Scottish Parliament Region: Glasgow

Case 200500470: Greater Glasgow and Clyde NHS Board[1]

Summary of Investigation

Category

Health: Hospital; Treatment and communication between hospitals

Overview

The complainants (Mr and Mrs C) raised a number of concerns that their relative, Mrs A (Mrs C's sister, Mr C's sister-in-law), had suffered as a result of a break in the skin of her left heel not being adequately monitored and treated. They also raised concerns regarding a potential communication breakdown between two hospitals when Mrs A was transferred from one hospital to the other.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) staff failed to inform Mrs A that she was suffering from a potential pressure sore on her left heel (*upheld*);

(b) staff at Western Infirmary, Glasgow (Hospital 1) failed to treat the potential pressure sore (*no finding*);

(c) Hospital 1 failed to advise Drumchapel Hospital (Hospital 2) about the potential pressure sore at the time of transfer (*not upheld*); and

(d) Hospital 2 failed to diagnose and treat the sore for approximately ten days after Mrs A's admission (*not upheld).*

Redress and recommendations

The Ombudsman recommends that the Board reiterate to the staff involved the importance of making clear notes after assessments.

The Board have accepted the recommendation and will act on it accordingly.

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[1] On 1 April 2006 the National Health Service (Variation of the Areas of Greater Glasgow and Highland Health Boards) (Scotland) Order 2006 added the area of Argyll and Bute Council to the area for which Highland Health Board is constituted and all other areas covered by Argyll and Clyde Health Board to the area for which Greater Glasgow Health Board is constituted. The same Order made provision for the transfer of the liabilities of Argyll and Clyde Health Board to Greater Glasgow Health Board (now known as Greater Glasgow and Clyde Health Board) and Highland Health Board. In this report, according to context, the term 'the Board' is used to refer to Greater Glasgow and Clyde Health Board as its successor.

Main Investigation Report

Introduction

1. On 2 September 2005, Mr and Mrs C brought their complaint to the Ombudsman's office. They demonstrated that they had exhausted the complaints procedure of Greater Glasgow and Clyde NHS Board (the Board) and the complaint was, therefore, eligible to be investigated by the Ombudsman.

2. The complaint covered four main points, which are detailed at paragraph 3 below. The core aspects of the complaint were that staff at both the Western Infirmary, Glasgow (Hospital 1) and Drumchapel Hospital (Hospital 2) had allegedly not identified and treated a break in the skin on Mrs A's heel while she was receiving treatment at both hospitals. Mr and Mrs C alleged that such a failure may have contributed to the deterioration in the condition of Mrs A's lower leg which ultimately resulted in Mrs A's lower left leg being amputated.

3. The complaints from Mr and Mrs C which I have investigated are that:

(a) staff failed to inform Mrs A that she was suffering from a potential pressure sore on her left heel;

(b) staff at Hospital 1 failed to treat the potential pressure sore;

(c) Hospital 1 failed to advise Hospital 2 about the potential pressure sore at the time of transfer; and

(d) Hospital 2 failed to diagnose and treat the sore for approximately ten days after Mrs A's admission.

4. During the course of my investigation, the Board accepted that the nursing notes taken in relation to the sore on Mrs A's heel and in particular the entry regarding the broken skin on Mrs A's left heel at Hospital 1 were not adequate and should have recorded at least further observations or treatment relating to a possible sore.

5. The notes indicate that a 'small broken area' was identified on Mrs A's left heel on 27 March 2004, however, no treatment of this area was recorded as having been completed and no further mention of the 'broken area' was made in the notes taken at Hospital 1. The Board have accepted that this omission constitutes incomplete record-keeping. These points are accepted by all relevant parties.

Investigation

6. In conducting my investigation I obtained written evidence from the complainants. I also made several written requests of the Board and obtained a detailed copy of Mrs A's medical and nursing notes. I also obtained a copy of the complaints correspondence and sought the views of the Ombudsman's clinical adviser (the Adviser).

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Mrs C and the Board were given an opportunity to comment on a draft of this report.

8. Mrs A suffers from a number of medical conditions including Diabetes Mellitus, Peripheral Vascular Disease and Rheumatoid Arthritis (an explanation of these terms is provided at Annex 2). On 14 March 2004, Mrs A was admitted to Hospital 1, to undergo a triple heat bypass operation. Prior to undergoing surgery, Mrs A was assessed for, among other things, her risk level of developing bed sores through the Waterlow Risk Assessment (a recognised method of identifying an individual's risk level of developing bed sores). Following her initial assessment, Mrs A was classed as being 'at risk' for developing bed sores.

(a) Staff failed to inform Mrs A that she was suffering from a potential pressure sore on her left heel

9. The complainants alleged that neither Mrs A nor her family were made aware that a small broken area had been identified on her left heel, which may have been an early indication of a developing sore. My investigation has found that an entry was made on 27 March 2004 in Mrs A's nursing notes that a 'very small broken area' was identified as present on Mrs A's left heel. The notes taken at Hospital 1 do not state that there was any action taken to treat the heel. Furthermore, there is no reference to indicate that the area of broken skin had improved or worsened. There is also no record that either Mrs A or her family were informed of this.

10. Due to Mrs A's diabetic condition, she found it very difficult to experience sensation from her extremities i.e. hands and feet. It is, therefore, possible that the break may have developed into a more serious ailment without Mrs A's knowledge.

(a) Conclusion

11. Mr and Mrs C, as well as Mrs A, remain adamant that they were never advised of the break in the skin. There is no evidence to contradict this assertion. When this is taken into consideration with the fact that Mrs A was classed as 'at risk' for developing sores, I conclude that the incomplete record-keeping and lack of communication constituted service failure. Mrs A was at risk of developing bed sores. A break in the skin was noted and no record of treatment to the break or further observations were made. I believe that Mrs A should have been made aware of this break given that she may not have been able to identify any pain in her feet as a result of her conditions. In conclusion, I uphold this aspect of complaint on the balance of probability.

12. Furthermore, given that the evidence does not show any further record of a skin break on the left heel until 14 April 2004, it is almost impossible to determine whether or not the initial break in the heel had healed, worsened or remained constant. I cannot, therefore, conclude how significant, if at all, this initial break in the skin was in contributing to Mrs A's subsequent amputation of her left lower leg.

(a) Recommendation

13. I am aware that the Board have issued an apology to Mrs A regarding this point of complaint prior to my investigation, which I welcome. I recommend that the Board strongly reiterate the need for staff to make clear notes when assessing and monitoring a patient.

(b) Staff at Hospital 1 failed to treat the potential pressure sore

14. As indicated above, the records do not mention any treatment or further observations being carried out in relation to the broken skin on the heel. I am aware that Skin Waterlow Assessments were carried out at Hospital 1 on 14 and 23 March and 4 April 2004. These do not appear to show any record of the break in the skin. However, it is essentially the incomplete notes which raise considerable doubt as to whether or not the break in the skin was adequately treated. The evidence demonstrates that a break was identified on the skin of a patient who was 'at risk' of developing sores and no immediate treatment was carried out at the time.

15. The Board have argued that the fact the break was not referred to again in the notes indicates that the break did not require treatment. The Board have

also reiterated that the staff dealing with Mrs A were aware of her conditions and how susceptible she was to developing bed sores.

(b) Conclusion

16. This point of complaint is relatively complex given that the evidence shows that no treatment was provided to the break in the skin, however, adequate checks were carried out regarding Mrs A's skin integrity condition. Again, evidence demonstrates that no treatment, such as applying Cavalon (this treatment was being applied to pressure sores elsewhere on Mrs A's body) to the broken skin, was being administered. Mrs A was at risk of developing bed sores and the broken skin may have indicated, or led to, an emerging sore.

17. Whether or not staff felt that treatment was not needed is an unknown point as the notes do not indicate that this is why no treatment is provided. The notes are essentially incomplete. However, I must take into account the fact that adequate assessments were being carried out and that staff were aware of Mrs A's conditions. In conclusion, there is equal evidence to both support and reject the claim that adequate treatment was not administered. As a result, I cannot reach a definitive conclusion on this aspect of complaint and, therefore, there is no finding.

(c) Hospital 1 failed to advise Hospital 2 about the potential pressure sore at the time of transfer

18. It has been alleged that staff at Hospital 1 failed to draw to the attention of staff at Hospital 2 that Mrs A had experienced a break in the skin of her left heel. On 5 April 2004, Mrs A was transferred from Hospital 1 to Hospital 2. The transfer documentation drew attention to an existing sore on Mrs A's sacral area (base of the spine) but did not, as accepted by the Board, mention the break of skin in the heel.

19. The issues to consider with regards to this point of complaint are whether or not the staff at Hospital 1 failed to communicate the potential problem of the broken skin on Mrs A's left heel and also whether or not the break was still present at the time of transfer. The latter point is something that I am not able to establish, due to the incomplete notes mentioned earlier. Therefore, I am unable to conclude whether or not there should have been mention in the transfer documentation of the break in the skin.

20. However, as I have previously concluded that the notes fail to demonstrate why no treatment was provided, this does not necessarily mean that treatment was not necessary. Therefore, the break in the skin may potentially still have been present at the time of transfer.

21. The evidence shows that Mrs A was assessed on 4 April 2004, one day prior to her transfer, for pressure sores through the Skin Waterlow Assessment. That assessment did not record any abnormalities with the skin on Mrs A's left heel.

(c) Conclusion

22. I believe that Mrs A was adequately assessed on 4 April 2004 and no record was made of any skin breaks on her left heel. Therefore, on the balance of probability, I do not believe staff at Hospital 1 failed to alert staff at Hospital 2.

23. I accept that the previous omission in the records may cast doubt on whether or not the record of the assessment was entirely accurate and I have taken this point into consideration. However, the evidence shows that an assessment was carried out and the break was not recorded at that time. As a result, I do not uphold this aspect of complaint.

(d) Hospital 2 failed to diagnose and treat the sore for approximately ten days after Mrs A's admission

24. Mr and Mrs C have alleged that a nurse at Hospital 2 identified a sore on Mrs A's left heel either on the first or second day of admission to Hospital 2, however, no treatment was provided for approximately ten days afterwards. The records show that Skin Waterlow Assessments were carried out in Hospital 2 on 5 April, 12 April and 18 April 2004. Mrs A was assisted in having full immersion baths and also putting on stockings which were to help treat a previous condition in the lower legs.

25. On 15 April 2004, a change in the skin integrity on the left heel was noted after staff had helped Mrs A to remove her treatment stockings. This is the first record of the skin on the left heel deteriorating while Mrs A was a patient at Hospital 2. Records show, and the Adviser and I agree, that appropriate treatment was carried out upon the discovery of the heel condition on 15 April 2004 and this continued through to Mrs A's discharge on 21 April 2004.

26. Mr and Mrs C, and other family members, are adamant that the skin on Mrs A's heel was not intact upon, or around the time of admission to Hospital 2. They believe that no action was taken to treat the heel for approximately ten days. I have taken this information into consideration when reaching my conclusion on this point.

(d) Conclusion

27. The evidence shows appropriate observations were made of Mrs A's condition while at Hospital 2 and appropriate treatment was provided upon the deterioration of the skin of Mrs A's left heel. Mr and Mrs C have adamantly claimed throughout the pursuit of the complaint through the Ombudsman's office that a sore was identified at the beginning of Mrs A's admission to Hospital 2, however, there is no documented evidence to support this.

28. There is also no evidence in the notes to indicate that either Mrs A or her family raised concerns over a lack of treatment during the ten days between the alleged identification of the condition of the heel and when treatment began. Given the lack of documented evidence to support Mr and Mrs C's claim, I do not uphold this aspect of complaint.

29. Furthermore, given the evidence available to me and taking into account the medical conditions which Mrs A suffers from, I cannot conclude how significant, if at all, the initial break in the skin, which was recorded on 27 March 2004, has been in the subsequent amputation of Mrs A's lower leg.

30. The Board have accepted the recommendation and will act on it accordingly.

18 July 2007

Annex 1

Explanation of abbreviations used

Mr C and Mrs C	The complainants
The Board	Greater Glasgow and Clyde Health Board
Mrs A	The aggrieved
Hospital 1	Western Infirmary, Glasgow
Hospital 2	Drumchapel Hospital
The Adviser	The Ombudsman's adviser

Annex 2

Glossary of terms

Diabetes mellitus	A disease characterized by persistent hyperglycemia (high blood sugar levels), resulting either from inadequate secretion of the hormone insulin, an inadequate response of target cells to insulin, or a combination of these factors. Diabetes is a metabolic disease requiring medical diagnosis, treatment and lifestyle changes.
Peripheral Vascular Disease (PVD)	A collator for all disease caused by the obstruction of large peripheral arteries.
Rheumatoid arthritis	Inflammation of the joints; a chronic progressive disease, it begins with pain and stiffness in the small joints of the hands and feet and spreads to involve other joints, often with severe disability and disfigurement. There may also be damage to the eyes, nervous system, and other organs. The disease is treated with a range of drugs and with surgery, possibly including replacement of major joints.