

## SPSO decision report

**Case:** 201406068, Lanarkshire NHS Board  
**Sector:** health  
**Subject:** nurses / nursing care  
**Outcome:** some upheld, recommendations

### Summary

Mrs C complained that her mother (Mrs A) did not receive adequate care during two admissions to hospital. Mrs A underwent surgery in Monklands Hospital to repair a fractured hip, before being transferred to Wester Moffat Hospital for rehabilitation. Mrs C complained that her mother had not been provided with reasonable nutrition at Wester Moffat Hospital, and that there had been a failure to take the appropriate steps in either hospital to prevent the development of pressure ulcers. Mrs C also felt an unacceptable standard of catheter care had been provided at Wester Moffat Hospital and that the board had taken an excessive and unreasonable length of time to respond to her complaint.

We took independent advice from our nursing adviser. The advice we received was that the evidence showed a reasonable standard of nutritional care was provided. Although there were gaps in the records, the board had recognised this failing and taken steps to address it. These gaps were not sufficient to show inadequate nutritional care. The advice said, however, that the standard of skin care was inadequate and nursing staff had failed to implement fully the recommendations of the specialist review of Mrs A's pressure ulcers. This represented an unacceptable standard of care.

Our investigation found that the standard of nutritional and catheter care was reasonable, but the standard of skin care was not. We also found the board's response was unreasonably delayed due to the reduced availability of a key member of staff, and a failure to progress the complaint in their absence.

### Recommendations

We recommended that the board:

- apologise for the failings identified;
- provide evidence that the findings of the investigation have been shared with senior staff and the failure by the board to identify inadequacies in the nursing care discussed;
- provide evidence of the on-going SSKIN education and training (a care plan for pressure ulcer prevention) being provided to nursing staff; and
- remind all nursing staff of the importance of responding fully to complaints.