SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 377 7330**
Web **www.spso.org.uk**

Scottish Parliament Region: Lothian

Case ref: 202307063, Lothian NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / Clinical treatment / diagnosis

Summary

The complainant (C) complained to my office about the nursing care and treatment given to their late parent (A) at home and in hospital (acute care) by Lothian NHS Board (the Board). A was an adult with multiple sclerosis (an autoimmune condition that affects the brain and/or spinal cord). Due to progression of the condition A was doubly incontinent, immobile, and unable to eat or drink independently. A required assistance daily from carers and weekly from district nurses.

A developed pressure damage to their skin whilst in the community, and they were later admitted to hospital with sepsis (overwhelming infection). A was discharged home and readmitted within a short period of time. They died shortly after their readmission to hospital.

C raised concerns that A did not receive appropriate treatment at home from the district nurses, and specifically that, pressure damage was not treated appropriately. C also raised concerns about the standard of acute nursing care specifically in relation to; pressure damage, nutrition, basic care, and record keeping.

The Board said that the district nursing team considered that they had provided reasonable nursing care to A whilst they were at home. The Board also said, acute nursing staff were made aware of A's needs and were concerned about the integrity of A's skin. The Board highlighted that regular drinks were offered to A, however, A declined these on occasions. It was noted that some documentation was not present in the medical records. An action plan was agreed to make improvements in staff awareness, completion of documentation, and the importance of charts.

During my investigation I sought independent clinical advice from a registered nurse with experience in both community and acute care settings and with particular knowledge of the management and treatment of pressure damage.

Having considered and accepted the advice I received I found that:

District nursing care

There was evidence of significant omissions in the care provided by the district nursing team including

- District nurses failed to update assessments accurately or in line with the minimum frequency.
- District nurses failed to check A's skin during joint visits.
- There was a failure to plan visits with two staff members.
- District nurses showed an over reliance on A to report the condition of their own skin.
- The pressure ulcer risk assessment was not appropriately completed and updated.
- There was a failure to have a person-centred care plan in place.

Acute nursing care

There was evidence of significant omissions in the acute care provided by the Board including

- The failure to provide reasonable basic nursing care and end-of-life care.
- Nursing staff failed to create and follow a person-centred care plan.
- Nursing staff failed to carry out and record reasonable care rounding.
- Nursing staff failed to carry out relevant assessments and failed to reasonably complete appropriate charts.
- There was a failure to provide continuity of wound care treatment and follow the appropriate national guidance.

- There was a delay in referral for assessments for pressure damage and nutrition.

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

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 the Board to do for C:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint point (a) I found that the district nursing care and treatment was unreasonable. Under complaint point (b) I found that the nursing care and treatment given to A in hospital during two admissions was unreasonable.	Apologise to C for the failures identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	A copy or record of the apology. By: 25 August 2025

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

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint point (a) I found that the district nursing team failed to i. Complete assessments in an appropriate timescale; ii. Review assessments/reassess A within a reasonable timescale; iii. Complete the Waterlow assessment appropriately; and iv. Develop a person-centred care plan	Patients receiving district nursing care in the community should be appropriately assessed and have appropriate care plans in place that are regularly reviewed and updated.	Evidence that the findings of my investigation have been fed back to the district nursing team involved in a supportive manner for reflection and learning. By: 25 August 2025 Evidence the Board have taken action to ensure all staff are proficient in completing risk assessments (including Waterlow) and developing person-centred care plans. By: 24 November 2025 Evidence an independent audit of patients within the district nursing care has been completed by an independent person external to the Board with the appropriate level of expertise and experience. The purpose of the audit should be to ensure that district nursing care has been appropriately undertaken. In particular that appropriate risk assessments (including Waterlow) are in place, along with a person-centred care

Rec. number	What we found	Outcome needed	What we need to see
			plan and where appropriate a wound care chart. If gaps are identified, evidence that action has been taken to rectify the situation in each case. Progress update by: 24 November 2025 Completed audit by: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint point (a) I found that the district nursing team failed to plan two person visits to A after it was identified this was required to complete basic nursing care, particularly skin checks. Under complaint point (a) I found that the district nursing team relied on A to report on their own skin condition when unable to assess their own skin.	Patients receiving district nursing care should be given basic nursing care with regular checks, such as skin checks, as required. Patients should receive safe and appropriate care from an adequate number of district nursing staff and in line with their assessed needs. Patients who are frail, immobile, experiencing deteriorating health, and who are unable to visually check, should not be expected to report on their own well-being or condition (i.e. skin health) in lieu of appropriate checks by a clinician.	Evidence that the findings of my investigation have been fed back to the district nursing team involved in a supportive manner for reflection and learning. Evidence an independent audit has been completed as detailed in recommendation 2. Progress update by: 24 November 2025 Completed audit by: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
4.	Under complaint point (b) I found that the hospital nursing team failed to i. Complete appropriate assessments on admission to hospital; ii. Develop a person-centred care plan; iii. Complete and maintain appropriate charts such as; wound chart, care rounding, and food intake chart.	Patients who are admitted to hospital should be appropriately assessed and have a person-centred care plan in place. These should be reviewed regularly. Patients in hospital should have their condition, well-being, and nutrition monitored and recorded appropriately. Appropriate monitoring and recording would include records added in their medical notes, care rounding, and charts.	Evidence that the findings of my investigation have been fed back to the relevant involved in a supportive manner for reflection and learning. By: 25 August 2025 Evidence an independent audit of inpatient nursing care, particularly in relation to the carrying out of nursing assessments and completion of patient paperwork/documentation. This should be carried out by a person independent to the Board with the appropriate level of expertise and experience. The purpose of the audit would be to ensure that appropriate nursing assessment and documentation is completed within the correct timescales, and that particular consideration has been given to ensure wound charts are completed as required by the Vale of Leven Enquiry recommendations 2014. Progress update by: 24 November 2025 Completed audit by: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
5.	Under complaint point (b) I found that there was a delay in making appropriate referrals for specialist review of A. Specifically there was i. An unreasonable delay in making a referral to the tissue viability nurse; and ii. An unreasonable delay in making a referral to a dietician.	Patients who require specialist review/input into their care should have referrals made without delay.	Evidence that the findings of my investigation have been fed back to the district nursing team involved in a supportive manner for reflection and learning. Evidence that the Board have robust referral pathways in place for: i. Tissue viability referrals; and ii. Dietician referrals By: 23 September 2025

Rec. number	What we found	Outcome needed	What we need to see
6.	Under complaint point (b) I found that care and treatment provided by nursing staff was unreasonable, particularly i. A's skin damage was not managed correctly, including the use of inappropriate products; ii. A was not repositioned regularly to avoid exacerbating pressure damage; iii. A was not assisted in eating and drinking regularly. iv. The basic nursing care offered to A was unreasonable, for	Patients who are admitted to hospital should receive reasonable basic nursing care to meet their needs. Patients with skin damage/pressure damage should receive care and treatment using appropriate and correct products that are safe for them and their condition. Patients with, or at risk of, pressure damage should receive reasonable nursing care and treatment including regular repositioning. When they are reluctant to be repositioned, they should be offered the use of turn assist equipment to help.	Evidence that the findings of my investigation have been fed back to relevant staff in a supportive manner for reflection and learning. Evidence staff members are aware of formulary products for skin damage, their use and contraindications. Evidence the Board have in place a process for assessing whether pressure assist equipment is needed and that this equipment is available for use when required. By: 23 September 2025 If any gaps in care are identified by the audit (in recommendation 4), evidence that these have been addressed to avoid a similar situation happening again. By: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
	example, mouth care was not carried out and led to oral thrush.	Patients who have been admitted to hospital should have their basic nutritional and hydration needs met, particularly when, they are unable to meet their own needs independently due to their medical condition. Patients should receive appropriate support from nursing staff.	

Feedback

Response to SPSO investigation

In providing information in response to enquires made by my complaints reviewer, the Board were asked to provide both clinical notes from admissions to hospital and the district nursing notes prior to admission to hospital. The district nursing notes were not provided in response to this initial enquiry.

When my complaints reviewer contacted the Board to notify them that the complaint would be investigated, they made a further specific request for district nursing notes to be provided. In response the Board provided a copy of the written 'house' notes from A's home. There was no indication that any other notes were available.

Very late in my investigation the Board disclosed that there were further electronic district nursing notes held within their TRAK system. Once aware that there were further electronic notes available, my complaints reviewer requested that these be shared with us.

When we make enquiries to organisations for records relating to a complaint, and particularly in the case of medical records, we ask that all the relevant records relating to the complaint be provided. In this case, both the written and electronic district nursing notes should have been provided in response to our initial request for medical records. Not doing so extended the time taken for me to complete my investigation.

I expect all Boards to provide all the relevant information in response to my office's initial request and I urge the Board to ensure this happens going forwards.

Points to note

1. I draw the Board's attention to the Adviser's view that there may have been potential breaches of the NMC's The Code. The Adviser told us they consider there may have been breaches in: delivering the fundamentals of care, preventing ill health, working with colleagues to preserve the safety of those receiving care, identifying risks, completing records, accuracy of records, putting situations right,

and escalating concerns. I strongly encourage the Board to consider this carefully, discuss with staff involved with a view to taking action or sharing a copy of this report with the NMC.

2. The written house district nursing records in this case do not always match the electronic TRAK records. On occasions some information is omitted from one or the other of the records. Records both written and electronic should be an accurate, complete record of what happened during a visit to a patient. I encourage the Board to reflect on the records in this case and consider whether there is any learning in relation to record keeping for the staff involved.

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 SPSO's role 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 nursing care and treatment that their late parent (A) received during admission to hospital and at home in the community from the Board.

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

   (a) The nursing care and treatment provided by the Board's District Nursing Team prior to A's admission to hospital was unreasonable *(**upheld**)*; and

   (b) The nursing care and treatment provided to A during their admissions to hospital in November 2022 was unreasonable *(**upheld**)*.

Investigation

3. In order to investigate C's complaint, my complaints reviewer and I carefully reviewed the documentation provided by C and by the Board in response to enquiries made of them. During my investigation I took independent advice from an appropriately qualified clinical adviser, a registered nurse with specific experience in both acute and community settings (the Adviser). The Adviser has had full access to the relevant medical records and complaint correspondence.

4. I have decided to issue a public report on C's complaint given my concerns about the serious failings in this case, the systemic nature of the failings and the significant personal injustice to A and their family.

5. I recently issued a public report against the Board which identified similar failings in skin care (case reference 202111459). This has contributed to my decision to issue a public report in recognition of the need to ensure there is appropriate learning and improvement from complaints, and as there may also be an opportunity for wider learning for other Boards.

6. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer and I have reviewed all the information

provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report.

Background

7. A was an adult in their 50s who had multiple sclerosis (MS). They were under the care of district nurses in the community whilst at home. Due to the progression of their MS, A was immobile and doubly incontinent. They required assistance daily from carers and weekly from district nurses.

8. A was unable to independently reposition themselves, or eat and drink independently due to the progression of their MS.

9. At the time of their admission to hospital in November 2022, A had pressure damage to their skin and had been diagnosed with sepsis. They were discharged home, but swiftly readmitted still suffering from sepsis and they died shortly after readmission.

10. Key events:

Date of event	**Details of event**
Prior to November 2022	A received care at home from the district nursing team. A was immobile and catheterised.
1 November 2022	A was admitted to hospital with fever/ sepsis.
7 November 2022	A was assessed as medically fit for discharge with a package of care in place and was discharged home.
11 November 2022	District nursing staff attended A at home for a skin check. Carers had asked for twice weekly visits (from nursing staff). The district nurse noted the wrong cream was being used, gave advice not to use that cream and decided twice weekly visits (from nursing staff) was not necessary.
12 November 2022	A was readmitted to hospital with fever/ sepsis.

Date of event	Details of event
24 November 2022	A passed away.

Relevant policies, procedures, and guidelines

11. During my consideration of the complaint, a number of relevant policies, procedures, and guidelines were taken into account. A full list is included in Annex 2.

(a) The nursing care and treatment provided by the Board's District Nursing Team prior to A's admission to hospital was unreasonable

Concerns raised by C

12. C raised concerns that the care that A received from district nursing staff before A's first admission to hospital was unreasonable. Of particular concern was the deterioration of A's skin. C questioned why district nursing staff did not take appropriate action to address this during their treatment or highlight the deterioration.

13. C was especially concerned with the damage to A's skin in sensitive areas and raised concern that this may have contributed to the level of infection A was experiencing during their admissions to hospital.

The Board's response

14. In their response to C's complaint the Board said:

i. District nurses attended A for catheter care and to examine A's skin. Specifically, on 18 October 2022 a district nurse attended, completed a catheter wash out, and examined as much of A's skin as possible.

ii. The Board said that the nurse recorded that they could not complete a full check of A's skin as two members of staff were needed to move them safely and comfortably. The district nurse planned the next visit for two nurses to enable the skin examination to be completed.

iii. The next visit was on 25 October 2022; however, this was not a joint visit as planned, due to staff absence. On this visit the catheter was washed out and A's skin examined as much as possible. Another visit was scheduled for seven days later.

iv. The next planned visit was the 1 November 2022. It was attended by a district nurse; however, A had been admitted to hospital.

v. The district nursing team were notified of A's return home on 7 November 2022 and attended on 8 November 2022 for a catheter wash out. A declined the catheter care offered as their catheter had been changed in hospital and they did not feel that this was needed.

vi. On 11 November 2022, a district nurse met with A's carers for a skin check. The carers requested twice weekly visits from the district nursing team and that a weekly urine specimen be tested. The nurse noted that there were areas of damage to the surface of A's skin and that the carers were using the wrong cream to treat these.

vii. The nurse reassured the carers that if the right cream was used, increased visits were not required. They also explained that a urine test would only be carried out if clinically indicated or if A was symptomatic.

15. In their response to the enquiries made by my complaints reviewer, the Board added that:

i. It is the opinion of the district nursing team that reasonable care was provided to A.

ii. The district nursing team worked closely with the social care provider and the family to ensure A's needs were met. Communication was considered to be good and the nursing team were contacted on a regular basis both in office hours and outside of office hours for advice, support and treatment.

iii. On the district nurse's last visit to A before their second admission to hospital (11 November 2022), the nurse noted moisture damage to A's buttocks and the tops of A's thighs but the skin was not broken. The nurse considered this to be new. It was noted the carers were using an inappropriate cream. The nurse identified the correct product to use, and the carers were instructed in its use. Advice was given around an appropriate skin regime including cleaning and drying. Advice was also given to A about changing their position.

iv. A's care was always discussed with them as they had capacity (the ability to understand information, make decisions, and communicate those decisions). The care would not always have been discussed with family members such as C unless A asked for this to happen.

Advice

16. I sought advice on the issues raised and can confirm that the Adviser saw the information provided by C and the Board, and the clinical records from the time including written and electronic records. The Adviser said:

i. On the basis of the records provided they were able to review district nursing care provided over a period of 29 months before A's first admission to hospital (1 November 2022) as well as, the care provided after A's discharge from hospital (7 November 2022).

ii. It was noted that assessments for care and subsequent care planning in relation to nutrition, skin integrity and general well-being were last carried out on 19 June 2020. These assessments should be redone every six months, or sooner if the patient's condition changes.

iii. A was frail, was experiencing swallowing deterioration due to the progression of MS, had skin breakdown due to faecal incontinence and the urinary catheter bypassing (when the catheter is blocked or obstructed and urine leaks around the catheter), and was physically deteriorating to the

extent that by the time of their second admission to hospital (around 12 November 2022) they were too weak to lift a cup to their mouth.

iv. These assessments should have been updated as a minimum in December 2020, June 2021, December 2021, and June 2022. These were not done. However, the Adviser was of the view that the increasing frailty of A would have warranted even more frequent re-assessments.

v. The last full skin check prior to A's admission to hospital on 1 November 2022 was carried out on 13 September 2022. This means it was 50 days until another skin check was carried out. Which was done in hospital and it was discovered A had damaged skin due to faecal and urinary incontinence.

vi. The district nursing team relied on A, as a frail and immobile person, to report on the condition of the skin on their bottom instead of physically checking. The district nurses should have checked A's skin at each visit. The Adviser noted that on the first visit after A was discharged from hospital on 8 November 2022, the district nurse did not check A's skin, when it was evident that skin damage was present.

vii. The district nursing notes record that on numerous occasions the nurses relied on A to report their own skin integrity, in the knowledge that they could not check their own bottom, for a number of months from March 2022 to October 2022.

viii. At times it was recorded that the reason for not undertaking skin inspections was that there was not a second person to assist. However, the notes indicate that a skin inspection was not carried out even when there were two nurses attending to carry out care (specifically on 24 September 2022). The district nursing team were aware that to undertake basic care, A required two nurses. As such, the visits should have been planned accordingly (i.e. with two people attending each visit). The Adviser

particularly noted that the same nurse failed to check A's skin on two consecutive weekly visits.

ix. It is noted the damage to A's skin was so significant that when A was admitted to hospital on both occasions but particularly on the second admission, the acute team recorded entries in their system (Datix) to record their concerns about A's skin and the damage present on each admission.

x. The pressure ulcer risk assessment (the Waterlow) was filled in without the year being completed. This was contained within the records from 2020 and areas of the records are completed with the date 18 June 2020, which suggests that this is when the Waterlow was also completed although this cannot be confirmed. It is noted that the Board said this was completed on 18 June 2022, although this also cannot be confirmed.

xi. There is a single entry on the Waterlow, with a score of 17 which means that the patient has a high risk of pressure damage. The score recorded is inaccurate, as the assessor failed to enter A's age, the fact that they smoked vapes, and had respiratory compromise. Adding these elements gives a higher score and would have put A in the very high risk category for developing pressure damage to their skin.

xii. The Waterlow was not updated. This should have been updated with any change in condition. A had numerous changes in condition including an admission to hospital but this was not captured in the Waterlow document.

xiii. The documentation provided by the Board was also missing evidence of a person-centred care plan, a wound assessment chart, a malnutrition risk assessment and a moving and handling risk assessment.

xiv. On reviewing photographs of A's skin, provided by C[1], the Adviser noted that there was evidence of moisture damage (peeling, weeping, very reddened skin) on A's bottom arising from exposure to urine and faeces with suspected deep tissue damage represented by deep purple areas. The photograph of A's foot shows suspected deep tissue damage and exceptionally dry skin (thickened, yellowed, and cracked skin) which should have been receiving emollient therapy to keep the skin moist and healthy.

xv. These photographs are evidence of a significant period of A not receiving appropriate moisturising.

17. Overall, the Adviser considered that the care provided by the district nursing team was unreasonable. There is evidence of omissions in care by the district nursing team throughout the records received.

18. I accept this advice.

19. The Adviser also commented on potential breaches of the code of practice developed and issued by the Nursing and Midwifery Council (NMC), known as The Code. As compliance with The Code is outwith my jurisdiction this has not been considered as part of my investigation, beyond informing my views on the reasonableness of care and treatment provided by the Board. However, I will be asking the Board to discuss this with the staff concerned with a view to taking action or sharing a copy of my report with the NMC.

District Nursing written and electronic records

20. The Board provided my complaints reviewer with a copy of the written records from C's house. These are records that remain in the home and are added to by a nurse on each visit to record what action was taken. Very late into the investigation the Board disclosed that there were further electronic records contained within their system TRAK,

[1] C provided photographs of A's skin and the damage present. C told us that these were taken in hospital during A's second admission.

and suggested that these contained more information of the care provided than was recorded in the written records. My complaints reviewer requested these records for review.

21. The Adviser and my complaints reviewer reviewed both the TRAK records and the written records. My complaints reviewer noted that a number of the records did not match, and that, on a number of occasions different information was recorded in one set of records but not the other. Examples of these discrepancies include the following;

i. 13 July 2022 – TRAK record indicates that A's skin was treated during a one person visit. Yet, the written record of the same date makes no mention of the skin being treated.

ii. 13 September 2022 – TRAK record states that the visit was a joint visit with a student and records care provided in regards to the catheter, but with no mention of a skin check or treatment. The written record makes no mention of the student nurse being present and records that a skin check had been completed.

iii. 18 October 2022 – TRAK record states the skin was not checked; however, the written record from the time states that some of the skin was checked but the nurse could not check A's bottom.

(a) Decision

22. 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.

23. C has complained to me that the Board failed to provide reasonable district nursing care and treatment to A. Before I turn to my decision, I would like to first acknowledge that what happened must have been very difficult for all affected. I recognise that this report is likely to be very difficult for C and their family to read. They have my utmost sympathy for their loss. I also recognise that this will be a difficult report for Board staff to read and I encourage the Board to ensure that they are supported.

24. During my investigation I have considered the information provided to me and I have taken independent advice from the Adviser (as outlined above). I have given careful consideration to the advice I received, which I accept. In summary the advice I have received is that:

i. The district nursing care and treatment provided to A was unreasonable.

ii. Assessments were not updated in line with the expected minimum frequency or as often as was required in this case.

iii. There were repeated failures to check A's skin during joint visits.

iv. Despite it being known that two members of the district nursing team were required, there was a failure to plan the visits to meet A's needs.

v. On a number of occasions nursing staff relied on A's own verbal report of their skin integrity, despite the fact that A was immobile and could not check their own skin.

vi. The pressure ulcer risk assessment, Waterlow, was not completed or updated appropriately.

vii. The assessment recorded on the Waterlow was wrong and A should have been in the very high risk category for developing pressure damage to their skin.

viii. There was a failure to have in place a person-centred care plan and appropriate assessments for: wounds, malnutrition, and moving and handling.

25. I also note that my investigation identified that:

i. On a number of occasions TRAK records do not correspond with the written records with different information recorded in each.

26. Having reviewed the evidence available to me and considering the advice I received, I am clear that the standard of care and treatment provided to A by the district nursing

team was unreasonable. It is also clear that there were repeated failures to complete the relevant assessments for A, to update the assessments with new information when A's situation evolved, and to appropriately assess A's risk of pressure damage.

27. Of particular concern is that the district nursing team knew, and documented, that A required two people to be moved safely. While they tried to arrange this for subsequent meetings, I have not seen evidence that they adjusted or created a care plan that would ensure two nurses attended visits. Of further significant concern is that even when two nurses attended appointments, they appear to have regularly failed to carry out checks to A's skin. I note from the period of May to October 2022, the records indicate that there were 11 joint visits to A. Of these visits, eight do not have any record (either written or on TRAK) of a skin check being carried out.

28. I also note from the records that on a number of occasions nursing staff recorded that skin checks were carried out when only one member of staff was present, despite it being known that two members of staff were needed. This suggests that, given the reason for two staff being needed, the check cannot have been thorough.

29. In light of the evidence I have seen and the advice that I accept, I consider that the care and treatment A received from the district nursing team was unreasonable.

30. As such, I uphold this complaint. Given the significant failings identified I have made a number of recommendations for urgent action.

(b) The nursing care and treatment provided to A during their admissions to hospital in November 2022 was unreasonable

Concern's raised by C

31. C raised concerns that the nursing care and treatment provided to A during their admissions to hospital in November 2022 was unreasonable. C's concerns covered a number of areas of nursing care including;

i. Nursing staff were witnessed writing in the records without performing any checks on A.

ii. Nursing staff failed to take care of A's skin appropriately, which C believes led to infection.

iii. Despite A being unable to eat food or drink independently, nursing staff failed to ensure that A had eaten and had drunk water (which was very important as A had a urinary infection).

iv. There was a lack of dignity for A at the end of their life.

v. Nursing staff did not carry out personal care towards the end of A's life.

vi. Despite asking earlier, A was only moved to a side room two hours before the end of their life.

The Board's response

32. In their response to C's complaint, the Board said:

i. The team providing care to A were concerned about their skin fragility. As such, they were referred to and seen by a tissue viability nurse who offered advice about dressings to help maintain skin integrity. There were no signs of skin infection (cellulitis); however, the intravenous (IV) antibiotics A was receiving would have covered any skin infections.

ii. It was raised at the ward safety brief (a briefing to nursing staff that happens at the start of every shift) that A required assistance with food, fluid, and nutrition. This was to ensure all staff on shift were aware that A would require assistance with eating and drinking.

iii. A was referred to the dietician on 18 November 2022 for a nutritional review. The dietician recommended full calorie snacks, full fat milk, and commencing a food record chart.

iv. A had a fluid balance chart in place to record the intake of fluid. The care rounding documentation indicated that A was offered regular drinks although they did not always want these.

v. The food record chart could not be located during the Board's investigation of C's complaint. This should have been in place as requested by the dietician. The Board apologised that it was not.

vi. It was noted that the medical records documented that A was on a new puree diet as they had trouble swallowing. It was also documented that A was struggling with the puree diet and that they were trying soups and puddings at mealtimes. A dietician review on 23 November 2022 suggested trialling high calorie supplement drinks.

vii. In terms of nutrition, the Board considered that A's needs were being assessed and planned for. Staff were offering assistance to A with managing their fluid and nutrition.

viii. At the time of A's discharge after their first admission to hospital, A was not showing signs of flu infection and so was moved from the 'red' ward (a ward set up during the COVID-19 pandemic to admit patients with active infection/COVID-19) to a different ward before discharge. The Board acknowledged that this was not communicated with the next of kin and apologised for this.

ix. During their first admission, nursing staff monitored A's condition and recorded that observations were stable. Nursing staff recorded that the catheter in place was leaking and so it was changed. Nursing notes recorded that A had managed to eat. On the day of discharge, it was noted A had eaten breakfast but had declined lunch.

Response to SPSO enquiries

33. The Board did not have anything further to add to the comments already made in the response; however, they did share an action plan in response to SPSO's enquiries. The action plan detailed areas noted for improvement which were:

i. staff awareness of patients who need assistance;

ii. the MUST (Malnutrition Universal Screening Tool) documentation being completed within 6 hours of admission/transfer to the ward. After reviewing a draft copy of this report, the Board clarified that the Lothian Accreditation and Care Assurance Standards require that MUST documentation should be completed within 24 hours. They confirmed that this has been raised directly with the Senior Charge Nurse of the ward involved in this complaint;

iii. general documentation being completed including food charts; staff should liaise with the meal coordinator; and

iv. education on the importance of nutrition/hydration and the need for charts.

Advice

34. The Adviser saw the documentation available relating to the nursing care and treatment provided to A during their admissions to hospital, including the information provided by C, the complaint response from the Board, the action plan provided by the Board and the medical records.

<u>General nursing care</u>

35. I asked the Adviser to consider the general nursing care that was provided to A during their admissions (i.e. the care provided in hospital rather than the care provided at home which was covered under (a) above). The Adviser said;

i. From the documentation available to view, it is clear that the nursing care provided to A was not to a reasonable standard. However, the second

admission especially demonstrated a number of failures in general nursing care.

ii. During A's second admission to hospital their health declined suddenly at the end of the two week admission. The nursing care received by A during this admission did not meet basic standards, including end of life care. As such, the nursing care was not to a reasonable standard.

iii. Medical staff (i.e. doctors) had to request mouth care on 20 November 2022. This is a basic care requirement and should have been recognised by nursing staff. A went on to develop oral thrush two days later. This should have been recognised and dealt with by nursing staff and a person-centred plan of care developed to address this need, and any nursing interventions undertaken to address this should have been recorded in the care rounding chart.

iv. During the second admission to hospital, medical staff documented that A had lost the ability to lift a cup to their mouth to drink and was unable to drink due to the progression of A's MS. A was nutritionally compromised because of this and in light of the fact they could not feed themselves. This should have been recognised and dealt with by nursing staff and a person-centred plan of care developed to address the need, with any interventions taken recorded on the care rounding documentation.

v. A referral to a dietician was delayed. Despite knowing from the first admission that A had low serum albumin (18 when it should normally be 35), a referral to a dietician was not made until 18 November 2022.

vi. These are basic needs that should have been assessed properly, a person-centred plan of care developed, implemented, and evaluated on every shift.

vii. From the records reviewed, there is no evidence of person-centred care planning, implementation, or evaluation. Basic nursing care is recorded in

the care rounding chart; however, in A's case there is only one entry in the care rounding chart from the second admission on 24 November 2022.

viii. A patient with A's presenting medical condition, co-morbidities (other medical conditions), skin damage, and decline in health should have been receiving two hourly interventions for comfort, dignity and prevention of pressure damage. There should have been evidence that A was offered basic nursing care two hourly. There was no evidence that this was done.

Care and management of A's skin during both admissions

36. I asked the adviser to consider the Board's position in regard to the care and management of A's skin during both admissions. The Adviser said;

i. It is acknowledged (as detailed in complaint point (a) above) that A's skin damage occurred at home and that it was present on A's admissions to hospital. However, the Board's management of A's skin whilst in hospital was also unreasonable.

ii. A went on to develop healthcare avoidable pressure damage to their heel that was only picked up by the tissue viability nurse specialist on 23 November 2022 (the day before A passed away and after A had been in hospital for almost two weeks).

iii. A was admitted to hospital with compromised excoriated skin (damaged skin often appearing red, raw, or irritated with visible scratches or marks) on 1 November 2022 and readmitted on 12 November 2022 when their skin was excoriated and bleeding. The Assess, Plan, Implement, and Evaluate (APIE) process should be followed. The risk assessments inform the person-centred care plan which is evaluated on each shift. There is no evidence of pressure ulcer risk assessment on either admission or a plan being developed to address any identified skin issues during either admission.

iv. There was no wound chart in place for either admission but A was receiving a variety of treatments for skin damage. The records indicated the use of the following; 'cream' (no specific detail of which cream), Drapolene, Sudocrem, Flaminal Forte, and Viscopaste. Therefore, there was no continuity of care and inappropriate care in some cases.

v. For example, Flaminal Forte is to be used for moderately to high exuding (fluid leaking) wounds and not usually for excoriation. Sudocrem can affect the absorbency properties of continence pads, therefore should be avoided when the patient requires to use continence pads.

vi. A referral to the tissue viability service should have been made on each admission as A was allergic to the standard treatment for their presenting condition (Cavilon) and as the hospital nursing team had concerns about the level of skin damage A had sustained in the community.

vii. During the second admission, it took 11 days before a referral was made to tissue viability, even though it had been documented that this was required. The family were told that the plan was to refer to tissue viability; however, this was not done for another seven days. The tissue viability nurse then reviewed A on the same day as the referral was received (23 November 2022).

viii. The Board failed to follow the national guidance for foot damage, known as CPR for feet (Check, Protect, Refer). A referral was never made to podiatry by the tissue viability nurse after their review of A. As noted above, there was an unreasonable delay in referring to the tissue viability service, especially in light of the concerns held about the care received by A in the community.

ix. A person-centred care plan should have been completed for skin integrity at each admission and it is mandatory in Scotland that a wound care chart is completed because A's wounds required ongoing management and

treatment. This became mandatory in Scotland in 2014 post the Vale of Leven enquiry.

x. A wound chart was not put in place by nursing staff on either admission; however, during the second admission the tissue viability nurse also failed to complete the wound chart, instead requesting the ward nursing staff do this (this was not done).

xi. Skin integrity is maintained through repositioning and this should be recorded in the care rounding chart. There is a single entry in the care rounding chart. A patient with A's presenting medical condition, co-morbidities, and skin damage should have been receiving two hourly interventions to reposition them to allow reperfusion (restoration) of blood to their bottom. The Board cannot evidence that this was planned or carried out. It was recorded on several occasions that A declined to be repositioned. However, the records do not demonstrate that the Board considered the use of turn assist equipment (or equivalent such as pressure assist equipment). This should be considered when a patient is reluctant to be repositioned.

xii. Whilst the damage to A's skin began in the community, the Board's management of A's skin in hospital on each admission was unreasonable.

Care and management of A's nutrition during each admission

37. I asked the Adviser to consider the Board's management of A's nutrition given the decline in their ability to manage this independently. The Adviser said;

i. From 3 November 2022 during A's first admission, blood tests indicated that A could be nutritionally compromised as one of the blood tests indicated that A had a low serum albumin. This result does not appear to have been acted on until 18 November 2022 (during the second admission) when a referral to a dietician was made.

ii. As noted above, from the second admission it was documented that A had lost the ability to lift a cup to their mouth to drink and was unable to drink due to MS progression. Therefore, A was nutritionally compromised as they physically could not feed themselves or give themselves a drink. This should have been recognised and dealt with by nursing staff.

iii. As with the points covered above, this need should have been recorded in a person-centred care plan and any nursing interventions taken should have been recorded in the care rounding chart.

iv. A's swallowing was compromised and they required the support of a Speech and Language Therapist. A national universal screening tool is used to ascertain if a person is at risk of malnutrition or not. This is called MUST (Malnutrition Universal Screening Tool). The Board had not provided a copy of MUST which should be completed on admission and repeated weekly.

v. A food intake chart has been provided; however, this has not been completed to a standard required to make an accurate assessment of food and fluid intake. There is no evidence of the Board following the APIE process as there was no risk assessment completed or person-centred care plan developed to address any swallowing or nutritional issues.

vi. On review of a draft copy of this report, the Board highlighted that they considered that it is a common misconception that low serum albumin reflects nutritional state and/or should be used as an indicator for dietic referral and intervention. The Board advised that a low serum albumin reflects either chronic inflammation; protein losing enteropathy; proteinuria or hepatic dysfunction but does not reflect malnutrition. Nutritional intervention will not improve serum albumin and the underlying cause of low albumin should be treated.

vii. The Adviser considered the Board's position. They reiterated their view that that low serum albumin *could* be an indication that a patient may be suffering from malnutrition. The Adviser recognised that there are other

clinical causes for low serum albumin. However, they highlighted their main point was that this should have been investigated by a holistic nutritional assessment particularly as it is documented that A could not hold a cup to their mouth and had swallowing difficulties.

viii. They accepted that serum albumin is only one aspect of a wider in depth assessment including the MUST. In this case, the Adviser's view remained that the low serum albumin should have been investigated alongside other malnutrition assessments. In A's case, the serum albumin level should have been a trigger to investigate the cause as part of a holistic nutritional assessment.

ix. A's family had to request that medication be converted to a liquid format to enable A to take them in light of the issues with swallowing. Clinical staff should have recognised this requirement and it should not have needed intervention of family members to request this.

x. The Board did not assess A's nutrition to a reasonable standard.

38. I accept this advice.

(b) Decision

39. C complained to me that the standard of nursing care A received in hospital was unreasonable. They were particularly concerned about the management of A's skin, their nutrition, and basic nursing care.

40. During my investigation I have carefully reviewed the information provided to me in detail and taken independent advice from the Adviser (as outlined above). I have given careful consideration to the advice I received, which I accept. In summary the advice I accept this that:

i. The Board failed to provide basic nursing care during both A's admissions to hospital.

ii. The Board failed to assess A's nutrition to a reasonable standard.

iii. The Board failed to develop, follow, and evaluate a person-centred care plan for A and to provide appropriate end of life care.

iv. The Board failed to carry out appropriate care rounding and failed to record nursing interventions in the care rounding documentation.

v. The Board failed to complete relevant assessment and monitoring documentation i.e. MUST and the mandatory wound chart. The Board also failed to complete the food intake charts reasonably.

vi. There was an unreasonable delay in referring A for assessments by a tissue viability nurse, and the dietician.

vii. There was a failure to provide continuity of treatment for A's skin damage, at times inappropriate products were used.

viii. There was a failure to follow and apply national guidance for pressure damage on A's foot.

41. Having reviewed the evidence available to me and considering the advice I received (and accept), I am clear that there have been significant failures in the nursing care provided to A during their admissions to hospital.

42. A was a particularly vulnerable patient with advanced MS which limited their ability to care for themselves and carry out basic functions such as taking a sip of water when thirsty. On top of this, it was clear to clinicians on A's admission to hospital that A had significant skin damage that did not appear to have been managed appropriately prior to admission, which must have been a source of significant discomfort and pain for A.

43. It, is therefore, of significant concern that there was a failure to provide basic nursing care to meet A's basic needs in hospital. It is also clear that there was a failure to provide appropriate nursing care to A to meet their nutritional needs. I consider this to be unreasonable.

44. Of particular concern is that the failure to appropriately manage and treat A's skin damage continued whilst A was in hospital. The advice I have accepted highlights that the

appropriate documentation was not completed, mandatory wound charts were not completed, wound assessments were not carried out, care rounding was not done nor recorded appropriately, and there was an unreasonable delay in referring A to be assessed by a tissue viability nurse. This was unreasonable.

45. I recognise that this period of care was during a time when the NHS was recovering from the impact of COVID-19 and I appreciate that this may have played a part in the pressures faced by nursing staff at the time, which I acknowledge would have been significant. However, I do not consider that by the end of 2022 the circumstances were such that nursing staff would not be able to carry out basic nursing care to ensure a patient's basic needs are met. As such, I consider that the nursing care and treatment provided to A during their admissions to hospital was unreasonable.

46. I am especially concerned by the repeating nature of the failures identified in this case. A's second admission was for a period of 13 days from their admission on 12 November 2022 to their passing on 24 November 2022. During this period A was undoubtably treated by a number of different nursing staff, yet there was only one single entry into care rounding documentation at the time. The appropriate assessments were not completed on admission; however, they were also not completed at any time during A's stay on the ward. There were many different clinicians involved in A's care, and yet, it appears it was not identified that the documentation was missing or incomplete and no instruction was given to the nursing staff to prompt them to complete this.

47. The tissue viability nurse, when noting that the mandatory wound chart was not present, failed to complete this and instead asked the ward nursing staff to complete it. This was a missed opportunity to put this in place, albeit I recognise this was unlikely to change the outcome given that the review by the tissue viability nurse was only carried out on the day before A passed away.

48. The evidence I have seen suggests that there were repeated failures involving multiple staff members which to me, indicates systemic failure. In particular in relation to patient assessment and care rounding; incomplete documentation and skin care.

49. Overall, in light of the evidence I have seen and the advice that I accept, I consider that the nursing care and treatment provided to A during their admissions to hospital was unreasonable.

50. As such, I uphold this complaint.

51. 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 dates specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

General comments

52. I am very aware that the details of what happened cannot be easy for C or their family to read and I appreciate that these findings will likely be very upsetting for A's family. I am grateful for their patience whilst my complaints reviewer and I investigated their concerns. I also recognise that this report will make difficult reading for the Board and encourage them to be supportive in how they share my findings with staff. Nevertheless, I believe my recommendations should lead to lasting learning and improvement and be of benefit to other patients in a similar position to A. I hope this will be of some comfort to C and A's family and I encourage the Board to act on these recommendations urgently.

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 Services Division to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint point (a) I found that the district nursing care and treatment was unreasonable. Under complaint point (b) I found that the nursing care and treatment given to A in hospital during two admissions was unreasonable.	Apologise to C for the failures identified in this report. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	A copy or record of the apology. By: 25 August 2025

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

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint point (a) I found that the district nursing team failed to v. Complete assessments in an appropriate timescale; vi. Review assessments/reassess A within a reasonable timescale; vii. Complete the Waterlow assessment appropriately; and viii. Develop a person-centred care plan	Patients receiving district nursing care in the community should be appropriately assessed and have appropriate care plans in place that are regularly reviewed and updated.	Evidence that the findings of my investigation have been fed back to the district nursing team involved in a supportive manner for reflection and learning. By: 25 August 2025 Evidence the Board have taken action to ensure all staff are proficient in completing risk assessments (including Waterlow) and developing person-centred care plans. By: 24 November 2025 Evidence an independent audit of patients within the district nursing care has been completed by an independent person external to the Board with the appropriate level of expertise and experience. The purpose of the audit should be to ensure that district nursing care has been appropriately undertaken. In particular that appropriate risk assessments (including Waterlow) are in place, along with a person-centred care

Rec. number	What we found	Outcome needed	What we need to see
			plan and, where appropriate, a wound care chart. If gaps are identified, evidence that action has been taken to rectify the situation in each case. Progress update by: 24 November 2025 Completed audit by: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint point (a) I found that the district nursing team failed to plan two person visits to A after it was identified this was required to complete basic nursing care, particularly skin checks. Under complaint point (a) I found that the district nursing team relied on A to report on their own skin condition when unable to assess their own skin.	Patients receiving district nursing care should be given basic nursing care with regular checks, such as skin checks, as required. Patients should receive safe and appropriate care from an adequate number of district nursing staff and in line with their assessed needs. Patients who are frail, immobile, experiencing deteriorating health, and who are unable to visually check, should not be expected to report on their own well-being or condition (i.e. skin health) in lieu of appropriate checks by a clinician.	Evidence that the findings of my investigation have been fed back to the district nursing team involved in a supportive manner for reflection and learning. Evidence an independent audit has been completed as detailed in recommendation 2. Progress update by: 24 November 2025 Completed audit by: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
4.	Under complaint point (b) I found that the hospital nursing team failed to iv. Complete appropriate assessments on admission to hospital; v. Develop a person-centred care plan; vi. Complete and maintain appropriate charts such as; wound chart, care rounding, and food intake chart.	Patients who are admitted to hospital should be appropriately assessed and have a person-centred care plan in place. These should be reviewed regularly. Patients in hospital should have their condition, well-being, and nutrition monitored and recorded appropriately. Appropriate monitoring and recording would include records added in their medical notes, care rounding, and charts.	Evidence that the findings of my investigation have been fed back to the relevant involved in a supportive manner for reflection and learning. By: 25 August 2025 Evidence an independent audit of inpatient nursing care, particularly in relation to the carrying out of nursing assessments and completion of patient paperwork/documentation. This should be carried out by a person independent to the Board with the appropriate level of expertise and experience. The purpose of the audit would be to ensure that appropriate nursing assessment and documentation is completed within the correct timescales, and that particular consideration has been given to ensure wound charts are completed as required by the Vale of Leven Enquiry recommendations 2014. Progress update by: 24 November 2025 Completed audit by: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
5.	Under complaint point (b) I found that there was a delay in making appropriate referrals for specialist review of A. Specifically there was iii. An unreasonable delay in making a referral to the tissue viability nurse; and iv. An unreasonable delay in making a referral to a dietician.	Patients who require specialist review/input into their care should have referrals made without delay.	Evidence that the findings of my investigation have been fed back to the district nursing team involved in a supportive manner for reflection and learning. Evidence that the Board have robust referral pathways in place for: iii. Tissue viability referrals; and iv. Dietician referrals By: 23 September 2025

Rec. number	What we found	Outcome needed	What we need to see
6.	Under complaint point (b) I found that care and treatment provided by nursing staff was unreasonable, particularly v. A's skin damage was not managed correctly, including the use of inappropriate products; vi. A was not repositioned regularly to avoid exacerbating pressure damage; vii. A was not assisted in eating and drinking regularly. viii. The basic nursing care offered to A was	Patients who are admitted to hospital should receive reasonable basic nursing care to meet their needs. Patients with skin damage/pressure damage should receive care and treatment using appropriate and correct products that are safe for them and their condition. Patients with, or at risk of, pressure damage should receive reasonable nursing care and treatment including regular repositioning. When they are reluctant to be repositioned, they should be offered the use of turn assist equipment to help.	Evidence that the findings of my investigation have been fed back to relevant staff in a supportive manner for reflection and learning. Evidence staff members are aware of formulary products for skin damage, their use and contraindications. Evidence the Board have in place a process for assessing whether pressure assist equipment is needed and that this equipment is available for use when required. By: 23 September 2025 If any gaps in care are identified by the audit (in recommendation 4), evidence that these have been addressed to avoid a similar situation happening again. By: 23 January 2026

Rec. number	What we found	Outcome needed	What we need to see
	unreasonable, for example, mouth care was not carried out and led to oral thrush.	Patients who have been admitted to hospital should have their basic nutritional and hydration needs met, particularly when, they are unable to meet their own needs independently due to their medical condition. Patients should receive appropriate support from nursing staff.	

Feedback for Lothian NHS Board - Acute Services Division

Response to SPSO investigation

In providing information in response to enquiries made by my complaints reviewer, the Board were asked to provide both clinical notes from admissions to hospital and the district nursing notes prior to admission to hospital. The district nursing notes were not provided in response to this initial enquiry.

When my complaints reviewer contacted the Board to notify them that the complaint would be investigated, they made a further specific request for district nursing notes to be provided. In response the Board provided a copy of the written 'house' notes from A's home. There was no indication that any other notes were available.

Very late in my investigation the Board disclosed that there were further electronic district nursing notes held within their TRAK system. Once aware that there were further electronic notes available, my complaints reviewer requested that these be shared with us.

When we make enquiries to organisations for records relating to a complaint, and particularly in the case of medical records, we ask that all the relevant records relating to the complaint be provided. In this case, both the written and electronic district nursing notes should have been provided in response to our initial request for medical records. Not doing so extended the time taken for me to complete my investigation.

I expect all Boards to provide all the relevant information in response to my office's initial request and I urge the Board to ensure this happens going forwards.

Points to note

3. I draw the Board's attention to the Adviser's view that there may have been potential breaches of the NMC's The Code. The Adviser told us that they consider there may have been breaches in: delivering the fundamentals of care, preventing ill health, working with colleagues to preserve the safety of those receiving care, identifying risks, completing records, accuracy of records, putting

situations right, and escalating concerns. I strongly encourage the Board to consider this carefully, discuss with staff involved with a view to taking action or sharing a copy of this report with the NMC.

4. The written house district nursing records in this case do not always match the electronic TRAK records. On occasions some information is omitted from one or the other of the records. Records both written and electronic should be an accurate, complete record of what happened during a visit to a patient. I encourage the Board to reflect on the records in this case and consider whether there is any learning in relation to record keeping for the staff involved.

Terms used in the report **Annex 1**

A	The person aggrieved by the complaint. In this case, C's late parent.
(the) Adviser	A registered nurse adviser with experience providing care both in the community and hospital settings.
C	The complainant, the person who brought the complaint to our office. In this case, the adult child of the aggrieved.
Excoriated	Damaged skin often appearing red, raw, or irritated with visible scratches or marks
NMC	The Nursing and Midwifery Council
Person-centred care plan	A plan of care developed by clinicians that should record the patient's personal circumstances and their needs in order to identify the level and type of care needed.
Skin damage/ Pressure damage	Injury caused to the skin from sitting or lying in one position for an extended period of time.
Skin integrity	The condition or health of the skin i.e. is it healthy and unbroken or broken.
TRAK	The Board's electronic note system used by the district nursing team.

The Waterlow	An assessment document that helps to identify a patient's risk of developing pressure damage to their skin.

List of legislation and policies considered **Annex 2**

Health Improvement Scotland (HIS) (2018) CPR (Check, Protect, Refer) for Feet

HIS (2021) Scottish Wound Assessment and Action Guide

HIS (2019) Wound Assessment Chart

Scottish Government (2014) Vale of Leven Enquiry Recommendations

HIS (2015) Antimicrobial wound dressings for chronic wounds

HIS (2017) NHS Lothian Ropper Ladder

Algorithm for Assessment and Management of Chronic Wounds (2017)

Scottish National Procurement Advanced Wound Management Contract (this feeds all Scottish Board Formularies)

NMC The code 2019

Scottish Government (2014) Vale of Leven Enquiry Recommendations

HIS Pressure Ulcer Prevention and Management Standards 2020 Prevention and management of pressure ulcers standards – Healthcare Improvement Scotland

HIS Food, Fluid and Nutritional Care Standards 2016 Food, fluid and nutritional care standards – Healthcare Improvement Scotland

Health Care Support Workers Code of conduct Scotland codeofConductHealthCareSupport.pdf (scot.nhs.uk)

NHS Education for Scotland Person centred care Person centred care - NES (scot.nhs.uk)

https://www.magonlinelibrary.com/doi/abs/10.12968/jowc.2020.29.9.496

https://www.rehab.research.va.gov/JOUR/2013/504/pdf/peterson504.pdf