mr C said the district nurse who saw him after his discharge from hospital advised him that he had a 'category four' pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle). Mr C said the district nurses saw him three times a week after his discharge from March until August 2016, when a dressing was no longer required. Mr C said he was still (at 31 August 2016) suffering some discomfort from the residual ulcer and had some scarring at the wound location.

**Complaint: Nursing staff at the Hospital failed to provide Mr C with appropriate pressure ulcer area care**

8. Mr C said the nursing staff failed to provide him with appropriate pressure ulcer area care. He said they failed to carry out visual inspections of his pressure areas and the only question he was asked was did he have any pain. Mr C said that as he was on morphine, the answer was 'no'. Mr C said that as a result of the nursing staffs' failings, he developed a pressure ulcer which required district nursing care for five months after his discharge.

*The Board's response*

9. In their response to Mr C's complaint, the Board said that nursing staff documented that Mr C was independent and mobile during his admission and, as such, they would not visually inspect Mr C's skin unless he raised concern. The Board detailed the assessments they carried out on Mr C when he was in each of the four wards at the hospital. They said it was not until 29 March 2016 that Mr C informed a nurse that his sacral area felt numb and, following investigation, it was noted that he had a pressure ulcer. The Board said treatment was provided the following day and Mr C was discharged home and the district nurse contacted to provide further assessment and review.

10. In their response to my office, the Board said Mr C was assessed on admission using the Pressure Ulcer Risk Assessment (PURA) tool (a tool used to identify individuals at risk of developing a pressure ulcer) and was not identified as being at risk. They said Mr C was mobile and independent. The Board said Mr C's care plan was up to date and 'intentional rounding' was well documented on a daily basis. (Intentional rounds are where staff carry out specific checks on a patient on a regular and prescribed basis. They are usually done one, two, four or six hourly, depending on the patient's needs and

are intended to ensure good nursing care is carried out, including personal hygiene, positioning and nutritional care.) The Board said at no time did the daily PURA assessment indicate a risk of Mr C developing a pressure ulcer, nor was there any record of him expressing any concerns until 29 March 2016.

*Nursing advice*

11. The Adviser said that at 23:15 on 8 March 2016, Mr C was admitted to the ACU at the hospital. They noted that, in their statement on Mr C's complaint, the Senior Charge Nurse indicated that Mr C's skin was intact on admission. The Adviser said Mr C was admitted with watery diarrhoea and it was noted on his care plan on 9 and 10 March 2016 that his skin was intact and that Mr C required no assistance or intervention for pressure area care. The Adviser said that Mr C was transferred to Ward 5 on 10 March 2016.

12. The Adviser said that whilst on Ward 5, Mr C's frequent loose stools continued and this was recorded on Mr C's stool chart, including six times on 19 March 2016 and 11 times on 20 March 2016. The Adviser said that this meant that Mr C was at very high risk of excoriation of his skin (skin breakdown), particularly in the sacral area. However, the Adviser said the nurses incorrectly assessed Mr C as not being at risk and incorrectly used the PURA tool throughout Mr C's hospital stay. The Adviser said that as Mr C was at risk of skin breakdown, the nurses should have used a SSKIN bundle (a five-step care plan for pressure ulcer prevention), which was a more in-depth assessment and monitoring tool. Using a SSKIN care bundle requires assessment of the Surface that the patient lies/sits on; a Skin inspection; Keeping the patient moving; monitoring Incontinence; and ensuring adequate Nutrition.

13. The Adviser said they understood the logic in using the PURA tool as all patients did not need their sacrum inspected if they were at low risk. However, the Adviser was critical that the nursing staff failed to recognise that Mr C was at risk due to the following factors:

- Mr C was diabetic;
- he had a poor appetite;
- he had significant weight loss; and
- he had significant watery diarrhoea (up to 11 times a day) leading to excoriation.

14. All of these factors meant that Mr C should have been cared for/assessed using the SSKIN care bundle.

15. The Adviser explained that the PURA tool allowed for skin assessment by the nursing staff or confirmation of the condition of the pressure areas to be provided by the patient. They said that the SSKIN care bundle would have required the nursing staff to carry out actual checks of Mr C's pressure ulcer areas, which is what was required in Mr C's case. The Adviser said that if the SSKIN bundle had been used appropriately, then it is likely that Mr C's pressure ulcer would have been prevented.

16. Even using the PURA tool, the Adviser noted that the 'skin inspected or discussed with patient' and 'skin intact or verbal confirmation with patient' headings on the chart were not ticked daily, with checks missing on 11, 13, 14, 15, 16 and 20 March 2016. The Adviser noted that there were no specific notes in the nursing notes of Mr C's skin being checked but explained that such notes would only generally be made when there was concern about a patient's pressure areas.

17. The Adviser said that after Mr C's operation on 23 March 2016, Mr C was taken to Ward 18 and his personal care record indicated that on assessment, Mr C was deemed not to be fully independent and the nursing notes on the record indicated that a SSKIN care bundle was in use and Mr C was to receive four hourly pressure area care. However, the Adviser said there was no specific note of Mr C's pressure areas being checked, other than the 'skin inspected and intact' entry on the PURA chart being ticked on 23, 24 and 25 March 2016.

18. The Adviser said that on 24 March 2016, on the day after Mr C's operation, it was noted that Mr C was 'fully independent'. The Adviser said that they were surprised at this assessment, as Mr C would have required full assistance after his surgery. They said this would have involved giving Mr C a bed bath and part of that would have involved positioning Mr C on his side to wash his back and bottom. The Adviser said that although the 'skin inspected and intact' entry on the PURA was ticked, there was no specific record in the nursing notes of how Mr C's pressure areas were. The Adviser said it may have been that this was done and there was no redness, but either way they said they would have expected nurses to have made notes on this check.

19. The Adviser said that when Mr C was transferred to Ward 16 on 25 March 2016, he was described as 'independent'. The Adviser noted that on 25, 26 and 27 March 2016, the 'skin inspected or discussed with patient' and 'skin intact or verbal confirmation from patient' entries in the PURA chart were ticked and there was no entry for 28 March 2016. The Adviser said that on 29 March 2016, Mr C's pressure ulcer was noted and his care from this point onwards was reasonable, with a wound chart being started; Mr C's wife being informed; a referral to the tissue viability nurse; a datix (accident and incident reporting system) entry completed; and then district nurse referral on discharge. The Adviser said Mr C's pressure ulcer was noted as being five by two centimetres and 90 percent necrotic (dead), which indicated the ulcer may have been present for some time.

20. The Adviser said they also found Mr C's Malnutrition Universal Screening Tool (MUST) (a way to screen patients to identify and treat adults at risk of malnutrition) to be inaccurate on all three times it was completed by nursing staff – on 8, 14 and 19 March 2016. They said that on the 8 and 14 March, despite recording a '2', for significant weight loss (and '0' for the other entries), Mr C's total score was given as '0'. The Adviser said this should have been '2', which meant Mr C was at high risk of developing pressure ulcers and should have resulted in a high risk care plan being used. The Adviser said that when the MUST was done again on 19 March 2016, the nursing staff failed to note Mr C's 'usual weight' and recognise Mr C's significant weight loss, which should have again resulted in a high risk score and a high risk care plan being used.

21. The Adviser explained that MUST is strongly correlated with risk of skin breakdown and failing to complete the MUST correctly meant there was a lost opportunity for the Board to provide Mr C with additional nutritional care. They said that if the MUST was accurate this would have resulted in Mr C being assessed as requiring the SSKIN bundle, which may have prevented his pressure ulcer. The Adviser explained that a 'No' entry in the PURA chart for well nourished, able to eat and drink (which the medical and nursing notes indicate should have happened), would have resulted in the SSKIN bundle being commenced.

22. The Adviser was asked to comment on Mr C's concern that the only question he was asked was did he have any pain and as Mr C was on morphine, the answer was 'no'. The Adviser noted that with the exception of 23 March 2016 (the day of Mr C's operation), the 'pain assessment' entries on

Mr C's Daily Progress Records indicated that no action was required. The Adviser explained that actual conversations about assessing pain would not be recorded and so she could not confirm exactly what Mr C was asked about pain.

23. When asked if the fact that Mr C developed a pressure ulcer whilst he was in the Hospital, and appeared to require district nursing care for five months after Mr C's discharge, suggested that nursing staff failed to provide Mr C with appropriate pressure ulcer area care, the Adviser said it did and they considered this failing to be a significant failing. The Adviser said they were very critical that after investigation by three senior charge nurses at the Board, Mr C's complaint was not upheld, as it was clear (from the Board's own admission) that no-one checked Mr C's pressure areas and Mr C developed a significant pressure ulcer. The Adviser said that no-one at the Board seemed to admit that Mr C had a number of risks:

- significant weight loss;
- loose watery stools for a prolonged period leading to skin excoriation;
- insulin controlled diabetic;
- poor appetite due to colitis (inflammation of the colon); and
- major surgery with a period of bed rest and requiring assistance with personal hygiene.

or that Mr C's MUST was incorrect. The Adviser was critical of the Board's response to Mr C's complaint and said they should have acknowledged that there was a failing and apologised, rather than saying Mr C did not tell the staff that there was anything wrong.

**Decision**

24. In Mr C's complaint to my office, he said the nursing staff failed to provide him with appropriate pressure ulcer area care. He said they failed to carry out visual inspections of his pressure areas and the only question he was asked was did he have any pain. Mr C said that as he was on morphine, the answer was 'no'. Mr C said that as a result of the nursing staff's failings, he developed a pressure ulcer which required district nursing care for five months after his discharge.

25. The Adviser has said that the nursing staff unreasonably failed to recognise that Mr C was at high risk of developing a pressure ulcer and,

therefore, failed to provide care/assess Mr C using the SSKIN care bundle, a more in-depth assessment and monitoring tool for pressure ulcers than the PURA chart. In addition to this, the Adviser has said the MUST was completed inaccurately on all three occasions it was completed. Had concern about Mr C's weight loss been noted in the MUST and the correct score applied, this would have resulted in Mr C being deemed at high risk of developing a pressure ulcer and a high risk care plan being used. Incorrect entries in the PURA for Mr C being well nourished and able to eat and drink meant that the SSKIN bundle was not commenced as it should. If the nursing staff had assessed Mr C correctly and used the SSKIN care bundle, it is likely that he would not have developed a pressure ulcer.

26. The Board have acknowledged that they did not carry out visual inspections of Mr C's pressure areas and I am critical of them in this regard. However, I am not able to determine that the only question Mr C was asked was did he have any pain, as questions in this area would not be recorded.

27. The Adviser has said that the fact that Mr C developed a pressure ulcer in the Hospital which appeared to require district nursing care for five months after Mr C's discharge, suggested that the nursing staff failed to provide Mr C with appropriate pressure area care and they considered the Board's failing to be significant. I am also concerned that during their own investigation of Mr C's complaint, the Board did not recognise the failings in Mr C's care and take appropriate remedial action.

28. In conclusion, I consider that the nursing staff at the hospital failed to provide Mr C with appropriate pressure ulcer area care and I uphold Mr C's complaint.

**Recommendations**

| 29. | I recommend that the Board: | *Completion date* |
|---|---|---|
| (i) | feed back my decision on this complaint to the staff involved; | 7 June 2017 |
| (ii) | ensure that in future nursing staff carry out appropriate assessment and monitoring of patients at risk of developing pressure ulcers; | 24 July 2017 |
| (iii) | ensure that in future, staff carry out a full and proper investigation of patients' complaints and recognise | 24 July 2017 |

failings where they exist; and

| | | |
|---|---|---|
| (iv) | provide Mr C with a written apology for the failings identified and offer to meet with him to discuss their learning and actions as a result of his complaint. | 23 June 2017 |

30. The Board have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The Board are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

**Annex 1**

## Explanation of abbreviations used

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| Mr C | the complainant |
| the Board | Lanarkshire NHS Board |
| the Hospital | Wishaw General Hospital |
| the Adviser | a nursing adviser |
| ACU | the Acute Care Unit |
| PURA | Pressure Ulcer Risk Assessment |
| SSKIN | the Surface that the patient lies/sits on; a Skin inspection; Keeping the patient moving; Incontinence; and Nutrition |
| MUST | Malnutrition Universal Screening Tool |

**Annex 2**

## Glossary of terms

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|---|---|
| excoriation of skin | skin breakdown |
| Malnutrition Universal Screening Tool (MUST) | a way to screen patients to identify and treat adults at risk of malnutrition |
| Pressure Ulcer Risk Assessment (PURA) tool | a tool used to identify individuals at risk of developing a pressure ulcer |
| sacral area | bottom |
| SSKIN bundle | a five-step care plan for pressure ulcer prevention |