Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Clinical Adviser

I set out below my request for clinical advice.

The complainant and their relationship to the patient

Mrs F is the late patient's (Mr F) wife

The complaints subject to investigation

- Mr F developed a pressure sore due to the Health Board's failure to re-position him in bed or assist him to sit in a chair
- The Health Board failed to appropriately maintain Mr F's Vacuum Assisted Closure ("VAC") therapy dressing as nursing staff were not trained to use it and did not know what to do when the tubing became blocked
- There was a delay in the Health Board identifying that Mr F had sepsis
- Mr F did not receive daily physiotherapy during the course of his inpatient stay
- Mr F was left without his pain relief medication for over an hour on 2 separate occasions due to a delay in recommencing the syringe driver

Background and the events

Mr F was a recovered brain cancer patient who was initially admitted into the [redacted] hospital with chest pains and then lost the use of his legs. After multiple investigations it was established that he had a tumour in his brain which had also spread to affect his spinal cord. From 9-25 September 2019 Mr F was an inpatient at [redacted] (cancer specialists) where he received radiotherapy. On 25 September he was transferred back to the [redacted]. At this point Mr F was discovered to have a pressure sore to his sacrum. Mrs F disputes the HB's account which was that this was developed at [redacted]. She has not made any complaint about his treatment at [redacted]; however, the [redacted] referred the issue to [redacted] and they undertook their own investigation (IPA subfile 3).

After referral to a Tissue Viability Nurse the sore was debrided by the surgical team on 1 October. Mr F was given antibiotics and VAC therapy was later used to keep the wound clean. The wound was checked and redressed by general nurses, and reviewed on several occasions by the TVN, however Mrs F complained that there

were occasions on which it became blocked and nursing staff did not know how to clear it. She also complained that if Mr F had been given physiotherapy he would not have deteriorated so badly. Mr F is thought to have developed sepsis on 3 occasions during his admission. Mr F's family had several meetings with relevant staff about his discharge, but there were delays in discharge due to his condition and lack of suitable provision (e.g., self turning mattress). A DNR was agreed. Mr F was discharged home on 7/11/21 and sadly died on 16.11.19.

Summary of the complaints procedure

In the Health Board's complaint response to Mrs F (April 2020) and its response to further questions asked by the original investigation officer (both in IPA file 1), the Health Board stated that the pressure sore was noticed very quickly after Mr F's return to the [redacted] from [redacted] and was swabbed and dressed at appropriate intervals. It said that VAC therapy should ideally not be redressed daily and the TNV nurse reviewed the wound at appropriate intervals. It said the ward Mr F was on was a medical ward and staff are not specifically trained in VAC therapy. It said that when a ward nurse has received training, then they can either change the canister or renew the dressing altogether, but that the NMC advises that all nurses must work within their limitations at all times. If the staff feel they are not competent at carrying out training specific tasks that they are not exposed to regularly they must not carry out the clinical tasks and should contact the TNV.

The Health Board accepted that communication around Mr F's physiotherapy may not have been clear enough but that due to his severely ill condition and the possible aggravation of the sacral wound physiotherapy would not have been suitable for him.

The Health Board acknowledged there were two instances where Mr F was without his syringe driver pain relief. It explained that the driver runs over hours, so that on 24 October 2019 it would have been due for renewal at approximately 13:30, and was not replaced until 14:00, making this delay a little over 30 minutes. It said that on 25 October 2019, the syringe driver was checked at 12:45 but not changed until 16:00.

The Health Board explained that although Mr F's wish to go home as soon as possible was made clear, his case had frequent input from palliative care, and it would not have been appropriate to discharge him while he was still receiving active treatment. It explained Mr F was very ill and there was a need to stabilise him before he came home. It also explained Mr F needed suitable equipment at home such as a specific mattress before he could be discharged.

Known guidance applicable in Wales

Health Board's Deteriorating Patient Policy (which incorporates guidance in relation to sepsis management) and the All Wales Guidance for the Use of Negative Pressure Wound Therapy (NPWT) (included in IPA file via embedded link in 26/8/21 letter from Health Board).

Questions

I set out below questions relating to the complaints. For each question, please would you set out what happened, what should have happened, the impact of any difference between the two, and any remedy or recommendations to prevent recurrence or improve care for the future.

1. Is there evidence of the pressure sore before Mr F was transferred to [redacted]?

2. Given the description of Mr F's weak condition, and the site of his pressure sore, would you have had any concerns about him receiving physiotherapy?

3. Were opportunities missed to identify and treat sepsis earlier?

4. Was the care and treatment of the pressure sore wound, including the frequency it was checked, changed and cleaned (before and after VAC treatment), sufficient?

5. Should general nursing staff be expected to be able to change the dressing/tubing of VAC therapy?

6. Were the checks by the TVN frequent enough?

7. How should staff have been aware that the pain relief syringe needed changing?

8. Was Mr F's general care and treatment sufficient?

9. Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.

Thank you for your advice. If you need to discuss the case, please do not hesitate to contact me.

Swyddog Ymchwilio/Investigation Officer

Ombwdsmon Ombudsman
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TO BE COMPLETED BY CLINICAL ADVISER

Provision of Clinical Advice for Public Services Ombudsman for Wales
Background Information
Case Identifier (Case Reference): 20210XXXX
Clinical Adviser's Name and Qualifications: [Name] MSc BA (Hons) RN
Relevance of qualifications and/or experience to clinical aspects of this case: [Relevant qualifications provided]
Conflict of Interest (clarification of any links with Body or clinicians complained about): I do not have any links with the Body or Clinicians complained about.
Confirmation that the Ombudsman's Clinical Standards [insert link] have been applied in the provision of the advice The Ombudsman's Clinical Standards have been applied in this case.

Please confirm the chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant clinical events

The chronology provided by the Caseworker in requesting this advice is correct and correctly identifies the relevant clinical events.

Clinical Advice

Any comments on Background and Chronology: I have no comments to make on the Background and Chronology.

Documentation Reviewed:

I have reviewed the request for advice and the entirety of the records that are contained in Subfiles 1-3.

Questions and Responses:

1. **Is there evidence of the pressure sore before Mr F was transferred to [redacted]?**

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear (International NPUAP/EPUAP Pressure Ulcer Classification System 2014 cited in All Wales Tissue Viability Nurses Forum 2014. Essential elements of pressure ulcer prevention and management All Wales Guidance for the Prevention and Management of Pressure Ulcers page 5).

National guidance makes a number of recommendations for the prevention and management of pressure ulcers. Recommendations for prevention emphasise the importance of initial assessment, skin assessment for those patients identified as being at high risk of developing a pressure ulcer, the development and documentation of an individualised care plan for adults who have been assessed as being at high risk, repositioning according to the identified risk and use of appropriate pressure redistributing devices. A care plan should be generated in response to a person identified as being at high risk of pressure ulcer development. (NICE 2014 CG179 Pressure ulcers: prevention and management sections 1.1.2, 1.1.3, 1.1.4, 1.1.5,1.1.8, 1.1.9, 1.1.13 and 1.3.1).

Recommendations for treatment include the need to categorise and measure any ulcer, nutritional assessment and dietician referral (as required), utilisation of appropriate pressure redistribution devices (for example, mattresses and seat cushions), repositioning (at least four-hourly) and use of appropriate wound care products for wound type (NICE 2014 CG179 Pressure ulcers: prevention and management sections 1.4.1, 1.4.2, 1.4.3 and 1.4.9).

A moisture lesion is defined as being caused by urine or faeces and perspiration which is in continuous contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft, skin folds and where skin is in contact with skin. The skin will either be excoriated which presents as superficial broken skin which is red and dry, or macerated presenting as red and white, wet, soggy and shiny (All Wales Tissue Viability Nurses Forum and All Wales Continence Forum 2014 All Wales Best Practice Statement on the Prevention and Management of Moisture Lesions pages 2-3).

There is evidence of initial and regular re-assessment of Mr F's pressure ulcer risk and he was consistently identified as being at high risk, utilizing a validated risk assessment tool (Subfile part 1- pages 512 and 528). There is evidence of regular re-positioning 2-4 hourly and Mr F was on a hybrid air mattress (Subfile part 1- pages 554-558). It is also apparent that Mr F was able, on occasions to move himself in bed (See for example, Subfile 1 page 518).

Reference is made to a moisture lesion on Mr F's sacrum (Subfile part 1- page 539 entry 7 September 2019 at 05:30 and SKIN Bundle page 557). Mr F had a urinary catheter in situ but did have episodes of faecal incontinence (see for example, Subfile part 1- entries on pages 520 and 522) which is likely to have contributed to the moisture lesion. There is no evidence of a pressure ulcer before Mr F was transferred to [redacted].

2. **Given the description of Mr F's weak condition, and the site of his pressure sore, would you have had any concerns about him receiving physiotherapy?**

I am not a qualified physiotherapist and therefore not fully cognizant with standards/guidelines regarding physiotherapy practice. It is, however, evident from multiple entries in the clinical records that physiotherapy during Mr F's in-patient stay was not indicated. This was due to his generally weak condition and the site of his pressure sore limiting his ability to sit in a chair to a maximum of 1 hour (see for example, Subfile part 1- tissue viability entry page 241, palliative care entry page 278, palliative care entry pages 317-319).

3. Were opportunities missed to identify and treat sepsis earlier?

Sepsis is a life-threatening organ dysfunction due to a dysregulated host response to infection. Suspected sepsis is used to indicate people who might have sepsis and require face-to-face assessment and consideration of urgent intervention (NICE July 2016, updated 2017 NG51 Sepsis: Recognition, diagnosis and early treatment- Terms used in this guidance).

Nurses must accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care (NMC 2015 updated 2018 The Code professional standards of Practice and behaviour for nurses and midwives' section 13.2). In 2012, the Royal college of Physicians developed a national early warning score (NEWS) to standardise the assessment of acute illness severity in the NHS (Royal College of Physicians 2012 National Early Warning Score (NEWS) Standardising the assessment of acute illness severity in the NHS). This was updated in 2017 but I note that during Mr F's in-patient stay the Health Board was still using the 2012 version.

It is evident from the records that there were 3 episodes of suspected sepsis/sepsis. The first episode was on 30 September 2019. I note that a sacral wound swab was taken on 26 September 2019 at 14:55 (Subfile 1 page 690). There is no indication of any cause for concern, based on physiological observations and monitoring between 25 and 29 September (Subfile part 1 page 828). On 30 September 2019 at 06:15, the NEWS was 4, due to an increased respiratory rate (24- score of 2) and increased heart rate (127 beats per minute- score of 2). Mr F's temperature at this stage was 36.8 degrees Celsius (score of 0). Sepsis screening should have been considered because of the symptoms of increased heart and respiratory rates, but there is no indication on the observation document that this happened (Subfile 1 page 827). Observations should have been repeated within an hour but were not repeated until 08:40 when Mr F's temperature was recorded as 39.1 degrees Celsius and his heart rate was 127 beats per minute. Nursing staff appropriately escalated Mr F's condition to medical staff and obtained routine bloods and blood cultures. It is not possible to establish, if Sepsis had been considered when observations were undertaken at 06:15, and if observations were repeated earlier, that this would have altered Mr F's management. You may wish to seek medical advice on this aspect of care.

The second episode was on 15 October 2019. There is no indication of any cause for concern, based on physiological observations and monitoring between 8 and 14 October 2019, with NEWS correctly calculated and ranging between 1-2 (Subfile 1 page 830). There was no indication that an opportunity was missed to identify and treat sepsis earlier.

The third episode was on 5 November 2019. There is no indication of any cause for concern, based on physiological observations and monitoring between 25 October and 4 November 2019, with NEWS correctly calculated and ranging between 1-3 (Subfile 1 page 834). There was no indication that an opportunity was missed to identify and treat sepsis earlier.

4. **Was the care and treatment of the pressure sore wound, including the frequency it was checked, changed and cleaned (before and after VAC treatment), sufficient?**

As noted in response to question 1, recommendations for treatment of a pressure ulcer include the need to categorise and measure any ulcer, nutritional assessment and dietician referral (as required), utilisation of appropriate pressure redistribution devices (for example, mattresses and seat cushions), repositioning (at least four-hourly) and use of appropriate wound care products for wound type (NICE 2014 CG179 Pressure ulcers: prevention and management sections 1.4.1, 1.4.2, 1.4.3 and 1.4.9).

On 25 September 2019, following Mr F's return from [redacted], he was noted to have an unstageable pressure ulcer on his sacrum. This involves full thickness loss in which the base of the ulcer is covered in slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough or eschar is removed to expose the base of the wound, the true depth and therefore category/stage cannot be determined (International NPUAP/EPUAP Pressure Ulcer Classification System 2014 cited in All Wales Tissue Viability Nurses Forum 2014. Essential elements of pressure ulcer prevention and management All Wales Guidance for the Prevention and Management of Pressure Ulcers page 5).

There is evidence of a wound management chart, with daily review but no initial care plan (Subfile 1, pages 782-784, 804-805). However, the dressing type and frequency of dressing change is clearly identified on the wound management reviews and there is an updated care plan on 6 November 2019, following removal of the VAC therapy (Subfile 1 page 769). Documentation, on type of wound and wound description has not been completed by ward nursing staff (Subfile 1- pages 783, 785 and 806) and as a consequence, there is no objective assessment of the condition of the wound, deterioration or improvement. It is, however, evident from the multiple entries by the Tissue Viability Nurse (TVN) that the wound was appropriately monitored and measured, with comprehensive care planning (see dates of review in response to question 6). The care plan was followed by ward nursing staff (Subfile 1- pages 782, 784, 804 and 805).

There is a multiplicity of wound care products available and wound dressings would be selected based on wound assessment and action of the product required. Frequency of dressing change would be in accordance with product guidance or recommendations made by Surgeons or as in Mr F's situation, TVNs (see for example, Subfile 1- page 304). Dressings were initially changed daily, and

additional dressing changes occurred on occasions, due to episodes when the faeces contaminated the wound as it was under the dressing. In these circumstances, dressing change was necessary to minimize the risk of wound infection. I have seen no evidence to indicate that VAC tubing was blocked.

Based on the available records, the care and treatment of the pressure sore wound, including the frequency it was checked, changed and cleaned before and after VAC therapy was in accordance with the cited guidance and appropriate.

5. **Should general nursing staff be expected to be able to change the dressing/tubing of VAC therapy?**

Nursing's regulatory body clearly states that nurses must recognise and work within the limits of their competence and ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of their competence (NMC 2015 updated 2018 The Code professional standards of practice and behaviour for nurses and midwives' sections 13 and 13.3). This is also clearly identified in the Health Board's guidance (Subfile 1 page 75). Mr F was being nursed on an acute medical ward, where nursing staff would have had limited exposure to VAC therapy/complex wound management. Unless, they had received training and demonstrated competency nursing staff would not have been able to have changed the dressing/tubing of the VAC therapy.

An entry by a TVN on 11 November 2019 (Subfile1 page 252) notes that a nurse was present during the TVN review and that other members of the team had previously had training. It is not however, possible to establish how recent the training had been and if those who had undertaken the training remained confident and competent to manage the wound dressing and VAC therapy system.

6. **Were the checks by the TVN frequent enough?**

There are no specific standards or guidelines that I can refer to regarding this issue. The frequency of TVN visits would depend on the initial wound assessment, complexity of the wound and wound management. It would also depend on the level of support required by ward nursing staff. A TVN initially reviewed Mr F on 4 October 2019, a comprehensive wound assessment and plan of care is documented in the records and further reviews were undertaken on 8 and 11 October, with the VAC therapy commencing on 11th October. Further reviews were undertaken on 14, 18, 21 and 25 October with evaluation of the wound indicating that the wound was continuing to heal slowly and was looking clean. Further reviews took place on 1 and 6 November 2019, with VAC therapy being discontinued prior to discharge and a clear management plan for on-going wound care in the community (Subfile 1- pages 240, 241, 244, 252, 255,272, 281, 296, 304, 309 and 322). There is nothing to indicate that more frequent review by the TVN was required as the wound was healing slowly and looking clean.

7. How should staff have been aware that the pain relief syringe needed changing?

A syringe driver provides continuous delivery of drugs into the subcutaneous tissue of patients for who oral administration would be a problem. A continuous infusion maintains stable blood plasma serum levels of medicines thus avoiding the periodic peaks and troughs of episodic administration. A syringe driver is calibrated in millilitres (mls) per hour and the standard delivery period for a continuous subcutaneous infusion is 24 hours. Nursing staff should use a syringe driver check chart (Syringe driver check chart-Health in Wales) and as a minimum check the syringe driver four-hourly. Integral to the check is the monitoring of the volume left in the syringe driver (Subfile 1- page 940) and this will provide an indication of when the syringe driver needs changing. As noted above, the standard delivery period is 24 hours and nursing staff should be aware of the date and time that the syringe driver had previously been changed.

It is evident from the clinical records that there was a delay in replenishing the syringe driver on 24 October 2019. It was checked at 12:50 and not replenished until 14:00 (Subfile 1- page 947). There is no indication that Mr F expressed pain during this period. On 25 October 2019, the syringe driver was checked at 12:45 but not replenished until 16:00 (Subfile 1- pages 948 and 949). This was an unacceptable delay in pain management.

8.Was Mr F's general care and treatment sufficient?

Assessment is the cornerstone to establishing the needs of any patient admitted to hospital and is necessary to inform a person-centered plan of care (NMC 2015 The Code professional standards of practice and behaviour for nurses and midwives' sections 1 and 10.2). There is evidence of assessment in the hospital admission document (Subfile 1 pages 331-341), risk assessment screening booklet (Subfile 1-page 771) complex needs assessment (Subfile 1 page 611) and CHC fast track assessment and care plan (Subfile 1 pages 650-687). Care plans were generated in response to Mr F's identified needs (Subfile 1 pages 786-790). Daily entries in the nursing records indicate that Mr F's fundamental care needs were met. The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration (NMC 2015, updated 2018 The Code Professional standards of practice and behaviour for nurses and midwives' section 1.2).

Good record keeping is a reflection of a safe and skilled practitioner (NMC 2015, updated 2018 The Code professional standards of practice and behaviour for nurses and midwives' section 10). When considered overall the standard of record-keeping is in accordance with the cited guidance. I have previously, identified in response to question 4, the lack of documentation on type of wound and wound description. In addition, the date is not easily identifiable or recorded on a number of nursing entries in the records. This is not in accordance with NMC standards (NMC 2015, updated 2018 The Code professional standards of practice and behaviour for nurses and midwives' section 10.4).

8. **Please let me know if, in considering my questions, you identify any other relevant clinical matter that gives you cause for concern.**

In considering your questions I have not identified any other relevant clinical matter that gives me cause for concern.

I trust that my responses have sufficiently addressed your questions. I am happy to discuss further as necessary.

Recommendations:

The Health Board should identify steps taken to ensure that standards of record keeping, particularly in reference to dating of entries, comply with national guidance.

The Health Board needs to identify steps taken to ensure that ward nursing staff are competent in syringe driver management, including the replenishment of prescribed medication to ensure continuous infusion of pain relief is maintained.

The Health Board should demonstrate how it proposes to monitor compliance with the accurate completion of the sepsis screening/awareness section (Subfile 1- page 69) on observation charts. This is necessary to ensure that nursing staff can demonstrate that sepsis has been considered in response to identified criteria.

Conclusions:

Mr F had a moisture lesion and not a pressure ulcer prior to his transfer to Velindre. The care and management of his unstageable pressure ulcer was in accordance with cited guidance with appropriate input from the TVN. Despite the lack of documentation of type of wound and wound description by ward nursing staff, it is evident that the TVN had appropriately assessed, described and reviewed the wound with a clear plan of care documented following review. Nursing staff followed the plan of care. When considered overall, it is apparent that there were no serious flaws or omissions in this aspect of Mr F's care.

There were two episodes when nursing staff failed to replenish the syringe driver in a timely manner. On the first occasion, there is no indication that Mr F suffered adversely as a consequence of this failing. On the second occasion, based on the available records, it is likely that he suffered unresolved pain, and this is unacceptable.

There is nothing to indicate that physiotherapy input would have been required, based on Mr F's overall poor condition and the risk of further deterioration in his pressure ulcer.

Sepsis screening does not appear to have been considered in light of two of the criteria identified when observations were undertaken on 30 September 2019 and there was a half hour delay in repeating observations. I am not medically qualified and cannot identify the impact of these failings.

Clinical Standards – List of Guidance and Policies Referenced (please provide link to relevant/current document)

All Wales Tissue Viability Nurses Forum and All Wales Continence Forum 2014 All Wales Best Practice Statement on the Prevention and Management of Moisture Lesions.
https://www.wwic.wales/uploads/files/documents/Professionals/Clinical%20Partners/AWTVNF/All_Wales-Moisture_Lesions_final_final.pdf

International NPUAP/EPUAP Pressure Ulcer Classification System 2014 cited in All Wales Tissue Viability Nurses Forum 2014. Essential elements of pressure ulcer prevention and management All Wales Guidance for the Prevention and Management of Pressure Ulcers.
https://www.wwic.wales/uploads/files/documents/Professionals/Clinical%20Partners/AWTVNF/PDF%20Essential%20Elements%20of%20Pressure%20Ulcer%20Prevention%20%20Management%20All%20Wales%20Guidance%202014%20Final%20Version.pdf

NICE July 2016, updated 2017 NG51 Sepsis: Recognition, diagnosis and early treatment
https://www.nice.org.uk/guidance/ng51

NICE 2014 CG179 Pressure ulcers: prevention and management
https://www.nice.org.uk/guidance/cg179

NMC 2015 updated 2018 The Code professional standards of Practice and behaviour for nurses and midwives
https://www.nmc.org.uk/standards/code/read-the-code-online/

Royal College of Physicians 2012 National Early Warning Score (NEWS) Standardising the assessment of acute illness severity in the NHS
https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

Syringe driver check chart-Health in Wales
http://www.wales.nhs.uk/sitesplus/documents/861/Syringe%20Driver%20Check%20Chart.pdf

Name & Signature:

Date: 15th December 2021