Scottish Parliament Region: Lothian

Case 201103459: Lothian NHS Board

Summary of Investigation

Category

Health: Hospitals – General medical; clinical treatment; diagnosis

Overview

The complainant (Mr C)'s wife (Mrs C) was admitted to the Western General Hospital (the Hospital). Mrs C is paraplegic and uses a wheelchair. Whilst in the Hospital, she developed pressure ulcers which ultimately required her to go into permanent residence in hospital. Mr C complained about the failure of Lothian NHS Board (the Board) to prevent her pressure ulcers. He also raised concerns about their staff's communication with Mrs C and questioned the appropriateness of the initial decision to discharge her from the Hospital.

Specific complaint and conclusion

The complaint which has been investigated is that care and treatment at the Hospital regarding the pressure ulcers and discharge home, including communication, were unreasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) provide training to their staff on the proper implementation of their pressure ulcer policies, including the completion of all relevant documentation in the clinical records;	25 July 2013
(ii) apologise to Mr and Mrs C for the issues highlighted in this report; and	31 May 2013
(iii) provide this office with evidence of the action taken to implement the action plan with particular reference to ensuring a multi-disciplinary assessment of patients' suitability for discharge.	25 July 2013

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

Main Investigation Report

Introduction

1. On 10 September 2011, Mrs C attended Accident and Emergency at the Royal Infirmary of Edinburgh, complaining of severe headache and neck pain. She was transferred to the Western General Hospital (the Hospital)'s Infectious Diseases Unit (IDU) on 12 September 2011 and was kept in hospital with suspected meningitis. She was treated in the IDU until her discharge home on 29 September 2011.

2. Following her return home, Mr C found that Mrs C had a large pressure ulcer on her buttock, and a severe pressure ulcer on her left heel. A further pressure ulcer developing on her hip subsequently worsened. He contacted the District Nurse for assistance with dressing the ulcers, as the hospital dressings had become crumpled. The District Nurse was reportedly unaware of Mrs C's pressure ulcers.

3. Mrs C was later returned to hospital because of extensive pressure ulcers and associated complications that meant she could not be nursed at home. She remains in hospital.

4. Mr and Mrs C were keen to praise the treatment provided by the Hospital's staff in relation to Mrs C's meningitis. However, Mr C submitted a formal complaint to Lothian NHS Board (the Board) about the failure to prevent Mrs C's pressure ulcers, the appropriateness of her discharge home, and communication between staff regarding the development of her pressure ulcers. Mr C also raised concerns about staff's communication with Mrs C who lost her hearing during her stay in the Hospital. Dissatisfied with the Board's response to his concerns, Mr C brought his complaint to the Ombudsman in May 2012.

5. The complaint from Mr C which I have investigated is that care and treatment at the Hospital regarding the pressure ulcers and discharge home, including communication, were unreasonable.

Investigation

6. In order to investigate this complaint, my complaints reviewer reviewed correspondence between Mr C and the Board and notes from meetings between the two parties. He also reviewed Mrs C's clinical records, obtained further information from the Board and sought the opinion of two professional

medical advisers: Adviser 1, a nursing adviser; and Adviser 2, a consultant in respiratory and general medicine. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Care and treatment at the Hospital regarding the pressure ulcers and discharge home, including communication, were unreasonable

7. Mrs C uses a wheelchair as she is paraplegic. She also has high blood pressure and visual and hearing difficulties. She was admitted to hospital in the early hours of 10 September 2011 complaining of severe headache and neck pain. Blood tests and a lumbar puncture were suggestive of meningitis and, following review by a consultant on 11 September 2011, she was transferred to the Hospital's IDU on 12 September 2011. Mrs C was reviewed by a consultant physician (Consultant 1) who noted that her headache and neck pain had resolved, but that she remained drowsy with an elevated temperature.

8. The clinical records show that, over the following days, Mrs C continued to experience a low-grade fever and was dependent on oxygen. Her condition and blood test results began to slowly improve and tests were carried out and discussions held with other services to determine the cause of her symptoms.

9. On 13 September 2011 an initial Waterlow Score (an assessment of the patient's level of risk to pressure areas) was recorded. Mrs C was given a Waterlow Score of 12, putting her at moderate risk of developing pressure ulcers. As a result of her score, she was provided with a repose mattress (a pressure redistribution mattress).

10. On 17 September 2011, Mrs C's Waterlow Score was reassessed and was found to have risen to 21. She was now considered to be at a high risk of developing pressure ulcers and was transferred to a Nimbus 3 mattress (an air-filled mattress). The clinical records show that Consultant 1 reviewed Mrs C on 18 September 2011 and found her to be a little better. The notes for 18 September 2011 also record 'nursing staff noticed heels and sacrum [bone at bottom of spine] have become marked over last 24 [hours] – will encourage regular turns and monitor skin'. A note recorded the following day noted that Mrs C's heel had been dressed due to the skin breaking down.

11. On 21 September 2011 a computerised tomography (CT) scan of Mrs C's chest showed changes consistent with atypical pneumonia. Her general condition continued to improve, however, and on 22 September 2011 plans were made for her to be discharged home once she completed a course of antibiotics. On 28 September 2011, following further improvement over the preceding days, Mrs C's condition was noted as being stable. Her pressure ulcers were re-dressed. Physiotherapy notes recorded '… would manage at home with own equipment … patient happy for this … happy for discharge'. Mrs C was discharged home on 29 September 2011 with a follow-up appointment arranged for one month later.

12. In his complaint to the Board, Mr C said that, when Mrs C was discharged from the hospital, he accompanied her in her wheelchair to their car. He said that Mrs C had great difficulty transferring into the car on a transfer board. Upon returning home and assisting Mrs C in the bathroom, Mr C found that she had one very large, and one developing pressure ulcer on her buttocks. She also had a 'very bad' pressure ulcer on her left heel. Mr C complained that he and his wife were not told about the pressure ulcers and no information about them was included in Mrs C's discharge letter.

13. Mr C raised further, specific complaints about the discharge process. In a letter to the Board dated 8 November 2011, he said that no discussion took place with him or Mrs C regarding arrangements for her care at home or any particular equipment she may need to manage her pressure ulcers. Due to the location of her pressure ulcers, Mrs C had difficulty transferring between her bed and her wheelchair. Given their location, the management Mrs C's pressure ulcers was further complicated by the fact that she was suffering from diarrhoea. The District Nurse felt that she should remain in bed and not aggravate the pressure ulcers by transferring to her wheelchair. A hospital bed was required and was brought into Mr and Mrs C's home on 13 October 2011. Mr C felt that these requirements should have been identified and put in place prior to Mrs C's discharge.

14. Mr C also felt that there was a lack of co-ordination between clinical, nursing and physiotherapy staff. He complained about a lack of a multi-disciplinary assessment of Mrs C's suitability for discharge and her ability to transfer from bed, to wheelchair, to toilet. He noted that the meningitis had caused Mrs C to completely lose her hearing during her admission to the Hospital. With this in mind, as well as Mrs C's diarrhoea, pressure ulcers, and

lack of upper body strength, Mr C questioned whether it was appropriate for her to be discharged.

15. With regard to Mrs C's loss of hearing, Mr C acknowledged that Consultant 1 communicated well with Mrs C by writing notes on a notepad. However, he complained that not all staff made similar efforts and he believed that Mrs C missed important information about her treatment as a result of staff assuming she had understood what was being said to her.

16. Mr C raised his concerns with the Board in a written complaint and at two meetings. In response to Mr C's complaints, the Board explained that, upon admission, the skin on Mrs C's sacral area was intact, but that her left heel was spongy and red. She was initially assessed as being at moderate risk of developing pressure ulcers and was provided with a repose mattress. Bed baths were provided daily. Following reassessment of her Waterlow Score on 17 September 2011, Mrs C's risk of pressure ulcers increased and a Nimbus 3 mattress was provided. However, despite this, during a bed bath on 19 September 2011, Mrs C's heel and sacral skin was found to have broken down. The Board said they understood that Mrs C had been told about the development of pressure ulcers, but acknowledged that she may not have realised this due to the problems with her hearing at the time. The Board apologised for this and agreed to a suggestion by Mr C that a discrete notice be placed above the beds of patients with hearing problems, alerting staff to the need to bear this in mind. The Board apologised to Mr C for the lack of communication with him and Mrs C regarding the pressure ulcers.

17. With regard to the decision to discharge Mrs C, the Board noted that physiotherapy staff assessed her ability to transfer between bed and wheelchair over a number of days and her ability to do so improved. Mrs C reportedly expressed a keenness to go home and staff considered that it was safe for her to be discharged. The Board noted that clinical, nursing and physiotherapy staff all agreed that she was fit for discharge. The District Nurse was asked to visit Mrs C at home and to change the dressings on her pressure ulcers. However, the Board accepted that Mrs C was not provided with appropriate dressings for her ulcers as she should have been. The Board also acknowledged and apologised that Mrs C was discharged home without discussions taking place regarding the facilities available for her care at home.

18. In their final response to Mr C's complaints, the Board acknowledged that there had been a number of shortcomings in their care of Mrs C. Specifically, they accepted that her Waterlow Score was incorrectly calculated, there was a lack of a tissue viability nurse service in the Hospital, there were communication issues and concerns around the discharge arrangements. The Board provided my complaints reviewer with a copy of an action plan created following Mr C's complaint, setting out a number of procedural changes and points for staff training resulting from the issues highlighted.

19. Whilst the Board had acknowledged problems with their communication with him and Mrs C, Mr C did not feel that they addressed his concerns regarding the development of Mrs C's pressure ulcers. He considered that these should have been preventable. He noted that Mrs C's pressure ulcers ultimately required her to be readmitted to hospital where she continues to receive long-term residential care. Mr C considered that, had the Board's staff not discharged her from hospital on 29 September 2011 and continued to monitor and treat her ulcers, this may not have been necessary.

20. My complaints reviewer asked Adviser 1 and Adviser 2 to review Mrs C's clinical records and comment on the steps taken to prevent the development of pressure ulcers. Adviser 1 commented on the nursing aspects of Mrs C's care. She explained that patients that are seated due to immobility are at increased risk of pressure ulcers. Adviser 1 highlighted guidance set out in the NHS Quality Improvement Scotland (2005) Best Practice Statement on pressure ulcer prevention (the Guidance), which is utilised by the Board. With the Guidance in mind, she said that she would expect nursing staff to assess the risk of pressure ulcers using a validated risk assessment tool and their own clinical judgement. A care plan should be formulated based on the identified risk and should include the frequency of skin inspection. Adviser 1 explained that opportune moments such as bed-bathing should be utilised to inspect the skin, however, more frequent checks are required for patients with reduced mobility. The condition of the patient's skin should determine how frequently they should change position. Adviser 1 said that, as Mrs C is a wheelchair user, she would expect to see reference made in the records, following consultation with Mrs C, to the length of time she was able to sit in her wheelchair. Adviser 1 would also expect to see evidence that Mrs C had received educational training concerning the distribution of her weight whilst sitting in her wheelchair.

21. Adviser 1 explained that there is no clear research evidence as to the most effective pressure-relieving mattress. She said that, when a decision is made to use a specialist mattress, this should be used as an integral part of a comprehensive assessment and prevention strategy, never as the sole intervention.

22. In Mrs C's case, Adviser 1 considered there to be evidence of initial and on-going risk assessment, care planning and evaluation of care delivery. She noted that the Board use charts to record patient repositioning, however, no such records were made in Mrs C's case and only two references were made throughout her admission to staff encouraging or actively changing her position. The turning and repositioning section of Mrs C's mobility care plan was not completed throughout her admission. There was no indication of instructions given to Mrs C regarding the weight distribution when sitting in her wheelchair. Adviser 1 said that this would have been essential, but acknowledged that it may have been difficult for Mrs C to achieve given that she was noted as being easily fatigued.

23. With regard to Mrs C's Waterlow Score, Adviser 1 said that the initial assessment carried out on 13 September 2011 was calculated incorrectly. She noted that no consideration was given to the fact that Mrs C is paraplegic or that she was acutely ill. Adviser 1 commented that, if these missing risk factors had been included in the calculation, Mrs C would have been identified as being at high risk of pressure ulcers from the outset. Mrs C was identified as being at risk, and a repose mattress was provided. Adviser 1 commented that the type of mattress used was not of serious concern, however, this appeared to be the only action implemented and Adviser 1 was concerned by the lack of evidence of action to minimise the risk of pressure ulcer development.

24. The reassessment of Mrs C's Waterlow Score on 17 September 2011 resulted in her risk of pressure ulcers increasing. Again, Mrs C's paraplegia was not mentioned in the risk calculation, but Adviser 1 noted that this would not have impacted on the identified level of risk. In response to the increase in risk level, a Nimbus 3 mattress was provided. Adviser 1 commented that, again, there was no indication of other actions being implemented to minimise the risk of pressure ulcer development.

25. My complaints reviewer asked Adviser 1 to comment as to how frequently a patient's Waterlow Score should be assessed. Adviser 1 was satisfied that

the wait between assessments was in line with good practice in Mrs C's case. There was evidence of initial assessment upon admission, further assessment upon transferring to the IDU and then again on 17 September 2011 when concerns were highlighted about Mrs C's heel and sacrum. Adviser 1 said that she was 'surprised' that no further assessments were carried out after 17 September 2011, however, she noted that Mrs C would have remained in a very high risk category. Adviser 1 highlighted that the nursing records show that Mrs C's pressure areas were inspected in line with good practice between 19 and 25 September 2011.

26. With regard to Mrs C's discharge from the Hospital, Adviser 1 stated that she should have had a multi-disciplinary assessment prior to being allowed to go home. An occupational therapist should have identified and discussed with Mr and Mrs C what equipment they had at home and any further equipment that would be required. As acknowledged by the Board, there was no evidence of that such a discussion took place. Adviser 1 said that nursing staff should have liaised with the District Nurse, providing information about the condition of Mrs C's pressure ulcers and the requirement for an appropriate pressure-relieving mattress. Adviser 1 commented that there was a lack of evidence of formal discharge planning and record-keeping was poor. For example, a note recorded on 28 September 2011 stated 'message left with District Nurse'. The content of the message was not documented and there was no written referral to the District Nurse within the records. As a result, Adviser 1 did not feel that there was evidence to indicate that district nursing staff were fully informed about the condition of Mrs C's pressure ulcers prior to her discharge.

27. Adviser 2 commented on the clinical aspects of Mrs C's care. He noted that Mrs C was treated for meningitis and pneumonia, both of which were severe and there was a substantial chance of her not surviving this illness. With regard to these conditions, Adviser 2 commented that the quality of the medical records was good, showing proper assessments, consideration of other reasonable diagnoses, timely involvement of other specialist teams and frequent consultant support of the junior members of the team. Adviser 2 considered the treatment of Mrs C's presenting conditions to have been 'excellent'.

28. With regard to her pressure ulcers, Adviser 2 noted that the records recorded nine separate attendances by Consultant 1. None of the corresponding entries made any comment on pressure ulcers. He highlighted

that there was only one entry in the multi-professional notes, on 18 September 2011, relating to nursing observations of a developing ulcer. As such, Adviser 2 did not consider there to be evidence that the medical team took account of the presence of pressure ulcers. He said that he would have expected this to be a matter for specific communication between nurses and doctors. He would then expect that the doctors would have been interested in whether there was any sign of infection in the pressure ulcers and to have ensured Mrs C received the best possible nutrition. Adviser 2 said that he would also have expected input from a specialist tissue viability nurse. Correspondence from the Board to Mr C, however, indicated that the Hospital did not have a tissue viability nurse at that time. The notes of Mr C's second meeting with the Board detail comments from the Board regarding the lack of a tissue viability nurse. They explained to him that the Hospital's tissue viability nurse had retired in March 2011. The tissue viability nursing structure was then reviewed but it took some time for the tissue viability nurse from another site to be asked to take on referrals at the Hospital.

29. Adviser 2 said that nursing staff would have been responsible for communicating multi-disciplinary issues to physiotherapy and district nursing staff. He noted that Mrs C's discharge summary made no mention of her pressure ulcers. With regard to the general communication between clinical and ward staff, Adviser 2 noted that Mrs C's records contain a unitary multi-disciplinary record in which doctors, nurses, physiotherapists and other staff make entries. He considered this to be good practice and an effective means of communication provided the various professionals look at each other's entries. With reference to the single entry of 18 September 2011 regarding Mrs C's pressure ulcers, Adviser 2 considered there to be evidence of inadequate record-keeping in the multi-disciplinary records.

30. With regard to Mrs C's discharge, Adviser 2 considered that the pressure ulcers should have been taken into account and arrangements made to ensure community nursing input was available to Mrs C at home before the decision was taken to discharge her. He highlighted that the clinical records include a discharge planning form. A section of this form entitled 'services in the community contacted' was ticked, however, no more detail was given. A subsequent telephone conversation between Mr C and physiotherapy staff the day after Mrs C's discharge suggests that arrangements were made with the District Nurse, but these were not adequately documented.

31. Adviser 2 explained that there are two aspects to decision making regarding discharge: whether it is medically safe; and whether all possible social care arrangements are in place to support the patient's needs at home. He said that, medically, discharge is safe if the patient's physiological observations are stable, if there is no need for treatment that could be provided outwith the hospital, and no need for further urgent hospital investigations. Adviser 2 explained that the development of pressure ulcers would not necessarily rule out discharge as long as the required care was set up at home. In Mrs C's case, the documentation in this regard was lacking. Therefore, Adviser 2 considered that the medical decision to discharge was not unreasonable, but the social care arrangements could not be shown to be robust.

32. The Guidance sets out specific guidance as to how patients should be monitored for the development of pressure ulcers and what steps should be taken to prevent their development should signs arise. Where skin redness is identified, the Guidance promotes increased monitoring of the skin with written documentation of what is observed and the use of non-perfumed moisturisers. Patients at risk of developing pressure ulcers should suitably positioned to minimise pressure and friction. The patient should be helped to reposition but also encouraged to reposition themselves.

33. The Board have their own pressure ulcer prevention form which sets out a check-list of considerations and actions for staff monitoring patients who have, or are at risk of developing, pressure ulcers. The points on the check-list relate closely to the advice offered in the Guidance.

34. NHS Quality Improvement Scotland provide further guidance regarding the treatment of pressure ulcers in their Scottish Wound Assessment and Action Guide. This publication provides advice as to how to monitor, clean and dress pressure ulcers. It requires the use of wound charts to document the state of the pressure ulcer upon examination. The Board provided my complaints reviewer with copies of their Assessment Chart for Wound Management, Formal Wound Assessment, and Pressure Ulcer Grade Recording Charts as well as additional documents provided for staff to record changes in the patient's position and other treatment provided for their pressure ulcers.

Conclusion

35. Mrs C's skin was monitored throughout her admission. She was identified from the outset as being at risk of developing pressure ulcers and was provided with a repose mattress. When her skin began to break down, action was quickly taken to provide her with a different mattress. In this regard, I am satisfied that there is evidence of staff being aware of the risk to Mrs C of pressure ulcers, and of an awareness that action was to be taken when her skin condition changed. However, my complaints reviewer's investigation highlighted a number of issues that suggest the action taken by staff, whilst prompt, fell short of the expected standard.

36. The evidence submitted to my complaints reviewer shows that the Board have in place procedures and recording tools to assess the risk of pressure ulcers, monitor skin condition and prevent against their development. I found the tools that were in place to be appropriate and in line with the Guidance. However, in this case, there is a stark lack of evidence within Mrs C's clinical records of the tools being utilised by the Board's staff.

37. The absence of a tissue viability nurse was a basic service failure. However, I acknowledge that this was a temporary problem and that this service has resumed.

38. The record-keeping in this case was generally poor, with significant information missing from the records regarding the monitoring of Mrs C's skin and preventative measures that may have been taken. This could be a failure of record-keeping, rather than evidence of a lack of action by staff, but record-keeping itself is a key factor in successfully monitoring and managing patients at risk of pressure ulcers.

39. The initial Waterlow Score calculation failed to include significant factors that would have seen Mrs C categorised as being at a high risk of pressure ulcers from the outset. As highlighted by Adviser 1, the records indicate that the only action taken to prevent the development of pressure ulcers was the provision of specialist mattresses. Whilst this is in line with the Guidance, I accept Adviser 1's view that the use of such mattresses alone is insufficient to prevent pressure ulcers. A range of other preventative and therapeutic measures were not carried out, decreasing Mrs C's chances of avoiding pressure ulcers.

40. Communication between hospital and community nursing staff was poor, as was the communication between nursing staff and Mr and Mrs C. I acknowledge that the Board have accepted and apologised for this, however, I found the implications for Mr and Mrs C to be significant. Mrs C suffered complete loss of hearing during her admission. Comments from the Board and Mr C suggest that information was given to her, but that assumptions were made that she had understood the information and would discuss it with Mr C. There is evidence that nursing staff provided some information to the District Nurse, however, subsequent events suggest that this was not detailed in terms of Mrs C's pressure ulcers. As such, Mr and Mrs C left the Hospital unaware of the extent of her pressure ulcers and returned home to find that the District Nurse also lacked key information and equipment.

41. Based on Adviser 2's comments, I found that, medically, it was not unreasonable for Mrs C to be discharged from the Hospital on 29 September 2011. The fact that she had pressure ulcers should not have precluded her from discharge, and the records indicate that she was keen to go home. That said, I consider that the Board failed to properly consult with Mr and Mrs C regarding the suitability of equipment they had at home given her particular needs. Mrs C should not have been discharged until a suitable bed had been sourced and provided ready for her return home. Again, the records lacked evidence of a multi-disciplinary assessment of Mrs C's suitability for discharge.

42. The Board accepted and apologised for a number of shortcomings, many of which I have highlighted in this report. They provided my complaints reviewer with a copy of their action plan, showing that they have already taken steps to prevent similar problems in the future. The steps taken by the Board are in most cases very simple, such as placing a sign above a patient's bed to alert staff to the fact they have hearing difficulties. Other actions include reminding staff of the need for clear communication and improving the information and medical supplies that are issued to patients upon discharge. I found these actions to be appropriate. That said, in this case, I found the key problem to be a lack of cohesion between written policy and staff performance. The Board have clear policies and tools in place for pressure ulcer prevention and for discharge. However, their staff carried out only parts of the policies, resulting in the action that was taken ultimately being ineffective.

43. I uphold this complaint.

Recommendations

44. I recommend that the Board:	*Completion date*
(i) provide training to their staff on the proper implementation of their pressure ulcer policies, including the completion of all relevant documentation in the clinical records;	25 July 2013
(ii) apologise to Mr and Mrs C for the issues highlighted in this report;	31 May 2013
(iii) provide this office with evidence of the action taken to implement the action plan with particular reference to ensuring a multi-disciplinary assessment of patients' suitability for discharge.	25 July 2013

45. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant's wife
The Hospital	The Western General Hospital
IDU	Infectious Diseases Unit
Mr C	The complainant
The Board	Lothian NHS Board
Adviser 1	A professional medical adviser to the Ombudsman (nursing)
Adviser 2	A professional medical adviser to the Ombudsman (respiratory and general medicine)
Consultant 1	A consultant physician employed by the Board
The Guidance	NHS Quality Improvement Scotland (2005) Best Practice Statement on pressure ulcer prevention

Annex 2

Glossary of terms

Nimbus 3 mattress	a specialist air-filled redistribution mattress
Repose mattress	a specialist pressure redistribution mattress
Waterlow Score	an assessment of a patient's level of risk to pressure areas

Annex 3

List of legislation and policies considered

NHS Quality Improvement Scotland (2005) Best Practice Statement on pressure ulcer prevention

NHS Quality Improvement Scotland: Scottish Wound Assessment and Action Guide

NHS Lothian Discharge Policy