SCOTTISH PUBLIC SERVICES OMBUDSMAN

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The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case ref: 202111459, Lothian NHS Board - Acute Division

Sector: Health

Subject: Hospitals / Nurses / nursing care

Summary

The complainant (C) complained to my office about the care and treatment provided to their late adult child (A) by Lothian NHS Board – Acute Division (the Board).

A was in their thirties and suffered from a number of chronic illnesses and very poor health. A had regular admissions to hospital and received treatment from community and district nurses between admissions to hospital.

A was admitted to the Royal Infirmary of Edinburgh (the hospital) on 6 June 2021 with shortness of breath. A's pre-existing leg wounds were treated in hospital during their admissions. A was discharged home on 24 June 2021. A continued to receive treatment at home from district nurses for their leg wounds.

A's condition deteriorated and they were admitted to hospital again on 26 August 2021. A's health continued to deteriorate, and A underwent a right knee amputation on 2 September 2021. A did not make a full recovery following surgery. A remained in hospital and suffered a cardiac arrest on 11 October 2021. Sadly, A died the same day.

C complained that A's wounds were not appropriately assessed or treated during their admission to hospital, or during the time they were cared for at home.

In their complaint response the Board said that throughout A's care, where infection was suspected by the district nursing team, appropriate treatment was provided. During the course of treatment at home by district nurses, A's care plan was reviewed regularly, changes were made to the wound care plan when necessary, dressings were changed when appropriate and a referral made to the tissue viability service.

In response to our enquiries the Board said that there was evidence of good practice during A's admission to hospital in June 2021 with respect to the management of A's wounds. The Board acknowledged a wound care chart was not completed on the day of admission, but there were clear entries thereafter evidencing A's wound care.

With respect to A's admission to hospital in August 2021, the Board said that A's wound care was appropriately documented and that available records evidenced appropriate nursing care during A's admission.

During my investigation I took independent advice from a registered nurse. Having considered and accepted the advice I received, I found that:

Care at home

- There was no evidence of appropriate wound assessments having been undertaken whilst A was treated by district nurses for their wounds.
- The choice of dressings was on occasion unreasonable and inappropriate to manage A's wounds.
- Whilst there were occasions where the frequency of dressing changes was stepped-up to daily changes, these were inconsistent. As a result A was left with wet and foul smelling dressings, which is unreasonable.
- There was an unreasonable delay in seeking specialist wound care when it was clear A's wounds were deteriorating.

Care during hospital admissions

- During both admissions A's wounds were not appropriately assessed and there were a number of instances of inappropriate and unreasonable wound care provided to A.
- During A's June 2021 admission to hospital there was an unreasonable failure to update their wound management plan and appropriately assess a deep abscess.
- During the admission from August 2021, inadine dressings were inappropriately prescribed and applied.
- Negative Pressure Wound Therapy (NPWT, a device to promote wound healing) was used on A's wounds without evidence of the appropriate assessments having been carried out prior to its use. NPWT was applied in circumstances where it was contraindicated. Its use was unreasonable.
- Clinicians and nursing staff did not appear to have the requisite knowledge in relation to the application of NPWT.

Taking all of the above into account, I upheld C's complaints

Recommendations

What we are asking Lothian NHS Board - Acute Division to do **for the complainant**

Rec. number	What we found	What the organisation should do	What we need to see
1.	In relation to (a) and (b) I found that: • A's wounds were not appropriately assessed • The frequency of dressing changes was not sufficient to manage A's wounds • There were missed opportunities to refer A to the Tissue Viability Specialists, and that there was an unreasonable delay in making the referral • Dressings applied to A's wounds were at times contraindicated or inappropriate to manage their wounds • Negative Pressure Wound Therapy was inappropriately and unreasonably applied to an actively bleeding wound and • Negative Pressure Wound Therapy was also inappropriately and unreasonably applied to a sloughy wound.	Apologise to C for the failures identified in my decision. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 February 2025.

We are asking Lothian NHS Board - Acute Division to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	A's wounds were not appropriately assessed.	Wound assessments for patients should be completed holistically and on a timely basis in line with the patient's presentation. Assessments should appropriately document the progression/ deterioration of a patient's wound and prescribe appropriate wound management.	Evidence that the Board have shared the decision with all staff involved with wound care in a supportive manner for reflection and learning. By: 19 February 2025. Evidence that the Board have reviewed their wound management guidance to ensure it appropriately takes into account relevant national guidance with details of how any changes will be disseminated to staff. Evidence that the Board have reviewed their wound care assessment training for relevant nursing staff in light of the findings of this investigation with details of how it will be rolled out to relevant staff. By: 16 April 2025

Rec. number	What we found	Outcome needed	What we need to see
3.	The frequency of dressing changes was not sufficient to manage A's wounds. On one occasion hospital at home staff attending A inappropriately left wet and soaked through dressings for district nursing staff to change which was unreasonable, and Dressings applied to A's wounds were at times not appropriate, contraindicated, or inappropriate to manage their wounds.	Wound dressings should be changed frequently enough to manage the level of exudate, to prevent 'strikethrough' and foul smells. Patients should not be left at home with wet or soaked through dressings unchanged.	Evidence that the Board have shared the decision with all relevant staff involved with wound care assessment in a supportive manner for reflection and learning. By: 19 February 2025. Evidence that the Board has ensured that staff delivering such services have received the appropriate training and ongoing professional development. This should include details of future plans to either / both provide training now and how expertise will be maintained. By: 16 April 2025

Rec. number	What we found	Outcome needed	What we need to see
4.	There was an unreasonable delay in referring A to Tissue Viability Specialists and there was an unreasonable delay in making the referral.	Where a patient's wounds deteriorate despite on-going treatment or are non-progressing over a period of time, nursing staff should consider immediate referral for specialist tissue viability assessment. Decisions in relation to referral should be documented and if the need for referral is identified this should be actioned without delay.	Evidence that The Board have shared the decision with relevant nursing staff involved with wound care in a supportive manner for reflection and learning. By: 19 February 2025. Evidence that the Board have an appropriate referral pathway for specialist wound management and that relevant nursing staff are aware of how to access it to make a referral. By: 16 April 2025.

Rec. number	What we found	Outcome needed	What we need to see
5.	Negative Pressure Wound Therapy was inappropriately applied to an actively bleeding wound. Negative Pressure Wound Therapy was also inappropriately applied to a sloughy wound.	Negative Pressure Wound Therapy should be applied in accordance with manufacturers guidance and in accordance with Board policy and HIS guidance.	Evidence that the Board have shared the decision with all relevant staff involved in wound management. By: 19 February 2025. Evidence that relevant staff are aware of the Board's policy on the use of Negative Pressure Wound Therapy and manufacturers guidelines, and that medical staff deemed competent in prescribing/applying Negative Pressure Wound Therapy have received training in its use. By: 16 April 2025

Feedback

Points to note

The ‘house held’ records which contain the written record of care provided at A’s home have been reported as lost. I encourage the Board to reflect on the circumstances leading to their loss, and whether there is any learning for them in relation to record keeping and records management policies and staff guidance.

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 C and the aggrieved as A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complainant (C) complained to me about the care and treatment provided to their late adult child (A) by Lothian NHS Board – Acute Division (the Board).

2. A was in their thirties and suffered from a number of chronic illnesses and very poor health. A had regular admissions to hospital and received treatment from community and district nurses between admissions to hospital.

3. A was admitted to the Royal Infirmary of Edinburgh (the hospital) on 6 June 2021 with shortness of breath. A's pre-existing leg wounds were treated in hospital during their admissions. A was discharged home on 24 June 2021. A continued to receive treatment at home from district nurses for their leg wounds.

4. A's condition deteriorated and they were admitted to hospital again on 26 August 2021. A's health continued to deteriorate, and A underwent a right knee amputation on 2 September 2021. A did not make a full recovery following surgery. A remained in hospital and suffered a cardiac arrest on 11 October 2021. Sadly, A died the same day.

5. C complained to my office about aspects of A's care and treatment. In particular, that there was a failure to provide appropriate nursing care in relation to the treatment of A's wounds during both their admissions to hospital in June and August 2021, and the care provided at A's home between the respective admissions.

6. The complaint from C I have investigated is that:

   (a) The Board failed to provide reasonable nursing care to A between 24 June 2021 and 26 August 2021, whilst they were treated by district nurses for their wounds *(**upheld**)*; and

   (b) The Board failed to provide reasonable nursing care to A, during their admissions to hospital on 6 June 2021 and from August 2021. *(**upheld**)*

Investigation

7. In order to investigate C's complaint, I and my complaints reviewer considered all of the documentation submitted by C and by the Board, including A's medical and nursing records for the relevant periods, and complaint correspondence[1]. I also obtained medical advice from an appropriately qualified adviser (the Adviser: a

[1] The Board have advised that A's 'house held' records which contain the written paper record of care provided by district nurses at A's home were reported as lost. C told our office that they had provided these to ward staff on A's admission to hospital in August 2021.

registered nurse). The Adviser had full access to the available relevant medical records and the complaint correspondence.

8. I have decided to issue a public report on C's complaint given my concerns about the serious and multiple failings in this case, and the significant personal injustice caused by the failings identified. I also consider there is the potential for wider learning from the complaint.

9. This report includes the information that is required for me to explain the reasons for my decision on this case. It also contains some technical medical terms and descriptions which I have considered necessary to include in order to provide the appropriate level of detail both in relation to A's condition, and to the advice I have received and taken into account. Wherever possible, explanations for these terms are provided in the report and / or in Annex 1.

10. Please note, I have not included every detail of the information considered but can confirm that all of the information provided during the course of the investigation was reviewed. C and the Board were given an opportunity to comment on a draft of this report.

Background

11. I have set out below the background and key events which relate to both complaint points (a) and (b).

12. A was in their thirties and suffered from a number of chronic illnesses. They had endured very poor health for a significant period of time prior to the aspects of care which are considered under this investigation.

13. A suffered with diabetes, asthma, obesity, endocrine disorders, and had peripheral vascular disease which had resulted in amputation of toes on their left foot around a year previous to the care considered by this investigation. A suffered from leg ulcers and diabetic foot ulcers for which they had been receiving fairly frequent treatment from community and district nurses between admissions to hospital.

14. A was admitted to hospital on 6 June 2021, with a three-week history of shortness of breath following a recent admission in April 2021 which required admission to the intensive care unit for community acquired pneumonia.

15. A had a history of amputations of their 4th and 5th toes on their left foot, which were observed to be healing. However, they had significant lower leg wounds for which they were treated during their time in hospital. A was discharged home on 24

June 2021, and follow-up with diabetic and respiratory clinics was arranged, together with community district nursing care for their leg wounds.

16. A's condition fluctuated at home over time and during August 2021, A's condition deteriorated with respect to the condition of their leg wounds, leg ulcers, oedema (swelling as a result of fluid retention), weight gain and also deteriorating respiratory health.

17. A was admitted to hospital again on 26 August 2021 with a history of recent previous admissions with foot ulcers, cellulitis (a skin infection), pneumonia, Clostridium Difficile (C-Diff, an infection of the large intestine caused by bacteria) and poor functional baseline.

18. On review of A on admission to hospital, there was concern that amputation of A's leg below the knee would have to be considered, but A wished to avoid this due to concerns that this would worsen their quality of life and also given the additional risks posed by their poor health.

19. A's health with respect to their wounds deteriorated and the decision was made to proceed to a right knee amputation given A's diabetic foot infection, heel necrosis and infection. The procedure was performed on 2 September 2021. A did not make a full recovery following surgery. A remained in hospital and suffered a cardiac arrest on 11 October 2021. Sadly, A died the same day.

(a) The Board failed to provide reasonable nursing care to A between 24 June 2021 and 26 August 2021, whilst they were treated by district nurses for their wounds, and

(b) The Board failed to provide reasonable nursing care to A, during their admissions to hospital on 6 June 2021 and from August 2021.

Concerns raised by C

20. The following paragraphs highlight the concerns C raised.

21. They questioned whether appropriate dressings were used to treat A's foot and that it was obvious, from the condition of A's foot when they were admitted to hospital again in August 2021, that their foot had significantly deteriorated.

22. Nurses were changing A's dressings every two days, administering bandages and dressings, and not allowing air to get to A's wounds to help them heal. C considered this care was inappropriate and did not allow opportunity for A's wounds to heal.

The Board's response to C's complaint

23. I do not intend to repeat the content of the Board's original responses to C's complaint, as all parties are aware of the content.

24. The main points of their response dated 21 January 2022 were that:

i. The 'house held' paper district nursing (DN) records which contain the written record of care provided at A's home had been reported as lost. The district nursing team had indicated that C had provided these to ward staff at a previous visit to hospital, and they had not been returned to the hospital[2]. In order to complete their investigation, they could only rely on their electronic records.

ii. Throughout A's care, where wound infection was suspected by the district nursing team, swabs were taken, and antibiotic treatment was prescribed by the GP where appropriate.

iii. In response to C's concerns that district nurses were changing A's wound dressings every two days, and this prevented healing, the Board explained A came under the care of district nurses on 30 June 2020 for wound care to their left 4th and 5th toe stumps following amputation as a result of infected foot ulcers.

iv. The vascular team's planning for A's discharge home from hospital intended to use Vacuum Assisted Closure (VAC), which is a negative pressure wound therapy (NPWT), using a suction pump, tubing, and a dressing to remove exudate (excess fluid leaking from the wound) and to promote wound healing. However, maintaining a seal was difficult and the wound became macerated (breakdown of skin due to prolonged exposure to moisture), so A was discharged from hospital with Inadine dressings and padding.

v. On discharge from hospital, A's wound was dressed daily due to exudate levels with the care plan recommended by the diabetes team, and A was taking antibiotics for their wound.

vi. During the course of A's treatment by district nurses, A's care plan was reviewed regularly, and their dressings were changed when it was assessed as being appropriate to do so. A referral was made to the tissue viability service (TVS) in August 2020.

[2] C told our office that they had provided these to ward staff on A's admission to hospital in August 2021.

vii. Changes were made to A's wound care plan to address fluctuating levels of exudate present on A's wound. Higher absorbency dressings were used where exudate levels were high, and reduced in response to lowering levels. The frequency of dressing changes was altered in response to exudate levels, with daily changes where levels were high.

viii. A regular review of wound infection was carried out with evidence of appropriate dressing changes prescribed to address infection; such as the use of Aquacel AG, which provides a barrier to bacterial penetration and prevention of infection.

ix. A had regular episodes of loose stool with C-Diff. The use of long-term antibiotics reduces the normal bacteria population in the intestine which triggers overgrowth of C-Diff in the intestine causing diarrhoea. Multiple doses of oral antibiotics for A's chest were prescribed, all of which they considered may have contributed to A's antibiotic resistance.

x. From a review of A's records from both the district nursing team and the acute hospital admission, A's wound healing was prevented by multiple underlying medical conditions.

xi. Dressing choices and frequency of A's dressing changes was appropriate and based on clinical assessment, with continued input from the specialist foot clinic, podiatry, and the tissue viability nurse, where appropriate.

The Board's response to my office

25. The main points of their response, dated 10 May 2024, to the notification of the complaint were that:

Care during hospital admission on 6 June 2021

i. During this time A was admitted for community acquired pneumonia, under the care of the respiratory team in Ward 204, and was discharged on 24 June 2021.

ii. Review of A's medical notes and TRAK (an electronic patient management system to record and store information for patient consultations, investigations, and treatments) entries show evidence of good practice during A's stay on Ward 204. Referral requests were made and reviewed by clinicians who advised the nursing team on best practice on wound care management.

iii. The respiratory team acknowledged there should have been wound care charts completed on the day of A's admission, but there are clear entries on A's TRAK

medical records of wound care being provided and reviews of A. They confirmed that the nursing team now electronically complete wound care charts, and this will improve their compliance.

iv. There is evidence the nursing team attended A predominantly for wound care management. There was no concern raised about the nursing care and there is an entry on A's TRAK notes of A thanking the team for the care that they received during their admission.

v. The respiratory team have confirmed that NPWT was not considered by clinicians advising on A's wound care management prior to their discharge on 24 June 2021. Having reviewed the complaints response of 21 January 2022, there are comments from the district nursing team where they mention discharge planning for A, but these comments do not relate to the June 2021 discharge (in relation to NPWT).

Care during hospital admission from August 2021

vi. A was under the care of the vascular team when admitted on 26 August 2021. Medical notes for A's admission show no evidence of paper wound charts having been in place. Two formal wound charts are documented on TRAK on 26 September and 6 October 2021. Ward 105 reviewed the wound care documentation and while A's wound care is appropriately documented within the nursing progress notes, they confirmed that wards now complete all wound care electronically within the wound chart bundle.

vii. VAC[3] was used on 14 September 2021, which lost suction two days later due to large clots being discharged. Nearly every nursing entry from then documents that A's wound was reviewed and dressings were applied.

viii. There is clear documentation of appropriate nursing care having been provided in A's electronic patient record for each twelve-hour shift. The documentation of A's care is person-centred and includes aspects of care such as oral intake and monitoring of skin integrity.

District nursing care between 24 June and 26 August 2021

ix. The district nursing team confirmed that most of A's related documentation was in paper form and kept in A's home as part of the DN records. TRAK notes were supplementary to DN records and completed by the district nursing team on their return to base, and not while in A's home.

[3] VAC is a form of negative pressure wound therapy (NPWT)

x. The DN records (reported as lost) would have contained any Wound Assessment Charts and any Wound Treatment Charts. They would also contain the National Early Warning Score (NEWS) record and any notes regarding the escalation of the NEWS.

xi. The Board considered that it is difficult to refute or uphold advice provided by the Adviser and shared with the Board as part of my investigation. There are a few instances of commentary regarding either the wound bed presentation and / or level of exudate, but these do not give a complete assessment of the wounds present.

xii. In relation to referral to specialist services, A was due to be reviewed by the Vascular Service in late May/ early June 2021, but A was unable to attend. The district nursing team contacted the hospital during A's admission in June 2021 to request a vascular review. This was completed while they were in hospital. Perhaps earlier referral to the tissue viability nurse and the Podiatry Service would have been of benefit for A, but this is difficult to assess without the DN records.

xiii. A was under the care of the Hospital at Home (H@H) Team from 26 July 2021 to 25 August 2021. A continued to receive wound care during this time, provided by the District Nursing Service.

xiv. In relation to an incident of care on 4 August 2021 raised by the Adviser and shared with the Board for comment as part of my investigation[4] , TRAK notes indicate that A was visited on Wednesday 4 August 2021. The Nurse Practitioner documented that A's dressings were soaked through and that district nursing staff were visiting that day to change A's dressings (as they were changed on a Monday, Wednesday and Friday).

xv. The H@H Team consider the Adviser misinterpreted the TRAK record in this instance. Rather than inferring that H@H staff ran out of time to change A's dressings (which were scheduled to be changed that day by District Nursing Staff), the record actually notes the staff member failed to contact the District Nursing team to increase A's visits to daily visits, given concerns identified during the visit about the condition of A's wound, as was their intention. There is no record of a telephone call, although subsequent visits note daily district nursing input for leg dressings which indicate the team were informed of the requirement for daily input for leg dressings.

Relevant policies, procedures and documentation

[4] The relevant entries from the clinical records can be found at Annex 2

26. The Adviser, in providing their advice (set out below), had regard to the following documents:

i. 'CPR for Feet' care bundle to improve foot assessment in inpatient diabetes. British Medical Journal (BMJ) Open Qual. 2018 Sep

ii. Scottish Wound Assessment and Action Guide. Healthcare Improvement Scotland (HIS), 2021

iii. Wound Assessment Chart. HIS, (2019)

iv. The Scottish Government's Response to the Vale of Leven Hospital Inquiry Report (June 2015)

v. Chronic wounds: advanced wound dressings and antimicrobial dressings. National Institute for Healthcare and Excellence (NICE) (2016)

vi. Best Practice Guidelines for the Use of Negative pressure Wound Therapy, NHS Lothian, April 2020.

vii. Algorithm for Assessment and Management of Chronic Wounds. NHS Scotland (2017)

viii. Professional standards of practice and behaviour for nurses, midwives and nursing associates, The Code, Nursing and Midwifery Council (NMC), 2019

ix. Management of Venous Leg Ulcers, Scottish Intercollegiate Guidelines Network (SIGN) (SIGN 120)

x. ‘What is the clinical and cost effectiveness of Negative Pressure Wound Therapy in chronic, acute and surgical wounds?’, HIS, SHTG Advice on health technologies, Evidence Note 88, January 2019. (Hereinafter referred to as ‘national NPWT evidence note’)

Advice received

27. In the course of providing their advice, the Adviser had sight of A’s clinical and available nursing records. These records covered the relevant period during A’s admission in June 2021, the care provided when A was discharged home in late June 2021, and the period following their re-admission to hospital in August 2021. As noted, the records do not include the paper DN records, relating to A’s care at home, which the Board have confirmed are not available.

28. The Adviser advised that no person, or specialty, took control of A's wound management. The Adviser explained that throughout the period covered by the complaint at points (a) and (b), there were examples of wound care which was unreasonable and below the expected standard, because:

- proper wound assessment was not undertaken;
- the choice of dressings was poor on many occasions, and on many occasions were not therapeutic, were contraindicated, inappropriate to manage the wound, and counterproductive (where two dressings were working against each other);
- the frequency of dressing changes was not sufficient to manage exudate levels; and
- specialist wound care was not sought when A's wounds were deteriorating.

29. The Adviser stated that any patient requiring ongoing management of a wound requires weekly assessment, documented on a wound assessment chart, detailing:

1. measurement of length, width, and depth of wound
2. percentage of tissue type
3. periwound (tissue around the wound) skin condition
4. signs of infection
5. exudate levels and type
6. prescribed care / rationale for treatment.

30. The Adviser advised the above level of assessment was not completed for any wound either in community, or in hospital. The Adviser explained that they could only find one wound chart that related to 23 June 2021 (the day prior to A's discharge from hospital on 24 June 2021). The Adviser advised that in August 2021 there was mention of A's wound in progress notes, but this did not constitute a wound assessment or meet basic requirements to ensure safe monitoring of wounds and adequate communication about treatment goals and therapy. This was against Scottish guidance, best practice, the Vale of Leven Hospital Inquiry Recommendations, and the NMC Code. Dressing choices on numerous occasions were inappropriate or contraindicated for A.

31. The Adviser advised that the prescribing of dressings should be handled in much the same way as prescribing medication, with dressings being key to treating wounds

and infections. It is therefore, very important wound assessments are carried out properly and appropriate wound dressings applied.

32. The Adviser provided advice with respect to each period of care as noted below. They advised that the care for each period was unreasonable as there were instances of inappropriate and unreasonable wound care and dressings used, which also evidenced unreasonable assessment of A's wounds.

Hospital admission – June 2021

33. On 16 June 2021, while A was in hospital, Pseudomonas (infection causing bacteria) were identified in A's wound. The Adviser advised that there was no update of A's wound management plan to address this, which should have been done.

34. On 18 June 2021, a 'deep' abscess, which had burst, had 'a protective dressing' applied. The Adviser stated that given the wound was described as 'deep', it would have required treatment to ensure healing from within the cavity. A holistic wound assessment should have been undertaken at that time to ascertain depth of abscess, if there was tracking and what type and amount of dressing was required. The Adviser advised that this assessment was not carried out.

35. On 22 June 2021, a podiatrist assessing A's wound documented that gauze swabs had been used as a primary dressing. The Adviser advised that gauze swabs have no therapeutic effect on a wound and have no place in wound care as a dressing. On the same day, despite clinical signs of infection being identified, antimicrobial dressings, which should be used in such circumstances, were not applied to the wound.

District Nursing – June to August 2021

36. District nurses visiting A at home on 30 June 2021 used both Potassium Permanganate and Prontosan to cleanse A's wound. The Adviser stated that only one product should be used; not both.

37. The district nursing records which were available on TRAK note Aquacel dressings were applied to A's wound instead of Aquacel AG. The Adviser stated the 'AG' product is an antimicrobial dressing and that it was not used on that occasion, because they had run out of it. The Adviser advised that this incidence of care was unreasonable as A needed an antimicrobial dressing which deals with infection. If no Aquacel AG was available, the district nurse should have applied another dressing with antimicrobial properties and the Board should have more than one antimicrobial dressing in their formulary.

38. The Adviser considered the impact of the missing DN records on their ability to properly assess the complaints, and the reasonableness of the management of A's wounds during A's care at home, particularly given the Board's position that these records would contain wound assessments and other relevant information.

39. The Adviser stated that, even without the paper DN records, they could still identify and determine care was unreasonable from the TRAK records, which were supplementary to DN records and completed by the District Nursing Team on their return to base. These records showed inappropriate wound assessment and deterioration in the patient's wounds which was not identified, or which did not result in any change in the plan of care.

40. The Adviser noted that there were instances in the records of A's wounds being wet and soaked through, and on an occasion, towels being used. The Adviser noted that, if there had been appropriate wound assessment during A's care, this would have identified the deterioration in A's wound and would have resulted in a change in the plan of care. This should have resulted in tailored dressing choices to capture and manage wound exudate. The Adviser advised that it was clear from the TRAK notes that there were instances where dressings applied, and the frequency of visits, were not appropriate and therefore unreasonable.

41. The Adviser stated that most dressings should be left in situ unless exudate is showing on an outer dressing – 'strikethrough'. If outer dressings are showing signs of excessive leakage, then they must be changed. The Adviser noted that 'strikethrough' was often recorded in the district nursing notes but, again, the plan of care and visits were not consistently increased to deal with the wet dressings.

42. The Adviser identified several examples within the records where soaking and foul-smelling dressings were left for an unacceptable length of time which caused discomfort to A, and which were having a detrimental effect on the wound.

43. The Adviser advised that given the recorded levels of strikethrough and levels of wet dressings, with maceration (a softening and breaking down of skin resulting from prolonged exposure to moisture) being recorded, that A should have at had a minimum of daily visits when this occurred. However, this did not happen consistently. Daily visits should have been implemented from the day A was discharged home on 24 June 2021. Two days gap between dressings was unreasonable given the condition of A's wounds. The Adviser said that, had daily visits not been helpful in containing and managing the levels of exudate, then twice daily visits would be expected until specialist review was sought.

44. The Adviser referred to the incident of care when two H@H nurse practitioners visited A on a Wednesday, recording that 'dressings were soaked through from Monday', and documentation appeared to suggest that they left A with soaking dressings and wrote 'ran out of time' to change dressings. The Adviser agreed that the Board's explanation of the records (summarised above at para 25 xiv and xv above), appeared reasonable, and the reference to 'running out of time' related to making a call to change the frequency of dressing changes rather than, as the Adviser had initially interpreted the records, as referring to not having time to change A's dressings.

45. Nevertheless, the Adviser advised that they had significant concerns about this incident given that, having assessed A and finding them with soaking wet dressings, which had been applied two days previously, the H@H staff took the decision to leave A to be seen by the district nurses who were scheduled to attend later that day. The Adviser advised that, irrespective of whether district nurses were attending later, it was unreasonable for the H@H staff to leave A at that time with the dressings in place.

46. The Adviser stated that section 14 of the NMC code of conduct requires that registered nurses should:

> 'act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.'

47. The Adviser advised that the H@H staff should not have left A but should have addressed and changed A's soaking wet dressings at that time given the impact the dressings would have had on A, and the risks posed to the wound bed and increased risk of infection. The H@H nurses had a duty of care to ensure the dressings were changed, and that leaving A in this condition was in breach of the NMC Code 2019 and was unreasonable.

48. The Adviser also advised that a referral to either a vascular specialist or a tissue viability nurse specialist, for appropriate wound and exudate management should have been done at the first sign of deterioration of A's wound which was apparent from the records on 25 June 2021. The Adviser highlighted that it was from this point that daily visits and dressing changes should have been implemented but were not.

49. Additionally, the Adviser stated a referral to a tissue viability nurse should be made after two weeks of a non-progressing wound. The Adviser said that in A's circumstances, they considered A's wound, from the records available, was not progressing. Therefore, even if disregarding the opportunity for earlier referral when there was evidence of deterioration on 25 June 2021, following this timeframe, a referral should have been made around mid-July 2021 on the basis of non-progression (see para 51 below - a referral to vascular was made on 20 August 2021).

50. The Adviser noted that A had numerous co-morbidities including diabetes, previous amputation of toes, poor vascular status, obesity and respiratory compromise. Therefore, there were numerous red flags to indicate urgent and immediate referral to vascular or a tissue viability specialist. The Adviser noted that A was recorded to be 'emotional about deterioration', on 8 August 2021; and on the same day it is recorded that A's wound was 'was beyond DN expertise'.

51. The Adviser noted that on 11 August 2021 the district nurse attending noted A's wound becoming inflamed and swollen, with a 'drastic deterioration' and 'new necrosis'. A podiatrist reviewed A on 16 August 2021 and stated a referral would be made to vascular specialists, but this was not done until 20 August 2021.

52. The Adviser noted that podiatry input was relevant for A's foot wounds, but it should have been a tissue viability nurse or vascular nurse specialist that gave expert advice on A's leg ulceration.

53. The Adviser stated that A warranted an urgent wound specialist review, but it took A voicing their concern, and notes recording the wounds were beyond the nurses' expertise, to trigger a referral which took 12 days to be completed. They considered this was an unreasonable delay in referring to a specialist.

Hospital admission – August 2021

54. With respect to A's re-admission to hospital the Adviser highlighted aspects of care which were of concern during this period. The Adviser noted that on 7 September 2021, staff did not use an antimicrobial dressing when one should have been used given that A's wound was showing clinical signs of infection.

55. The Adviser stated that on 23 September 2021, Inadine was applied to a bleeding wound with a supra-absorbent secondary dressing (Kerramax). This combination was inappropriate as Inadine should not be applied to a bleeding wound and should only be put on a wound with very little or no exudate. A secondary dressing should be a simple dressing, and Kerramax should only be applied to a heavily exuding wound. It was also the case that Inadine should not be used with patients with kidney problems, which A was noted to have.

56. The Adviser advised that there were two uses of NPWT, both of which they considered to be unreasonable. The Adviser stated that NPWT is contraindicated for a bleeding wound and should not be placed on sloughy (non-viable tissue produced as part of the inflammatory process) wounds, this goes against the Board's own policy (Best Practice Guidelines for the Use of Negative pressure Wound Therapy, NHS Lothian, April 2020 own policy, at pages 7 and 8) and the 2019 national NPWT

evidence note and best practice. Specifically, page 15 of the national NPWTevidence note highlights established contraindications for NPWT which include:

- *Clotting disorders (risk of bleeding) and acute mild to moderate bleeding in the wound region after injury/debridement. Suction could result in continuous removal of blood leading to significant blood loss*

- *Exposed organs, vessels and vascular anastomoses which might be altered or damaged by NPWT*

- *Necrotic wound bed. Necrotic tissue acts as a barrier to new tissue growth. The use of NPWT must therefore be preceded by radical debridement.*

57. The Adviser advised that on 15 September 2021, it is documented that NPWT was applied to a bleeding wound. On 1 October 2021, the adviser noted that NPWT was applied to a sloughy wound.

58. The Adviser advised that on both occasions when NPWT was applied, there should have been a holistic assessment prior to its use. There was no evidence in the records that this level of assessment was carried out on the occasions where it was administered

59. The Adviser explained that NPWT is a medical device which requires all users to have undergone training and deemed competent in its use. The Adviser noted that the decision to prescribe and use NPWT would be made either by a clinician or a specially trained tissue viability nurse. In A's care, the NPWT was prescribed by a clinician. The Adviser said that, from the evidence available, clinicians and nursing staff were not aware that applying NPWT to a bleeding and sloughy wound was contraindicated which resulted in its being prescribed and administered unreasonably on both occasions.

(a) Decision

60. The basis on which I reach conclusions and make decisions is 'reasonableness'. My investigation looks at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

61. C complained to me that the Board failed to provide reasonable nursing care to A between 24 June and 26 August 2021, while they were treated by district nurses for their wounds. In investigating this complaint, I have obtained professional advice from the Adviser (as outlined above). I have carefully considered this advice, which I accept. In summary, the advice I have received is that:

i. there was no evidence of appropriate wound assessments having been undertaken during the period. Even if the missing paper DN records contained such assessments, a proper assessment would have identified the deterioration in A's wound and would have resulted in a change in the plan of care. The records available evidenced inappropriate wound assessment. Deterioration in the A wounds was not identified and / or did not result in appropriate changes in the plan of care,

ii. the choice of dressings was on occasion unreasonable and inappropriate to manage A's wound,

iii. the frequency of dressing changes was not sufficient to manage exudate levels, and

iv. there was an unreasonable delay in seeking specialist wound care when it was evidenced A's wounds were deteriorating.

62. Wound assessments are fundamental to establishing a 'baseline' from which clinicians and those treating wounds can assess whether and to what extent a wound is improving or deteriorating.

63. I accept the advice I have received that there was a lack of appropriate and ongoing wound assessment in A's case. Had there been appropriate wound assessment during A's care at home, this would have identified the deterioration in A's wounds which would have resulted in a change in the plan of care resulting in tailored dressing choices to capture and manage wound exudate. It is clear from the records available and the advice I have received, that dressings applied were at times inappropriate and / or contrary to guidance.

64. The Board's position is that the missing DN records would have contained any wound assessment charts and any wound treatment charts. While that may be the case, there is little doubt in my mind that there was a lack of appropriate wound assessment by district nurses caring for A which resulted in incorrect care being provided in relation to wound management. This is unreasonable. Had there been appropriate wound assessment carried out when A was receiving care at home their wounds would have been more suitably cared for, in line with relevant guidance and may not have deteriorated to the extent that they did. I am also critical of the standard of the record keeping and records management.

65. In addition, daily wound dressings should have been carried out by district nurses from 25 June 2021, when the deterioration of the wounds was such that daily dressings were required to manage the levels of exudate. While there were occasions

where the frequency of dressings was stepped-up to daily changes, these were inconsistent, and A was left with wet and foul-smelling dressings. Again, this is unreasonable and, I can't imagine how distressing this must have been for A.

66. With regard to referral to a tissue viability specialist, it is apparent that a number of red flags indicating immediate referral to specialists were missed by district nurses attending A. The delay in referral between June and August 2021 was significant and was patently unreasonable. In addition, once the requirement for referral was identified this was not actioned for a number of days. Again, this is unreasonable.

67. While my investigation of this complaint focuses on the actions of district nursing staff the Adviser has also commented on the care provided by H@H staff on 4 August 2021. Given this relates to the period of care under investigation I have taken account of the advice I have received in this regard. The Adviser was especially critical of the care provided at this time; in particular, they considered the decision to wait for district nursing staff to change A's wound dressings would have prolonged A's considerable discomfort given the condition of their dressings which were wet and soaked through.

68. I acknowledge that the attendance of district nursing staff later that day was a factor in their decision making, and can appreciate that services generally would have been under pressure. However, I accept the advice that the approach from the H@H staff was unreasonable, and that A's dressings should have been changed, rather than leaving A to wait for district nursing staff to attend later that day. It is clear from the advice I have received that A would have been in significant discomfort at the time, and that A's suffering was unnecessarily prolonged.

69. Taking into account the advice I have received and, in view of the failings identified, I uphold this complaint. My recommendations for action are set out below.

(b) Decision

70. C complained to me that the Board failed to provide reasonable nursing care to A during two admissions to hospital in June and August 2021. In investigating this point of the complaint, I have obtained professional advice from the Adviser (as outlined above). I have carefully considered this advice, which I accept.

71. During the two periods of admission under investigation, A required significant and substantial care. The nursing assessments of A's wound, including the choice and application of the correct dressings, were not only important for A's own comfort and general health, but also critical to wound care and progression. The advice I have received is that A's wounds were not appropriately assessed during each admission

and there were a number of instances of inappropriate and unreasonable wound care provided to A during each admission to hospital.

72. During A's hospital admission in June 2021 there was a failure to update A's wound management plan to address infection causing bacteria identified in A's wound. There was a lack of detailed assessment of A's abscess which was noted to be "deep" and gauze swabs were inappropriately applied. This was unreasonable.

73. It is also notable that during the August admission an Inadine dressing was applied to a wound, when not only was this contraindicated given the wound was bleeding but also, concerningly, this was inappropriately prescribed and applied given A was known to have kidney problems.

74. In relation to the use of NPWT, the advice I have received, which I accept, is that, on each occasion it was used, the level of assessment of the suitability of its use was not in line with the Board's policy or published guidance. There was also no evidence of the required level of holistic assessment being carried out prior to its use.

75. NPWT was applied to a bleeding wound, which is contraindicated. The advice I have received and accept is this was unreasonable. On a second occasion, NPWT was applied to a sloughy wound but there is no evidence of the required assessment demonstrating that the condition of the wound was taken into account before prescribing the treatment. This is unreasonable.

76. The advice I have received is that those using NPWT require specific training and should be competent in its use. I am concerned that, in this case, it appears clinicians and nursing staff were not aware that applying NPWT was contraindicated. This raises a question as to whether the Board has ensured that the clinicians, and nursing staff involved in A's care, had the requisite knowledge in relation to its application.

77. Taking account of the evidence and the advice I have received, and in view of the failings identified, I uphold this complaint. My recommendations for action are set out below.

78. It is clear to me that the failures identified in wound care while A was at home and in hospital will have caused them considerable discomfort and distress at what was already a difficult and challenging time. This will undoubtedly make difficult reading for C and A's family, and they have my heartfelt sympathy. Although I recognise the significant time that has passed since these events, I believe my findings and recommendations, if implemented, should lead to lasting improvements in wound care by Board staff and may also generate wider learning and improvement in

this important area of care for other health boards. I hope that this brings some comfort to C and their family.

79. I also recognise that my report will make difficult reading for staff involved in A's care, and encourage the Board to be mindful of how they share my findings and the recommendations I have made.

Recommendations

Organisation: Lothian NHS Board - Acute Division

SPSO ref: 202111459

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints, and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Lothian NHS Board - Acute Division to do **for the complainant**

Rec. number	What we found	What the organisation should do	What we need to see
1.	In relation to (a) and (b) I found that: • A's wounds were not appropriately assessed • The frequency of dressing changes was not sufficient to manage A's wounds	Apologise to C for the failures identified in my decision. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets	A copy or record of the apology. By: 19 February 2025.

Rec. number	What we found	What the organisation should do	What we need to see
	• There were missed opportunities to refer A to the Tissue Viability Specialists, and that there was an unreasonable delay in making the referral • Dressings applied to A's wounds were at times contraindicated or inappropriate to manage their wounds • Negative Pressure Wound Therapy was inappropriately and unreasonably applied to an actively bleeding wound; and • Negative Pressure Wound Therapy was also inappropriately and unreasonably applied to a sloughy wound.		

We are asking Lothian NHS Board - Acute Division to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	A's wounds were not appropriately assessed.	Wound assessments for patients should be completed holistically and on a timely basis in line with the patient's presentation. Assessments should appropriately document the progression/ deterioration of a patient's wound and prescribe appropriate wound management.	Evidence that the Board have shared the decision with all staff involved with wound care in a supportive manner for reflection and learning. By: 19 February 2025. Evidence that the Board have reviewed their wound management guidance to ensure it appropriately takes into account relevant national guidance with details of how any changes will be disseminated to staff. Evidence that the Board have reviewed their wound care assessment training for relevant nursing staff in light of the findings of this investigation with details of how it will be rolled out to relevant staff. By: 16 April 2025.

Rec. number	What we found	Outcome needed	What we need to see
3.	The frequency of dressing changes was not sufficient to manage A's wounds. On one occasion hospital at home staff attending A inappropriately left wet and soaked through dressings for district nursing staff to change which was unreasonable, and Dressings applied to A's wounds were at times not appropriate, contraindicated, or inappropriate to manage his wounds.	Wound dressings should be changed frequently enough to manage the level of exudate, to prevent 'strikethrough' and foul smells. Patients should not be left at home with wet or soaked through dressings unchanged.	Evidence that the Board have shared the decision with all relevant staff involved with wound care assessment in a supportive manner for reflection and learning. By: 19 February 2025. Evidence that the Board has ensured that staff delivering such services have received the appropriate training and ongoing professional development. This should include details of future plans to either / both provide training now and how expertise will be maintained. By: 16 April 2025

Rec. number	What we found	Outcome needed	What we need to see
4.	There was an unreasonable delay in referring A to Tissue Viability Specialists and there was an unreasonable delay in making the referral.	Where a patient's wounds deteriorate despite on-going treatment or are non-progressing over a period of time, nursing staff should consider immediate referral for specialist tissue viability assessment. Decisions in relation to referral should be documented and if the need for referral is identified this should be actioned without delay.	Evidence that The Board have shared the decision with relevant nursing staff involved with wound care in a supportive manner for reflection and learning. By: 19 February 2025. Evidence that the Board have an appropriate referral pathway for specialist wound management and that relevant nursing staff are aware of how to access it to make a referral. By: 16 April 2025

Rec. number	What we found	Outcome needed	What we need to see
5.	Negative Pressure Wound Therapy was inappropriately applied to an actively bleeding wound. Negative Pressure Wound Therapy was also inappropriately applied to a sloughy wound.	Negative Pressure Wound Therapy should be applied in accordance with manufacturers guidance and in accordance with Board policy and HIS guidance.	Evidence that the Board have shared the decision with all relevant staff involved in wound management. By: 19 February 2025. Evidence that relevant staff are aware of the Board's policy on the use of Negative Pressure Wound Therapy and manufacturers guidelines, and that medical staff deemed competent in prescribing/applying NPWT have received training in its use. By: 16 April 2025.

Feedback

Points to note

The ‘house held’ records which contain the written record of care provided at A’s home have been reported as lost. I encourage the Board to reflect on the circumstances leading to their loss, and whether there is any learning for them in relation to record keeping and records management policies and staff guidance.

Terms used in the report **Annex 1**

A	the aggrieved
the Adviser	a registered nurse
the Board	Lothian NHS Board
C	the complainant
DN records	District Nursing records
exudate	Excess fluid leaking from a wound
the hospital	Royal Infirmary of Edinburgh
H@H	Hospital at Home service
NPWT	Negative Pressure Wound Therapy, a treatment that helps wounds heal by delivering negative pressure (a vacuum) to the affected wound.
NEWS	National Early Warning Score, a tool used to detect clinical deterioration in adults.
TVS	Tissue Viability Service

Extract clinical record incident 4 August 2021 **Annex 2**

The care relates to a home visit by the H@H team, the record of the visit is lengthy, but relevant sections are provided below:

Progress:

…Legs have also started leaking more last 2 days. Dressings soaked through from Monday (DNs are visiting today to dress these), going through 3 towels a day underneath legs…

Examination:

…Lower legs bandaged but falling off due to increased fluid leaking. (DNS dressing today)…

Plan:

…Phone DNS to dress legs daily – please do this on visit tomorrow (apologies, ran out of time today)