Scottish Parliament Region: South of Scotland

Case 200503321: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mrs C) raised a number of concerns about the nursing care her late mother, Mrs A, received at Ayr Hospital and Biggart Hospital between October 2004 and February 2005 regarding pressure sores (heel) her mother developed. She also complained that staff failed to keep the family informed of Mrs A's condition.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the management of Mrs A's pressure sores was inadequate (*upheld*); and

(b) staff communication with Mrs A's family was poor (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) provide evidence that the implementation of improvements in the prevention of pressure ulcers has resulted in an increase in standards. This should include: information relating to the monitoring of standards of pressure ulcer prevention; the role of the senior nursing and specialist nursing staff in the monitoring process; and details of the provision of training and support for staff in making decisions about choices of pressure-relieving equipment and appropriate dressing materials; and

(ii) provide evidence to demonstrate that changes in communication strategies for carers had resulted in improved care.

The Board have accepted the recommendations and will act on them accordingly

Main Investigation Report

Introduction

1. On 13 March 2006 the Ombudsman received a complaint from Mrs C about the nursing care her late mother, Mrs A, received at Ayr Hospital and Biggart Hospital between October 2004 and February 2005 and the failure of staff to keep the family informed of Mrs A's condition. Mrs C complained to Ayrshire and Arran NHS Board (the Board) and attended a meeting with clinicians but remained dissatisfied with their responses and subsequently complained to the Ombudsman.

2. The complaints from Mrs C which I have investigated are that:

(a) the management of Mrs A's pressure sores was inadequate; and

(b) staff communication with Mrs A's family was poor.

Investigation

3. In writing this report I have had access to Mrs A's clinical records and the complaints correspondence from the Board. I obtained advice from the Ombudsman's professional medical and nursing advisers (Adviser 1 and Adviser 2) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of the medical terms used in this report can be found at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) The management of Mrs A's pressure sores was inadequate

Clinical history

5. Mrs A, who was 82 years old, suffered a fractured hip following a fall at home on 10 October 2004. She underwent a hip replacement operation on 13 October 2004 at Ayr Hospital. She remained in Ayr Hospital until 19 October 2004 when she was transferred to Biggart Hospital for rehabilitation. Mrs A was discharged home on 30 December 2004. She was re-admitted to Ayr Hospital during the period 12 to 14 February 2005 for treatment for bladder retention and again on 19 February 2005 when she was diagnosed with deep vein thrombosis and an infected heel ulcer. Mrs A was seen by a Tissue Viability Nurse Specialist (Specialist Nurse) on 24 February 2005 and treatment for her heel ulcer was commenced shortly thereafter. Mrs A was admitted to

the High Dependency Unit (HDU) on 26 February 2005 as she was thought to be in kidney failure. She sadly died on 3 March 2005.

6. Mrs C complained to the Board that Mrs A developed heel sores following the operation on 13 October 2004. When Mrs A was transferred to Biggart hospital, Mrs C noted on one occasion that Mrs A was lying in bed with her heels on a plastic cushion with no dressings on. Mrs A was allowed home during the day on Christmas Day and Boxing Day, where it was noticed her heel sores were very bad. Mrs A was formally discharged on 30 December 2004 following the insertion of a catheter. The community nurses attended daily to dress the pressure sores. On 19 February 2005 the community nurse asked Mrs A's GP to look at Mrs A's heels and it was also decided she should be readmitted to Ayr Hospital for a scan. Mrs C said the community nurse had told her that Mrs A's dressings should remain in place even though Mrs A would be in hospital. Mrs C continued that on 20 February 2005 a nurse told her sister that Mrs A had had a comfortable night and that a swab had been taken from her heels. When it was pointed out this was against the community nurse's instructions her sister was told it was because the wound smelled.

7. Mrs C noted Mrs A's death certificate stated the cause of death as 'sepsis: Infection Pressure Sore (Heel)'. The family were still extremely distressed and concerned at the incident where Mrs A's open heel sores were lying on a plastic cushion without dressings and they were actually sticking to the cushions. Mrs C felt Mrs A's heel sores were treated as a minor sideline because staff said that they were the least of her worries compared to her medical problems. Mrs C felt that if the pressure sores had been treated immediately the other medical problems would perhaps not have arisen and she complained that staff neglected the heel sores.

8. The Board's Director of Nursing (the Director) responded that a review of the nursing documentation from 10 October 2004 to 21 December 2004 had revealed serious concerns regarding the care plans initiated to minimise the risk of Mrs A developing heel sores and how they were treated. A more detailed investigation of that issue would, therefore, take place (see paragraph 9). Insofar as the February 2005 admission was concerned, nursing staff were aware of the community nurse's instructions about leaving the dressings intact but staff were concerned about the risk of infection. It was explained to Mrs A that the dressing would be changed; the sores reassessed and a swab would be taken to test for infection. The Director was sure the action taken was

appropriate and the swab provided information which was helpful in trying to combat the infection. The decision of the nurse was supported by a doctor and the Specialist Nurse. The Director explained that as no post mortem was carried out the cause of Mrs A's death was based on the clinical diagnosis. The symptoms Mrs A experienced included renal failure and low blood pressure which was suggestive of sepsis. Mrs A was known to have an infection in her heel sores and tests carried out on this area had shown the existence of a bacteria called Pseudomenas and E-Coli. It was possible that this caused Mrs A's sepsis, however, this was not conclusive from the tests carried out. Mrs A's heel sores were treated with antibiotics which are prescribed for treatment of skin infections.

9. Following the further investigation referred to at paragraph 8, the Director wrote to Mrs C and explained that the nursing documentation in Mrs A's case notes was inadequate. It was not possible to identify fully the standard of care Mrs A received to minimise the risk of her developing pressure sores or to appreciate fully what care plan was initiated when the sores first developed. A care plan was initiated at Biggart Hospital on 26 October 2004, which recommended regular ongoing assessment and dressing of the heels. However, the care plan should have been initiated on 19 October 2004. The Director also explained there was a delay in referring Mrs A to the Specialist Nurse and that it did not happen until Mrs A's subsequent admission in February 2005. It was not possible to say if involving the Specialist Nurse earlier in Mrs A's care would have altered the management of her heel sores once they had developed. It was a concern that the documentation was inadequate and as a result urgent action would be taken to improve standards of care and quality of documentation on the wards. The Board would advise Mrs C in the future as to what action had been taken and the Director personally apologised for the poor documentation. The Director subsequently advised Mrs C that a more formal method of recording of pressure sore management had been introduced to patient's notes, with improved communication links to the Specialist Nurse.

10. Adviser 2 said in the first admission to Ayr Hospital a Waterlow score (pressure sore assessment tool) was obtained on admission to the ward and further scores obtained on a daily basis from 12 October 2004. The score was 18 (high) on admission and 23 (very high) on revaluation on 12 October 2004. The nursing assessment form showed Mrs A to have a weight of 14 stone; a history of arthritis; that her skin was 'tissue dry'; and that her buttocks, whilst

red, did not have broken skin. This, in addition to her broken hip, should have resulted in an intensive pressure ulcer prevention programme. Adviser 2 could not locate any specific care plans for pressure ulcer prevention, other than a general care plan for a patient with a fractured hip, which makes brief reference to the need for two-hourly pressure area care. Whilst daily nursing progress records were regular and detailed (and provide evidence of pressure area intervention), Adviser 2 would have expected to see a complex nursing care plan to manage Mrs A's risk of pressure sores, especially once blisters had developed. On admission, Mrs A was nursed on a soft foam mattress. By 17 October 2004 blisters had appeared on Mrs A's buttocks and she was then nursed on a pressure-alternating mattress. Adviser 2 said following surgery on 13 October 2004, Mrs A's risk status would have changed as she was less mobile for a time and was beginning to show signs of skin changes. It would have been preferable had the mattress been changed to a pressure-alternating one at this stage, rather than when the blisters appeared.

11. Adviser 2 noted there was no mention of heel blisters. Adviser 2 was concerned that no attention had been paid to the heel area in terms of initial and ongoing assessment, as this area would have been at great risk in a patient following hip surgery whose heels would have been rubbing on bedclothes. Following a risk assessment which was high, all of the pressure areas should have been routinely reviewed on a daily basis (and committed to documentation). Whilst nursing records refer to a review of 'pressure areas', Adviser 2 could not be sure that the assessment included the heel areas. In the absence of clear assessment, it was possible that Mrs A had begun to develop heel blisters prior to her transfer to Biggart Hospital. Adviser 2 thought that referral to the Specialist Nurse at an early stage would have been appropriate as soon as it was seen that Mrs A had blisters. The Patient Transfer Form to Biggart Hospital referred to buttock blisters but no other skin damage.

12. Adviser 2 said that the nursing progress records for Biggart Hospital were detailed and it was possible to gain a relatively accurate picture of daily events as they occurred. However, robust care plans for the management of Mrs A's pressure ulcers were lacking at least until 1 November 2004. On admission on 19 October 2004, the buttock blisters were recorded and the following day, Mrs A's Waterlow score risk assessment was 24 (very high). Adviser 2 could not locate a further risk assessment until 1 November 2004, although the records indicate daily pressure area nursing intervention in terms of the buttock area. Adviser 2 said the first indication of heel sores in the nursing records is

27 October 2004 where it stated 'heels re-dressed'. At this time, a specialised heel pad and surgical bandage were applied but Adviser 2 could not confirm whether this was in place previously. This suggested to Adviser 2 that there was prior knowledge of heel ulcers but, in the absence of any records, it is not possible to state at which precise point they developed. Adviser 2 felt it was entirely possible this occurred prior to the transfer to Biggart Hospital, however, both nursing teams had responsibility for indicating the state of all Mrs A's pressure areas at risk of developing sores (ie, all bony prominences, which include the back of the head, shoulder blades, buttocks, elbows and heels).

13. Adviser 2 continued that on 30 October 2004 it appeared that the blister on the left heel burst and that an Inadine (iodine-impregnated) wound dressing was applied. Also, due to the lack of comprehensive care planning it was not possible to ascertain how long the Inadine dressing was used in Biggart Hospital. She advised that Inadine was an appropriate first choice of dressing once the heel blister had burst, as one of its properties is to prevent infection of exposed tissue when the damage is new. However, its use would only be recommended for a maximum of five days, at which stage another form of dressing would have been more appropriate as prolonged usage of Inadine can affect wound healing. The pressure ulcer care plan completed on 1 November 2004 indicated that both heels contained blisters. Although there was regular nursing interventions in respect of pressure ulcer care, Adviser 2 felt it was disappointing that the Specialist Nurse was not contacted to assess Mrs A. Equally, the pressure care plan was not reviewed again until 22 November 2004, which is also inadequate, especially as there was no clear description of the wounds anywhere in the records. Adviser 2 could find no evidence that Mrs A's heels were left on a plastic cushion but the fact it was not recorded did not mean it did not happen, especially as it was not until 1 November 2004 that a care plan was devised.

14. Adviser 2 noted that on 5 November 2004 the records indicated the left heel sore was beginning to resolve and that there was no evidence of surrounding cellulites. It appeared that by the end of November 2004 another small sacral sore had developed, which had previously healed, however, records showed that on 19 November 2004 Mrs A was complaining of a sore and swollen left leg. The medical records for 27 November 2004 indicated that the left heel was showing 'granulation (healing) tissue' and that there were no signs of inflammation.

15. Adviser 2 continued that on 29 November 2004 swabs were taken from both of Mrs A's heels. There is no further reference in the nursing records to the heel sores until 12 December 2004. The right heel microbiology result showed there was no infection but there was no note of the result of the left heel swab. (Note: I have since established, after an enquiry to the Board, that the left heel swab result was that no infection was present). A decision was made to change the wound dressing to Varidase (enzyme-based product which assists in the removal of dead tissue) on 18 December 2004. Once Mrs A was discharged she was cared for by the community nurses who continued the wound care dressings. Adviser 2 commented that on 19 February 2005, Mrs A was admitted back to Ayr Hospital and her heel wound was clearly infected, as evidenced by the recorded description of the wounds by the staff nurse who rightly decided to remove the dressings to view a foul-smelling heel wound. Repeated wound swabs were obtained which confirmed an infection and Mrs A was finally seen by the Specialist Nurse on 24 February 2005, which Adviser 2 believed was some months too late. Adviser 2 concluded that the standard of delivery of care regarding pressure ulcer management (and the documentation of that care) was inadequate in respect of both Ayr and Biggart Hospitals. Adviser 2 also said there was good evidence that nursing staff addressed Mrs A's nutritional needs in that there were regular entries pertaining to her dislike of some of the hospital food and the actions taken to ensure her needs were met. Mrs A was also reviewed by the dietician whilst in Biggart Hospital.

16. Adviser 1 commented on the possible underlying reasons for the deterioration of the ulcer during Mrs A's second admission. He said that despite being at home for about six weeks and having the left heel dressed daily by the community nurses, he had to presume that Mrs A's nutrition had obviously not been good, as she was admitted again with low serum albumen levels and dehydration. Adviser 1 told me that to have an infected ulcer and deep vein thrombosis in that leg would have prejudiced the left heel ulcer in any case and the debilitated state in which Mrs A was in on admission meant that the ability for her tissues to respond were more limited. Adviser 1 thought that it was understandable that Mrs C assumed Mrs A's condition had worsened because of poor treatment of her heel ulcer but it was not wholly consequent upon that clinically. Adviser 1 believed that it was a combination of infections to Mrs A's heel, bladder and bowel, and that she was already a debilitated elderly patient with a poor response to reasonable antibiotic therapy, which caused her death.

(a) Conclusion

17. Mrs C believed that the management of Mrs A's pressure sores was inadequate and that the failure to take prompt action might have prevented her other medical problems arising. The advice which I have received and accept is that there were major failings in the standard of delivery of care regarding the pressure ulcer management. Adviser 2 has highlighted concerns that Mrs A was not provided with a pressure relieving mattress until blisters had appeared on her buttocks. She has advised that Mrs A should have been provided with this immediately following her operation, as she would have experienced mobility problems and was at high risk of developing sores. Matters were compounded by the inadequate level of documentation which showed no evidence that a comprehensive care plan had been initiated which would monitor the status of the pressure sores and set out what treatment was planned. There were also concerns that the Specialist Nurse was not consulted until Mrs A was readmitted to hospital in February 2005. I am pleased to note that the Board have acknowledged some of the failings in this regard and have taken action to address the issue (paragraphs 8 and 9). Notwithstanding this, given the extent of the failings identified in this investigation, I have decided to uphold the complaint and the Ombudsman has made recommendations as outlined below. However, although failings have been identified in the management of Mrs A's pressure sores, the advice I have received is that it was a combination of infections in her heel, bladder and bowel, coupled with the fact she was already a debilitated patient who was poorly responding to antibiotic therapy, which sadly led to Mrs A's death.

(a) Recommendation

18. The Ombudsman recommends that the Board provide evidence that the implementation of improvements in the prevention of pressure ulcers has resulted in an increase in standards. This should include: information relating to the monitoring of standards of pressure ulcer prevention; the role of the senior nursing and specialist nursing staff in the monitoring process; and details of the provision of training and support for staff in making decisions about choices of pressure-relieving equipment and appropriate dressing materials.

(b) Staff communication with Mrs A's family was poor

19. Mrs C complained that there was a lack of communication with the doctors and nursing staff and each time the family enquired, either by telephone or in person, what was wrong with Mrs A they were merely advised of different symptoms. Staff would only say that Mrs A was a very ill woman and gave no

further explanations or information as to why Mrs A's temperature kept fluctuating. When the family also asked what type of infection Mrs A was being treated for, a doctor said he would have a word with his colleague but no information was ever provided.

20. The Director responded that nursing staff have a duty of care to ensure no breach of confidentiality occurs when receiving a telephone enquiry and it was when the nurse was satisfied she was speaking to Mrs A's daughter she gave her further information. The Director explained that included in the Relatives Communication Sheet in Mrs A's notes there was detailed documentation of the communication between the nurses on the ward and Mrs A's family. Mrs A had a fairly large family and staff were communicating with different relatives. The consultant responsible for Mrs A's treatment (the Consultant) had tried unsuccessfully to explain to the family that Mrs A had multiple medical problems such as a chest infection, deep vein thrombosis and diarrhoea. The Consultant had confirmed he did not know the cause of Mrs A's fluctuating temperature but it could have been related to the deep vein thrombosis, diarrhoea or the heel sores.

21. The Director subsequently advised Mrs C that, with regard to communication, action had been taken, in that there is now a set time each week when members of the multi-disciplinary team make themselves available to speak to relatives so that complex issues can be discussed. A communication sheet has been introduced to every care plan to record key discussions with relatives, including any issues of concern raised by relatives. The Director again apologised for the shortcomings in the systems and communications which had been highlighted and said that, as a result of investigating the complaint, lessons had been learnt and changes had been implemented to reduce the risk of similar problems occurring in the future.

22. Adviser 2 could find no record of communication between nursing staff and Mrs A's family while she was at Ayr Hospital from 10 to 19 October 2004. While some level of communication must have taken place, there is no evidence of its regularity or content. The patient care plans and progress updates did not refer to the family as part of the care delivery process and, as a result, details of any communication were missing. In contrast, Adviser 2 found that in Biggart hospital the 'Relatives Information Communication' sheets were detailed and showed very regular information was provided. It was clear from the nursing

and medical records that both nursing and medical staff at Biggart Hospital communicated with Mrs A's family on a very regular basis.

(b) Conclusion

23. Mrs C complained that the level of communication which medical and nursing staff provided to the family was inadequate and that information about Mrs A's condition was not forthcoming. While I can appreciate that staff have a duty to preserve confidentiality, there is also an expectation that relatives are provided with information which gives them an understanding of the treatment which has been provided to the patient and what further treatment is proposed. It is clear from the documentation that the level of communication between staff and Mrs A's family varied considerably between Ayr and Biggart Hospitals. While regular communication was provided by staff at Biggart Hospital, the opposite can be said for Ayr Hospital where there is no record of communication with Mrs A's family, particularly during the first admission. I, therefore, understand why Mrs C brought this complaint to the Ombudsman. As my investigation has shown, there were communication failures and I uphold the complaint. I am pleased to report that the Board have acknowledged the failures in communication and have already taken action to improve communications.

(b) Recommendation

24. The Ombudsman recommends that the Board provide evidence to demonstrate that changes in communication strategies for carers have resulted in improved care.

25. The Board have accepted the recommendations made in this report and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

21 November 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	Mrs C's mother
The Board	Ayrshire and Arran NHS Board
Adviser 1	Ombudsman's professional medical adviser
Adviser 2	Ombudsman's professional nursing adviser
Specialist Nurse	Tissue Viability Nurse Specialist
HDU	High Dependency Unit
Director	Board Director of Nursing
The Consultant	The consultant responsible for Mrs A's treatment

Annex 2

Glossary of terms

Cellulites	Inflammation of soft skin tissue
Deep Vein Thrombosis (DVT)	Blood clots in the veins of the inner thigh or leg
Dehydration	Inadequate fluid intake or excessive fluid loss leading to reduced circulating blood volume
Sepsis	Bacterial infection of deep tissues, including the blood stream
Serum albumen levels	Protein levels
Waterlow score	Pressure ulcer prevention assessment tool