SPSO decision report

Case: **202210099, Grampian NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their parent (A) when A was admitted to hospital with ongoing pain and mobility issues following a fall. A suffered from significant leg ulcers and had received a package of care while at home. While in hospital, A developed sepsis and did not respond to treatment. A died a few months after admission.

C complained of failings in how A's leg ulcers had been managed, stating that A's dressings were being changed less frequently than when A was in the community. C highlighted times when family members had raised the need for A's wounds to be dressed with nursing staff who repeatedly failed to respond to these requests. C also complained of similar failures to provide catheter care and stated their belief that these were contributing factors in A's deterioration.

We took independent advice from a nurse. We found significant failings had occurred with regards to washing and dressing the wounds, and a failure to adhere to the standard of monitoring, risk assessment and record keeping as per the relevant professional Nursing and Midwifery Council (NMC) code. We considered that the nursing care provided was unreasonable and upheld this part of C's complaint.

The adviser also highlighted concerns about the medical care and treatment provided and on this basis we took additional advice from a geriatrician (specialist in medicine of the elderly). We found that the wound care provided lacked a coherent and consistent approach, and in particular, that A's legs were not examined until a number weeks after admission. We also found insufficient attention was given to wound swab results and blood tests, as well as A's level of pain and overall condition. We found that the medical care and treatment provided to A was unreasonable and upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Nursing staff should act in line with the NMC Code of Conduct, in particular Section 10 relating to documentation.
- Where there is concern about possible infection, such as in a patient with a raised CRP, any wounds should be examined within 48 hours of admission. If there is urgent concern, wounds should be examined immediately.

We have asked the organisation to provide us with evidence that they have implemented the recommendations

we have made on this case by the deadline we set.