Local Government
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Ombudsman

Report by the Health Service Ombudsman for England and the Local Government Ombudsman on a joint investigation into a complaint made by Mrs L

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Foreword

We are laying this report before Parliament to help others learn from the service failure and poor complaint handling it describes.

The complaint is about NHS Wakefield District Primary Care Trust (the Trust) and Wakefield Metropolitan District Council (the Council). The complaint was made by Mrs L about the care provided to her late father, Mr M, at a care home funded by the Council and by a visiting community nurse from a team funded by the Trust.

This report describes service failure by the care home and the nurse and finds maladministration in the way the complaint was investigated by the Council and the Trust. It illustrates the importance of effective communication between staff involved in a person's care and highlights the need for clear ownership of complaint handling by the organisations commissioning services.

We are laying before Parliament, under section 14(4) of the Health Service Commissioners Act 1993 (as amended), this report on a joint investigation into a complaint made to us as Health Service Ombudsman for England and Local Government Ombudsman for England.

Dame Julie Mellor DBE
Health Service Ombudsman

Dr Jane Martin
Local Government Ombudsman for England

June 2013

Summary

The complaint

Mr M (aged 80) had dementia. He had regular visits at home by district nurses to treat a longstanding, intermittent pressure ulcer and to provide care of a catheter (a tube inserted into the bladder to drain urine) in place to manage incontinence. From August 2008 Mr M had regular admissions for respite care at a care home (the Care Home - funded by Wakefield Metropolitan District Council). He was admitted there on 6 October 2009 for this reason. On 13 October a nurse (the Nurse) from a community nurse team (funded by NHS Wakefield Primary Care Trust) was called to Mr M to deal with a catheter problem. That evening Mr M was found to be unwell and was taken by ambulance to hospital. Shortly after arrival Mr M was found to have a grade 4 necrotic (dead tissue) pressure ulcer on his sacrum (a large, triangular bone at the base of the spine). He was treated for urinary sepsis and initially improved but he died on 23 November from urinary tract infection. Mrs L (Mr M's daughter) complained to the Council and the Trust about aspects of her father's care. Mrs L complained to the Ombudsmen that the Care Home failed to deal with her father's pressure ulcer and the Nurse failed to notice its seriousness.

Our investigation

We investigated the care provided for Mr M by staff at the Care Home between 1 September and 13 October 2009; and the care provided for Mr M by the Nurse on 13 October. We also investigated the Council's and the Trust's handling of Mrs L's complaints.

Our findings

The Care Home Manager assessed Mr M's needs on his first admission to the Care Home. At a later admission she recorded on his care plan that staff should apply cream twice a day to his pressure area. On 26 September 2009 the district nurses who visited Mr M in his own home devised a treatment plan for a pressure ulcer on his sacrum; this included twice weekly dressing changes. When Mr M re-entered the Care Home on 6 October his needs were reassessed but his pressure area care plan was not updated. As such, it was unclear which pressure area care plan the Care Home should follow. We found the Care Home's approach to recording care was haphazard and without accountability. Some carers recorded when they had applied cream and others did not. We found that Mr M's Care Home records had been altered after he left the Care Home, which gave the impression of an attempt to conceal inadequate care. There was no record to show that the Care Home gave any attention to Mr M's positioning during the afternoon and evening of 13 October. Our Nurse Adviser said long periods sitting in the same position increase the risk of developing pressure ulcers and cause existing ones to deteriorate. We concluded that the Care Home failed to provide adequate care for Mr M's pressure area needs. This was service failure. As a result, Mr M's existing pressure ulcer deteriorated to such an extent that it was assessed as grade 4 on admission to hospital on 13 October. It was unlikely that a grade 4 pressure ulcer could have developed in the short time after Mr M had left the Care Home. This injustice to Mr M was in consequence of the Care Home's service failure. We did not find that Mr M's seriously ill condition on 13 October 2009 was caused by this service failure. It was his underlying problem with urinary tract infections - not the pressure ulcer - that led to his deterioration and hospitalisation.

The Nurse attending Mr M on 13 October 2009 dealt appropriately with the emergency problem of his blocked catheter. It was unclear whether Care Home staff asked her also to look at Mr M's pressure ulcer but she recorded in the district nurse notes that she checked this and gave care for Mr M '*as per the care plan*'. The district nurse care plan stated that a dressing should be used and changed twice a week. Recollections differed about whether this was still in place on 13 October. The Nurse told us the ulcer was about a grade 2, that she left the area uncovered, and advised Care Home staff to apply cream. We accepted that she made her own clinical judgment based on what she observed at the time. However, this was **not** in line with the district nurse care plan. Our Nurse Adviser said the Nurse should have applied a dressing if the skin was broken (grade 2 or above damage). As Mr M was found to have a grade 4 pressure ulcer later that day, our Nurse Adviser said the pressure damage may have been underneath the surface when the Nurse saw him. We therefore found that the Nurse misclassified the grade of the ulcer. We also found that she failed to record the size or grade of the pressure ulcer; failed to document the finding of a grade 2 pressure ulcer as a local clinical incident; and delayed following up the need for a pressure-relieving mattress for Mr M. We concluded that the care provided by the Nurse on 13 October 2009 fell so far below the applicable standards that it amounted to service failure. However, this did not lead to any injustice to Mr M. Even if the Nurse had correctly identified the extent of the damage at the time, it would have made no difference because it had been occurring over time, and Mr M was admitted to hospital later that day for a reason unrelated to his pressure ulcer.

We found maladministration in both the Council's and the Trust's investigations of Mrs L's complaints. The Council took account of unreliable information when deciding not to uphold Mrs L's complaint about the Care Home. The Trust ignored the fact that the hospital found that Mr M had a grade 4 pressure ulcer on admission in October 2009 and found no failings by the Nurse when she attended Mr M. We reached different conclusions on those matters, which called into question the adequacy of the original investigations.

Conclusion

We upheld Mrs L's complaint about the Council and partly upheld her complaint about the Trust.

The Council and the Trust agreed to: write to Mrs L to acknowledge the service failures and maladministration we identified and apologise for their impact; each pay £250 compensation for the distress and inconvenience she suffered as a result of their poor complaint handling; and prepare an action plan that describes what they have done to avoid a recurrence of the failures identified.

Section 1: Introduction

1. This is the report on our joint investigation into Mrs L's complaint about Wakefield Metropolitan District Council (the Council) and NHS Wakefield District Primary Care Trust (the Trust). It contains our findings, conclusions and recommendations with regard to Mrs L's complaint.

The complaint

2. Mrs L complained about the care that her father, the late Mr M, received at a council- funded care home, Hazel Garth (the Care Home) and from a visiting community nurse (the Nurse) funded by the Trust. On 6 October 2009 Mr M (aged 80) was moved to the Care Home for respite care. On 13 October the Nurse was called out to deal with a problem with Mr M's catheter.[1] Mrs L complained that the Nurse failed to notice that Mr M had a serious pressure ulcer. Mrs L said that as a result of the Nurse's failings, Mr M collapsed and staff at the Care Home failed to deal with his pressure ulcer or notice that he had fallen into a coma.[2] Later in the day Mr M was taken to hospital by ambulance. Sadly, he died in hospital on 23 November 2009.

3. Mrs L complained to the Council and the Trust about these matters but was dissatisfied with their responses. She complained to both Ombudsmen that Mr M '*died prematurely as a result of neglect by Hazel Garth and the District Nurse*'. She said the Council and the Trust failed in their duty of care to him and she wanted them to admit the errors that occurred and to apologise to her. She also wanted compensation.

Matters investigated

4. The Local Government Ombudsman and the Health Service Ombudsman agreed to jointly investigate Mrs L's complaints:

   about the Council that:

   (a) the care provided for Mr M by staff at the Care Home between 1 September and 13 October 2009[3], and

   (b) the Council's handling of Mrs L's complaint, were inadequate; and

   about the Trust that:

   (c) the care provided for Mr M by the Nurse on 13 October; and

   (d) the Trust's handling of Mrs L's complaint, were inadequate.

Our decision

5. Having considered all the available evidence related to Mrs L's complaint about the Council and the Trust, including her recollections and views, and having taken account of clinical advice, we have reached the following decision.

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[1] A catheter is a thin, sterile tube inserted into the bladder to drain urine.

[2] On 6 November 2012 the Council wrote to us to provide their comments on the draft report. In response to Mrs L's comment that Care Home staff did not notice that Mr M had fallen into a coma, they pointed out that (a) the Care Home staff sought medical assistance as soon as they noticed that Mr M was unresponsive; and (b) Mr M was not assessed as being in a coma but had a reduced level of consciousness when he arrived at hospital (footnote 20).

[3] Although the scope of the investigation runs from 1 September to 13 October 2009, during that time frame Mr M was only in the Care Home from 19 to 25 September and 6 to 13 October.

Local Government Ombudsman's findings on the complaint about the Council

6. I find that the care provided for Mr M by the Council (at the Care Home) between 6 and 13 October 2009 fell so far below the applicable standard that it amounted to service failure. In consequence of this, Mr M's existing pressure ulcer deteriorated to such an extent that it was assessed by the Hospital at his admission on 13 October as grade 4. This was an injustice to him. There were also systemic failings in the record keeping at the Care Home. I also find maladministration in the Council's complaint handling. In consequence of this maladministration, Mrs L experienced distress and inconvenience. I therefore uphold the complaint about the Council.

Health Service Ombudsman's findings on the complaint about the Trust

7. I find that the care provided by the Nurse on 13 October 2009 in relation to care of Mr M's pressure ulcer fell so far below the applicable standard as to amount to service failure. This service failure did not result in any injustice to Mr M because his pressure ulcer damage had already been occurring over time, he was admitted to hospital later that day for a reason not related to his pressure ulcer and there is no evidence to say that his pressure ulcer was probably the cause of his septicaemia or his subsequent death. I also find maladministration in the Trust's complaint handling. In consequence of this maladministration, Mrs L experienced distress and inconvenience. I therefore partly uphold the complaint about the Trust.

8. We consider that the actions that the Council and the Trust have now agreed to take will provide an appropriate remedy for the injustice suffered.

The Health Service Ombudsman's jurisdiction and role

9. By virtue of the *Health Service Commissioners Act 199*3, the Health Service Ombudsman is empowered to investigate complaints about the NHS in England. In the exercise of her wide discretion she may investigate complaints about NHS organisations such as trusts, family health service providers such as GPs, and independent persons (individuals or organisations) providing a service on behalf of the NHS.

10. In doing so, she considers whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the organisation, a failure by the organisation to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the organisation. Service failure or maladministration may arise from action of the organisation itself, a person employed by or acting on behalf of the organisation, or a person to whom the organisation has delegated any functions.

11. If the Health Service Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with her Principles for Remedy, she may recommend redress to remedy any injustice she has found.

The Local Government Ombudsman's remit

12. Under the *Local Government Act 1974* Part 3, the Local Government Ombudsman has wide discretion to investigate complaints of injustice arising from service failure or maladministration by local authorities (councils) and certain other public organisations. She may investigate complaints about most council matters, including social services and the provision of social care.

13. If the Local Government Ombudsman finds that maladministration has resulted in an unremedied injustice, she may recommend redress to remedy any injustice she has found.

Powers to investigate and report jointly

14. *The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* clarified the powers of the Health Service Ombudsman and the Local Government Ombudsman, with the consent of the complainant, to share information, carry out joint investigations and produce joint reports in respect of complaints that fall within the remit of both Ombudsmen.

15. In this case, we agreed to work together because the health and social care issues in Mrs L's complaint were so closely linked. A co-ordinated response, consisting of a joint investigation leading to a joint conclusion and proposed remedy in one report, seemed the most appropriate way forward.

Section 2: Basis for the Ombudsmen's determination of the complaint

16. In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, we generally begin by comparing what actually happened with what should have happened.

17. So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those organisations and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

18. The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

19. Having established the overall standard, we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the organisation or individual complained about constitutes a departure from the applicable standard. If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard as to constitute service failure or maladministration.

20. The overall standard that we have applied to this investigation follows.

The general standard: the *Ombudsman's Principles*

21. The Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[4] are broad statements of what the Health Service Ombudsman considers public organisations should do to deliver good administration and customer service, and how to respond when things go wrong. The same six key Principles apply to each of the three documents. These six Principles are:

    - Getting it right
    - Being customer focused
    - Being open and accountable
    - Acting fairly and proportionately
    - Putting things right, and
    - Seeking continuous improvement.

22. The Principle of Good Administration relevant to this complaint is:

    - '*Getting it right*' – which includes that all public organisations must comply with the law and have regard for the rights of those concerned. They should act according to their statutory powers and

[4] The *Ombudsman's Principles* is available at www.ombudsman.org.uk.

duties and any other rules governing the service they provide. In addition, public organisations must act in accordance with recognised quality standards, established good practice or both, for example about clinical care.

23. Two of the Principles of Good Complaint Handling are particularly relevant to this complaint:

- '*Being open and accountable*' – which includes providing honest, evidence-based explanations and giving reasons for decisions.
- '*Acting fairly and proportionately*' – which includes treating the complainant impartially; ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

The specific standards

24. We have set out the specific standards applicable to this complaint in an annex to this report (Annex A).

Section 3: The investigation

25. Our investigators discussed with Mrs L the nature of the complaint and confirmed to her in writing the issues we would be investigating.

26. During the investigation we have examined all the relevant documentation. This includes records held by the Care Home, Mr M's hospital records, the district nurse records for Mr M at his home, the records of the personal carers who attended Mr M at his home, the social work records, telephone records, the reports and meeting notes pertaining to a safeguarding case conference, and the papers relating to the attempted resolution of Mrs L's complaint by the Council and the Trust. Our investigators interviewed a number of staff at the Care Home, the social worker, an independent investigator appointed by the Council to investigate Mrs L's complaint, and the Nurse who attended Mr M on 13 October 2009. We have taken account of the comments received from Mrs L in her correspondence with our Offices.

27. We also obtained advice from two of our clinical advisers: a tissue viability nurse and a consultant general and renal physician. The Ombudsmen's advisers are specialists in their field, and in their roles as advisers to the Ombudsmen they are independent of any NHS organisation.

28. In this report we have not referred to all the information examined in the course of the investigation, but we are satisfied that nothing significant to the complaint or our findings has been omitted. Mrs L, the Council and the Trust have had the opportunity to comment on a draft of this report, and their responses have been taken into account in coming to the decision.

Key events

29. Mr M, who was 80, had a history of heart disease, Parkinson's disease, and dementia. He ordinarily lived with his wife (who is not Mrs L's mother). During the period relevant to this complaint, Mr M was receiving two visits per day in his own home for personal care from carers provided by the Council. He also received visits from the district nursing team to treat a longstanding, intermittent pressure ulcer and for care of a catheter which had been in place since May 2009 to manage incontinence. According to the Care Home records, Mr M went into the Care Home on six occasions for respite care from September 2008 onwards. He stayed for approximately one week each time. In August 2009 Mr M underwent an operation to treat a hip dislocation and was discharged home on 29 August.

30. On 19 September 2009 Mr M was placed in the Care Home. Following his discharge home on 25 September, his wife noticed that he had a pressure ulcer on his sacrum.[5] On 26 September she telephoned the district nursing team to notify them of this.

[5] A large, triangular bone at the base of the spine and at the upper and back part of the pelvic cavity. Pressure ulcers usually occur on the skin over a bony prominence, such as the sacrum.

A district nurse visited Mr M that day and drew up a care plan to treat the pressure ulcer. This involved twice-weekly changes of dressing (see Annex B for more detail).[6]

31. On Tuesday 6 October Mr M was again placed in the Care Home.[7] In the evening of 12 October it was noted that his catheter was blocked and that a district nurse might need to be called. The following morning the Care Home requested a district nurse visit to deal with the catheter.

32. The Nurse attended Mr M at the Care Home at about 11am. She changed the catheter and recorded that she looked at the area of his pressure ulcer which she noted was '*scuffed*' (see Annex B for more detail). In the evening, Mr M was found to be unwell and so the Care Home telephoned the emergency services and Mr M was taken by ambulance to hospital at about 9pm.

33. In hospital Mr M was diagnosed as having urinary sepsis[8] and was found to have a grade 4 necrotic (dead tissue) pressure ulcer on his sacrum. He was treated with antibiotics and recovered somewhat, but he died on 23 November 2009. The cause of death was urinary tract infection.

Safeguarding investigation

34. While Mr M was still in hospital, on 16 October 2009, Mrs L made a complaint to social services about safeguarding concerns for him. She expressed further concerns directly to a social worker (the Social Worker).[9] The individual who was subject to the safeguarding concern was not employed by the Council or the Trust. As part of the investigation of this matter, the Social Worker visited the Care Home on 20 October 2009. On 22 October there was an Adult Protection case conference to look into the matter. The minutes of the case conference record the following:

'[The Social Worker] *stated Mr M presented with a pressure sore to* [the medical assessment unit at the hospital] *however there is some discrepancy regarding whether this was a Grade 2 or Grade 4 ... it is difficult to identify the timescale of the deterioration of the pressure sore.*

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[6] It is not clear from the available records whether Mr M continued to have a need for visits by the community district nurses for pressure area care once he went into the Care Home on 6 October 2009. However, the team who visited him at home would not have attended him at the Care Home because this was in a different geographical area.

[7] According to *The Care Home Regulations*, care homes should make arrangements for the service user to be registered with a general practitioner of their choice (paragraph 100). This would ensure that a district nurse team allocated to the chosen GP surgery would also be readily accessible. There is no evidence that the Care Home arranged GP registration for Mr M on his admission on 6 October 2009.

[8] A condition in which the body is fighting a severe infection that has spread through the bloodstream. Sepsis means the same as septicaemia.

[9] The minutes of the Adult Protection case conference on 22 October 2009 state that these further concerns were provided to the Social Worker by email, but Mrs L has said that she and her family gave them to the Social Worker in person.

'Assistant Manager at [the Care Home] *stated the pressure sore was a Grade 1 when* [Mr M] *was admitted there for respite care. On 13.10.09 staff at* [the Care Home] *reported that Mr M had a sore bottom and cream was applied.'*

35. The following conclusion was recorded: '*It was agreed that the pressure ulcer had not developed as a result of negligence prior to* [Mr M's] *hospital admission*'.

36. There was a further case conference on 30 October 2009 to discuss other concerns raised by Mr M's children about '*possible neglect prior to his hospital admission*'. Nurses from the hospital were present at this case conference but there were no representatives from the Care Home and the Nurse who attended Mr M on 13 October 2009 was not present either. The minutes state:

    'Social worker contacted [one of the district nurses who attended Mr M in his own home, who] *reported that when she last saw Mr M on 29.9.09 his pressure sore was classed as Grade 1 (superficial) and that cream and appropriate dressings were being applied. On admission to* [the Care Home] *for respite care Mr M's pressure sore areas were observed and classed as Grade 1/2 and this remained the case when he was admitted to Medical Assessment Unit on 13.10.09. Nursing staff present at the meeting explained that pressure sores develop very quickly and that there could be significant deterioration over a 24-hour period. They also explained that the sores are sometimes difficult to detect because they develop under the surface of the skin before they erupt onto the surface. Mr M was described as a frail, slim gentleman who had not been eating or drinking very well prior to admission.*[10] *He also had poor mobility. This would have caused his pressure sores to deteriorate very quickly to a Grade 4, even though they may not have appear* [sic] *serious when he was first admitted.'*

The complaint to the Council

37. Mrs L made a complaint to the Council on 6 December 2009. She complained that her father was *'in such a state'* before he was admitted to hospital. She also raised concerns about the safeguarding case conference. The Council appointed an independent investigator (the Council's Investigator) to look into the matters raised.[11] The Council's Investigator interviewed three members of the Care Home staff (the Care Home Manager and two senior carers) and examined Mr M's records from the Care Home. The Council's Investigator considered the following complaints:

    (i) The Council and the Care Home failed to care for Mr M adequately and failed to seek appropriate and timely medical help.

[10] It is not clear who made this observation, and it is not borne out by the Care Home records (Annex A). At interview with the Ombudsmen's investigators, no Care Home staff recalled that Mr M had a problem with eating and drinking until the evening of his admission to hospital.

[11] In their response (dated 6 November 2012) to the draft report, the Council pointed out that when Mrs L's complaint was first received, they made efforts to investigate it jointly with Mr M's health care providers. They also pointed out that they appointed an independent investigator, in accordance with their complaints procedures, to ensure an independent view of the complaint.

The Council's Investigator did not uphold this complaint. The three members of the Care Home staff he had spoken to said they were all aware that Mr M needed to have cream applied to his pressure area morning and night, though this was not always recorded. The Council's Investigator said in his report that recording this would have been good practice and the Council would have expected this to be done. He noted that Care Home staff said: '*if they had noted that morning that Mr M's skin had been broken they would have informed the* [Nurse]' but they were not aware of any skin breakdown prior to Mr M's hospital admission on 13 October 2009. The Council's Investigator concluded that '*by the following day there was a dramatic and significant change to the sore*'. He noted that hospital nurses who attended the safeguarding case conference had explained how quickly pressure ulcers can deteriorate and also that it had been discussed at the safeguarding case conference that Mr M's poor eating and drinking before admission to hospital could have contributed to this deterioration.[12]

(ii) The Care Home failed to inform Mr M's family that he had been admitted to hospital.

The Council's Investigator did not uphold this complaint. He found that the Care Home staff had attempted to contact Mr M's wife and had also tried a second emergency contact number that had been provided. Neither was available and the Care Home had no other contact details.

(iii) Not all the family were allowed to attend the case conference; there was considerable delay in Mrs L receiving the minutes and they were inaccurate.

The Council's Investigator found that it was reasonable that only one family member attended the case conference so that the person about whom the safeguarding allegations had been made would not feel intimidated. The Council's Investigator upheld the complaint that there was a delay in sending out the minutes, and he said it would have been better if they had been dated and signed. He acknowledged that Mrs L's email about concerns over the minutes had not reached the intended recipient.

(iv) At the conclusion of the case conference meeting, staff behaved in an unprofessional manner, laughing and giggling, and this was whilst the person against whom the safeguarding allegations had been made remained in the room.

The Council's Investigator thought there was insufficient evidence to uphold this, as there were conflicting accounts and he was unable to find any independent information that supported either version of events.

38. The Council's Investigator made a number of recommendations:

- Mrs L should receive a full apology for the upheld complaint (complaint iii);
- Mrs L should receive a full response to her email about the case conference minutes;
- consideration should be given to ensuring that participants in safeguarding case conferences enter and leave the meeting at the same time;

[12] Note: the Council's Investigator did not attend the case conference but saw a copy of the minutes.

- where possible, alternative contact details should be provided for residents admitted to respite care; and
- the Care Home should be reminded of the need to record all treatments provided for residents.

39. The Council's Investigator produced a report on his findings on 26 May 2010. The Council sent a copy of the report to Mrs L with an accompanying letter on 21 June 2010. They told Mrs L that they agreed with the Council's Investigator's findings and conclusions. They informed her that their Family Service Medication Policy had recently been revised and reissued with specific instruction to staff on how cream should be applied.[13] They said they had asked their social workers and care home staff to seek secondary contact details where possible. The Council apologised to Mrs L that she did not receive a copy of the case conference minutes sooner. They said it had not been possible to determine what happened to Mrs L's email about the minutes and they apologised for the failure to respond to her. They said they had forwarded the Council's Investigator's recommendation that all participants should enter and leave case conferences at the same time to the relevant service manager for consideration. Mrs L was dissatisfied with the Council's response and made a complaint to the Local Government Ombudsman on 18 July 2010.

The complaint to the Trust

40. In August 2010 Mrs L complained to the Trust about the care provided for her father by the Nurse who attended him on 13 October 2009, including that she missed his serious pressure ulcer and the septicaemia bruising on his hands and arms. The Trust initially told Mrs L they would not investigate her complaint because she was not Mr M's next of kin.[14] Mrs L complained to the Health Service Ombudsman's Office in October 2010. The Health Service Ombudsman's Office contacted the Trust and they agreed to investigate Mrs L's complaint.

41. The Trust asked Wakefield District Community Services (Community Services) to investigate the complaint on their behalf.[15] Community Services asked the Nurse about the events complained about and then asked her to check their proposed reply to the complaint. The Nurse emailed them on 10 November to say '*I have looked at your letter and I*

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[13] When the Ombudsmen's investigators visited the Care Home in October 2011, the staff showed them the new charts kept in the rooms of residents who required the application of cream. These charts are to be filled in when cream is applied.

[14] The Trust had also seen a copy of a letter written by Mr M's wife which she had sent to the hospital Trust in December 2009 expressing her view that there was no fault in the care provided by the district nurses, the Care Home or the Nurse and that Mr M's pressure ulcer (which had been intermittent) had deteriorated only once he was admitted into hospital (footnote 16).

[15] The Trust told us that Community Services were the '*provider arm*' of the Trust, which (at the time of the events complained about) provided a range of community-based health services including district nursing. Community Services had responsibility for the investigation of Mrs L's complaint. Their complaints team was not managed by the Trust's complaints team but the Trust's chief executive had ultimate accountability for the investigation.

am happy with what you have said, only where you said I didn't remember if staff said he was ill on the day in question, they did not express any concerns, only that his catheter was not draining ...'.

42. The Trust responded to Mrs L on 17 November 2010. They said the district nursing records did not comment on the septicaemia bruising. They said they had spoken to the Nurse, who confirmed she had not seen any signs of septicaemia or bruising, or that Mr M appeared extremely ill. The Trust said the Nurse had not met Mr M before and so was unable to comment on whether his condition had deteriorated. She did, however, remember that at no time did any of the Care Home staff express concern about him and that the only concern was about him having a blocked catheter. The Trust said that the district nursing records showed clearly that the catheter was changed and that urine was draining into the catheter bag. They said it was also recorded that the Nurse had checked Mr M's bottom for signs of pressure damage and found a '*scuff*'. The Trust concluded that there was only minimal pressure damage and that cream was the right treatment for mild pressure ulcers. The Trust copied their response letter to Mr M's wife.

43. Mrs L emailed the Trust on 19 November 2010 to express her dissatisfaction with their response. She complained that they had not sought her permission to share her correspondence with Mr M's wife. The Trust wrote to Mrs L on 22 November, offering her a meeting to discuss her complaints and try to resolve her concerns. Mrs L declined this offer, saying the NHS had been given enough time to sort out her complaint and that she would now be continuing her complaints with the Ombudsmen. In a further letter dated 26 November the Trust told Mrs L that they did not consider they had breached her confidentiality. They said they had already informed her that they had shared her letter of complaint with Mr M's wife and that they would share with her a copy of their response to Mrs L's complaint. Mrs L maintained that the Trust had not informed her of this.

44. Mrs L remained dissatisfied and emailed the Trust on 27 November 2010, pointing out that the hospital had found a grade 4 pressure ulcer when Mr M was admitted, and that someone from the Care Home told her that the Nurse was not told about any pressure ulcer and had only looked at the catheter.[16]

45. The Trust's head of corporate governance assessed Mrs L's outstanding complaints. On 29 November 2010 she emailed the Trust's chief executive to say:

    'I have since confirmed the position on this admission with the Complaints Manager at [the hospital Trust] *who has checked the records which confirm a Grade 4 pressure ulcer. I queried why this discrepancy with* [Community Services'] *responses had not been picked up prior to the letter from* [Community Services] *being sent which stated scuff on buttocks. It was not considered. I have since sent the information about the G4 pressure sore on admission to* [staff at Community Services] *...'.*

[16] We were not able to interview this member of the Care Home staff as he was on leave at the time of the interviews. We subsequently decided that it would not add anything to speak to him. Other members of staff and the Nurse herself were specifically questioned about whether the Nurse had been asked to look at Mr M's pressure ulcer or just the catheter.

Regarding the breach of confidentiality she said:

'The background is that Mr M's wife became aware of the complaint to [the hospital Trust] *and wrote ... thanking both the hospital and the District Nurses for the care given and requesting information about the outcome of the inquiry (complaint made by daughter). The patient was alive at this point and he had given his verbal consent to this complaint hence* [the hospital Trust] *investigated.*

'At no point did [Community Services] *send the deceased patient's wife a copy of the complainant's letter. When the daughter complained our view was that she was not the next of kin and we could not investigate. The daughter wrote to the Ombudsman who confirmed back to us that they considered it appropriate for the complaint from the daughter to be investigated. Their interpretation of the rules around consent* [is] *much looser than we have been working to.*

'The complaint was therefore investigated and the complainant was informed by [Community Services] *in a letter of 11 November that Mr M's wife would be advised of the investigation and informed of the outcome of this and was duly copied into the final complaints response.*[17] *From our perspective we would have usually checked this out with the complainant before sending this information as is our usual practice, however staff at* [Community Services] *did not do this. This is why we want to ask Mr M's wife if she is happy for us to send the complainant a copy of her letter saying that she wanted to know the outcome of the inquiry – this does have* [personal information in it] *and I would be surprised if she agrees. This is our usual practice and the fact that* [Community Services] *did not do this and the contrast with our approach has been highlighted by the complainant.*

'My plan is to contact Mr M's wife and then draft a letter for you to respond to the complainant on the basis of this point only.

'... I would advise that the only further response we should make is an acknowledgement of [Mrs L's] *email and to say that we will send a response about the letter from Mr M's wife and that the other aspects are being pursued by the relevant parties.'*

The complaint to the Ombudsmen

46. In the meantime, on 19 November 2010, Mrs L asked the Ombudsmen to jointly investigate her complaints. Her letter of complaint included:

'... our father was admitted to Pontefract Hospital on 13 October with a NECROTIC Grade 4 pressure sore and his body [was] *ravaged with septicaemia with extensive bruising to the hands and arms ...*[18]

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[17] We have seen a copy of this letter, which makes it clear that the Trust's response will be copied to Mr M's wife.

[18] During the assessment process before we had decided whether or not to investigate Mrs L's complaint, we sought clinical advice from one of the Ombudsmen's nursing advisers. She said septicaemia means blood poisoning and would not be used to describe bruising on the hands and arms. She could find no reference in the medical or nursing records to bruising on Mr M's hands and arms.

'[Community Services say] *the* [Nurse's] *records have no comment either way on my father's health on 13 October and when spoken to says she did not observe any signs of septicaemia or bruising when she attended our father on 13 October or that he appeared extremely ill. Was she visiting the same man?*

'Again this is extremely concerning that this woman failed to spot the signs and failed to notice how unresponsive our father was.

' ... she does however remember that at no time did any of the staff at the home express concern about our father being extremely ill or that his health had rapidly deteriorated, their only concern was related to his blocked catheter.

... The staff at [the Care Home] *failed to notice or implement a lot of things, in particular they all "forgot" to record that they had applied barrier cream to my father's pressure sore. That is because not one of them did this ...*

' ... [Community Services said that] *the* [Nurse] *changed the catheter and that urine was draining into the catheter bag ... and checked for any sign of pressure damage ...*

' My family and I have been told previously that the [Nurse] *did not look at the pressure sore, that* [the Care Home] *staff did not ask her to look at it ... Now which is it, she either checked the pressure sore or she did not, why is this story garbled?*

'If she checked the pressure sore which had caused the septicaemia on our father's body and led to him being admitted in a dangerously ill condition ... please do not ... insult my intelligence by telling me the pressure sore degraded between 11am from a scuff to a necrotic life threatening Grade 4 pressure sore because it will not wash ...

'... the [Nurse] *failed to notice that a "scuff" was indeed a necrotic Grade 4 pressure sore and had recorded that she actually applied "Cavilon" to the wound.*[19] *I find it incredible that she failed to notice how bad this wound was. Had she spotted the severity of the wound... our father would have received help earlier ...*

'Also I would like to ask was this the only time a district nurse visited him during this stay in [the Care Home]*, we are told that this was the first time this nurse met my father, surely with a catheter causing so much trouble there should have been at least other nurses visiting ...*

'Our father was admitted [to hospital] *in a Glasgow coma*[20] *... it is in the* [Care Home records that he] *was found unresponsive slumped in a chair ... it is stated that the* [Nurse] *has asked* [Care Home staff] *to ... "push" fluids – how many times did* [they] *administer fluids, which we all know is*

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[19] See Annex A. The Nurse did not record that she had applied Cavilon but she wrote in the district nursing notes that she advised Care Home staff to do this. The Trust did not say in their letter of 17 November 2010 that she had applied cream.

[20] Mr M's hospital records show that on admission to hospital he had a reduced level of consciousness with a Glasgow coma score of between 9 and 11. This does not mean he was comatose or unconscious. The Glasgow coma score is a widely used tool to assess a patient's neurological status, a score of 15 being fully conscious.

vital to keep hydrated and have nutrition with pressure sores, presumably they failed to record this too, and failed to notice that unresponsive was in fact in a coma!!

'... I would ask that [the Care Home and the Nurse] *make a full and frank apology to my family because they failed in their duty of care to my father and* [his family].

'... I would also ask that both Ombudsmen please look into the breach of confidentiality ... '

Mrs L said she also wanted the Trust, the Council and Community Services to admit the errors that occurred and to apologise to her family. She also wanted compensation for her family.

Evidence

47. In the early stages of the investigation, in October 2010, a request was made for documentation, including records from the Care Home, the district nurses and the hospital. The Ombudsmen's investigators also interviewed Care Home staff and the Nurse in October 2011. Relevant information from the records is set out in Annex B, and from the interviews in Annex C.

Responses to our enquiries

48. On 28 November 2011 the Trust wrote to the Ombudsmen in response to enquiries we made about their complaint handling. They said that the chief of service delivery for Community Services had investigated Mrs L's complaint. They said it was regrettable that the issue of the grade 4 pressure ulcer was not fully investigated and addressed in their response to Mrs L. They thought that if there had been an opportunity for further local resolution, Mrs L's dissatisfaction with their answer to this matter could have been explored further. They confirmed that they shared an acknowledgment letter dated 11 November 2010 to Mrs L, and their substantive response of 17 November 2010, with Mr M's wife. They said that Mr M's wife had declined the request to share her letter of 15 December 2009 with Mrs L. They said that at the time there were two separate complaints teams, but that was no longer the case.

Clinical advice

49. We have attached the clinical advice on which we have relied as Annex D to this report.

Our findings

The Local Government Ombudsman's findings in relation to the complaints about the Council

Complaint (a) – the care provided for Mr M by staff at the Care Home between 1 September and 13 October 2009

50. The Care Home should have acted in line with the *Care Homes Regulations 2001* (the Regulations, paragraph 99) and the national minimum standards (paragraph 101) that were in force at the time.

51. Regulation 14(1) required the Care Home to get a copy of Mr M's assessment and consult him or his representative. It then had to confirm in writing to Mr M that it could meet his assessed needs for his health and welfare. Regulation 14(2) required the Care Home to keep Mr M's assessment under review and revise it when necessary as circumstances changed. Standard 8.3 of the national minimum standards required someone trained to do so to have assessed Mr M for risk of

developing pressure ulcers when he went into the Care Home, and recorded an appropriate intervention in his care plan.

52. Regulation 15(i) required the Care Home to have a care plan for Mr M.

53. Regulations 17(1)(a) and Schedule 3 required the Care Home to keep a record of Mr M's pressure ulcers and treatment. Standard 8.4 of the National Minimum Standards requires the Care Home to record the incidence of pressure ulcers, treatment and outcome in the care plan and for this to be '*reviewed on a continuing basis*'.

54. The Care Home Manager carried out a full assessment of Mr M's needs when he first went into the Care Home. The Care Home Manager did a Waterlow[21] assessment in March 2009. It showed that Mr M was then at risk of developing a pressure ulcer. When Mr M went into the Care Home from hospital on 19 September, the Manager had noted his sacral area was '*very sore on discharge from hospital*'. She added that staff should apply cream twice a day and report and record any changes to his care plan.

55. Mr M went home on 25 September and the next day district nurses assessed a pressure ulcer on his sacrum and drew up a care plan to treat it. The district nurse records do not show the grading of the ulcer, if or when the dressing was removed, or whether the care plan of 26 September should still be followed. A district nurse had calculated a Waterlow score of 22 for Mr M on 29 September, which meant that he was deemed to be at '*very high risk*' of developing a pressure ulcer. The last recording of the dressing was 1 October, made by the carers who helped Mr M in his own home. They recorded that Mr M's wife had changed the dressing.

56. When Mr M returned to the Care Home on 6 October, the district nurses' notes and the care plans they produced for his pressure ulcer went with him. There is no record that the Care Home did its own assessment of his pressure ulcer. It updated his overall assessment on 7 October with no changes to his personal plan for skin care. The Care Home could either have produced its own care plan for managing Mr M's pressure ulcer or followed the plan produced by the district nurses. Its own plan of 19 September was that cream should be applied twice a day. The Care Home's records provide no clarity about which, if either, care plan it was following.

57. Mr M was at high risk of developing pressure ulcers. The district nurses caring for him in his own home and the Care Home staff knew this. We have not investigated the actions of these district nurses, but they had drawn up a plan to treat Mr M's pressure ulcer at that time. The Care Home staff were not helped in their care of Mr M's pressure area by the fact that no one appears to have informed them whether this plan was still to be followed when Mr M went into the Care Home on 6 October. Irrespective of that, however, I find that the Care Home failed to comply with national minimum standard 8.3 and Regulation 17(1). Additionally, in line with the Regulations, the Care Home should have made arrangements for Mr M to be registered with a general practitioner (paragraph 100). There is no evidence that they did so for his admission on 6 October 2009. However, this omission does not appear to have had any negative

[21] A commonly used pressure area risk assessment tool.

impact on Mr M because, when there was a need for the district nurses to attend him on 13 October 2009, they came immediately.

58. The Care Home's approach to recording was haphazard and entirely without accountability – see Annex B. The Care Home Manager said it did not record every day that someone is washed and has cream applied because this is standard and repetitive. The records show that some care workers recorded applying cream and others did not. There is no record that Care Home staff regularly repositioned Mr M to help prevent, or mitigate existing, pressure ulcers.

59. On the day that Mr M was admitted to hospital, the Care Home records note that he ate well at lunchtime but little at tea time and had spent most of the afternoon asleep in the reception area. Long periods in the same position increase the risk of developing pressure ulcers and will cause existing ulcers to deteriorate. There is no evidence that the Care Home gave any attention to Mr M's positioning during that afternoon and early evening.

60. The Care Home did not consistently and accurately record its treatment of Mr M's pressure ulcer. This means it did not comply with the statutory requirements of Regulations 17(1) and (3). In the absence of evidence that care was provided, there are no grounds for me to conclude that it was. I find that the Care Home failed to provide adequate care in response to Mr M's very clear need for pressure area management. As a result, his existing pressure ulcer deteriorated to such an extent that it was assessed by the hospital at his admission on 13 October as grade 4. I cannot say exactly when the ulcer deteriorated to grade 4 but, given that the Care Home did not provide adequate care, it is likely to have deteriorated during his stay there, and was likely to have worsened while Mr M was left sitting in the reception area in the same position during the afternoon of 13 October.

61. In making this finding I have considered whether there were other factors that could have led to that pressure ulcer developing or deteriorating rapidly during 13 October. I do not think that there were. Mr M did not have either persistent undiagnosed sepsis or terminal illness, which are the clinical situations that might cause such rapid development of the pressure ulcer or skin deterioration. (Although Mr M had had persistent bladder or urine infections, that does not mean he had been suffering from sepsis.)

62. The Care Home's records for Mr M were altered after he was admitted to hospital and the Council had begun its safeguarding investigation. This gives the impression of an attempt to conceal inadequate care.

63. Standard 8.5 of the National Minimum Standards states that equipment necessary for the prevention or treatment of pressure ulcers should be provided in care homes for older people. The guidance issued by NICE and the RCN (paragraph 103) says:

    - people with pressure ulcers should have access to pressure-relieving support surfaces throughout the day; and
    - decisions about choice of these should be made by registered health care professionals.

    NICE and RCN guidance are not mandatory regulations for care homes but they are recommendations that should have been regarded as established good practice, and they are in keeping with Standard 8.5 of the national minimum standards.

64. Mr M took a pressure cushion into the Care Home on 6 October. The Care Home did not update his care plan to show how this should be used at that time, although if Mr M brought it in, it is reasonable to expect staff to use it. The district nursing care plans of 26 September for Mr M's pressure ulcers did not refer to this or to the use of a pressure-relieving mattress.

65. There was no decision by a district nurse or any other registered health professional that Mr M should sleep on a pressure-relieving mattress. The use of this item was not part of Mr M's overall care plan devised by the Care Home or the one devised by the district nurses who visited him in his own home. The Care Home is not a nursing home and cannot be expected to have decided whether a pressure-relieving mattress was '*necessary*' for Mr M. That decision should have been taken by a health care professional. In these circumstances, I find that the Care Home was not at fault in not providing a pressure-relieving mattress. However, the Care Home could have sought advice on this from a health care professional, given that Mr M clearly had pressure area problems and needed a pressure cushion.

Complaint (b) – the Council's handling of Mrs L's complaint

66. The Council should have acted in line with the Complaints Regulations (paragraph 105). These regulations are not prescriptive about how organisations should investigate a complaint, but the Council should have acted in the spirit of the Principles of Good Complaint Handling. The Council should have investigated Mrs L's complaint thoroughly and fairly, and its response should have been based on evidence.

67. The Council appointed an independent investigator (the Council's Investigator) for Mrs L's complaint. He interviewed members of Care Home staff and examined Mr M's records from the Care Home. The Council accepted his findings and conclusions and acted on his recommendations. It took the outcome of the investigation seriously.

68. The Council's Investigator did not uphold Mrs L's complaint about the care provided for her father at the Care Home. The Council's Investigator did not identify and resolve a number of discrepancies in the evidence about this aspect of the complaint.

69. The Care Home staff interviewed by the Council's Investigator said they knew that Mr M needed to have cream applied twice daily. The Council's Investigator assumed that this meant **all** staff knew about this, even though Care Home staff did not always record this information.

70. The Council's Investigator did not refer to the requirement in the Regulations for a care home to keep a record of the incidence and treatment of pressure ulcers. He said only that it would have been '*good practice*' to record the information and that the Council would have '*expected*' it to be recorded. The Council did, however, introduce a specific form to record the relevant information.

71. The Care Home staff interviewed by the Council's Investigator said that **if** there had been a problem with Mr M's pressure areas, they would have asked the Nurse to check them. This implied that there was no problem and she was not asked. However, the Nurse **did** check and this is recorded in the district nurse records held with the Care Home records. This important fact should have come to light during the Council's investigation, and the Council's Investigator should have explored the apparent discrepancy in the evidence.

72. When reaching his conclusions on the actions of the Care Home, the Council's Investigator took into account information contained in the safeguarding investigation case conference notes. The source of some of that information is not clear. For example:

    - the case conference minutes of 30 October 2009 record that Mr M had not been eating and drinking and had been unwell in the days before being admitted to hospital (paragraph 36). This is not borne out by the Care Home's records. Our investigators asked Care Home staff about this at interview. The staff said that Mr M's health and appetite and fluid intake had been fine until the evening of 13 October 2009. This comment in the case conference minutes was not attributed and did not match the documentary evidence; and

    - the case conference notes stated that Mr M's pressure ulcer had been about grade 1 on 29 September (that is, before he went into the Care Home for the last time). While it was reasonable that the Council's Investigator should bear that evidence in mind, it was only part of the story. It was the actions of the Care Home leading up to Mr M's admission to hospital on 13 October 2009 (two weeks later) that were under investigation.

73. The research findings published by the Department of Health (see Annex D) in 2010 (after the events complained about) have given us a better understanding of the development of pressure ulcers. We have had the benefit of that research when reaching our own, different, conclusions from those of the Trust about the state of Mr M's pressure ulcer on 13 October 2009. Nonetheless, I find that the Council's investigation was not thorough, did not establish the facts, and drew erroneous conclusions on the matters complained about. This was maladministration.

The Health Service Ombudsman's findings in relation to the complaints about the Trust

Complaint (c) – the care provided for Mr M by the Nurse on 13 October 2009

74. The first matter I have considered is Mrs L's complaint that the Nurse did not deal adequately with Mr M's pressure ulcer on 13 October 2009. In reaching my findings I have taken account of the Principle of Good Administration – '*Getting it righ*t' (paragraph 22). In order to 'get it right', the Nurse should have acted in line with the NMC's Code of Conduct (paragraph 102) and the guidance on pressure area management issued by the RCN and NICE (paragraph 103). I have also taken account of the clinical advice (Annex D).

75. The Code of Conduct states that nurses must '*Provide a high standard of practice and care at all times*' that is '*based on the best available evidence or best practice*' and that they must keep clear and accurate records of the assessments they make and the treatment they give. The Nurse was asked to attend Mr M as an emergency patient to deal with the pressing problem of his blocked catheter. She dealt with that matter and documented her action and advice about it. To that extent, then, her actions were in line with the Code of Conduct.

76. However, I am concerned about her actions regarding Mr M's pressure ulcer. There are differing accounts about whether the Care Home staff asked the Nurse also to look at Mr M's pressure ulcer, or whether she did this of her own volition. Either way, she made a record in the district nurse notes to show that she

did look at the ulcer and gave advice to Care Home staff about how to deal with it.

77. The Nurse said she consulted the district nurse notes that were brought in with Mr M when he moved to the Care Home. The notes for September 2009 (before he came into the Care Home) contain two separate care plans made by the district nurses on 26 September 2009 that refer to ulcers on Mr M's sacral area – one on the left and one on the right. This suggests there were two separate pressure ulcers on the left and on the right sacrum. The Nurse and the Care Home staff refer only to one pressure ulcer, though I note that the Nurse made entries in both care plan 8 and care plan 9. The hospital records indicate that there was just one ulcer across the left and right sacrum. I have not been able to resolve the discrepancy about whether there were two separate wounds or just one on Mr M's sacrum. It was also recorded in the district nurse notes for 26 September that a dressing (or dressings) had been applied and that it (these) should be replaced twice a week. It is unclear if or when the dressing was removed. One of the carers (the fourth Carer – Annex C) recalled that there had been a dressing in place when she attended Mr M on 13 October, but other Care Home staff did not recall this, and the Nurse said there was no dressing in place.

78. In terms of pressure area care, the Nurse recorded in the district nurse notes October 2009 *'as per the care plan'*. The Nurse confirmed at interview that she left the area uncovered and advised the application of cream only. She did not write down the size or grade of the pressure ulcer, in line with the RCN and NICE guidelines, but she said at interview (two years after the event) that it was about a grade 2. I accept that the Nurse made her own clinical judgment based on what she observed at the time, but her actions were **not** in accordance with the care plan, which indicated that dressings should have been used and changed twice weekly. I therefore consider that the Nurse did not act in line with established good practice (because she did not grade the ulcer), or in accordance with the care plan (because she did not apply a dressing). As I have already explained, Mr M did not have persistent undiagnosed sepsis, nor was he terminally ill at this time (paragraph 61), and so it is unlikely that a grade 4 pressure ulcer developed in the time after Mr M had left the Care Home on 13 October. However, taking into account that the Nurse recorded only '*scuffing*'; her later recollection of the appearance of the pressure ulcer; and the Nurse Adviser's comments (paragraphs 148 and 153), I cannot say that the severity of the pressure ulcer should have been evident to the Nurse at the time. It is possible that the damage at that stage was beneath the surface of the skin, which had not yet broken down. While the Nurse treated it as if it were less serious than it actually was (and later miscategorised it), it is not clear that she should have been able to assess the true extent of the damage in the presenting circumstances. However, she should still have given care in accordance with the care plan and recorded her findings comprehensively in the district nurse notes.

79. The RCN and NICE guidelines state that people with grade 1 or 2 pressure ulcers should have appropriate pressure-relieving equipment in place. The guidelines also state that pressure ulcers graded 2 or above should be documented as local clinical incidents. The Nurse said she reported her findings to a district nurse colleague after she left the Care Home but

this was not written down. The Nurse said she had not seen any such equipment and intended to follow this up. In the event, however, no action was taken due to Mr M's admission to hospital by the time the Nurse telephoned the Care Home the following day.

80. I conclude that the Nurse did not make an accurate record of the ulcer (although she may have recorded what was visible to her – a scuff); she did not act in line with established good practice or give care in accordance with the district nurse care plan; and she delayed getting back to the Care Home about follow up. Therefore, I consider that her actions fell so far below the applicable standards that they amounted to service failure.

Complaint (d) – the Trust's handling of Mrs L's complaint

81. The second matter I have considered is the Trust's handling of Mrs L's complaint. In reaching my findings I have again taken account of the Principle of Good Administration '*Getting it right*' (paragraph 22). In order to 'get it right', the Trust should have acted in line with the Complaints Regulations (paragraph 105) and also the Principles of Good Complaint Handling (paragraph 23). The Principles of Good Complaint Handling that are relevant to this aspect of the complaint are *'Being open and accountable*' and '*Acting fairly and proportionately*'. The Trust should have investigated Mrs L's complaint thoroughly and impartially and their response should have been evidence-based.

82. The Trust asked Community Services to investigate the complaint. This was appropriate because they were the organisation that supplied the district nurse care for Mr M and they would have easier access to staff involved and any relevant documentation. Community Services investigated the complaint by looking at the documentary evidence, speaking to the Nurse, asking her to comment on their draft response letter, and taking account of her comments before sending it. To this extent, the process they followed was thorough and evidence-based, though it might have been helpful to have asked the Nurse for a full written statement of her actions at the time.

83. On the basis of Community Services' investigation, the Trust concluded that Mr M did not have a grade 4 pressure ulcer when he was examined by the Nurse on 13 October 2009. We have found, to the contrary, that it was highly likely that Mr M had a grade 4 pressure ulcer when the Nurse saw him (although the true extent of the damage may not have been visible). Community Services were aware that the hospital had found that Mr M had a grade 4 pressure ulcer on admission but they did not explore the discrepancy in the evidence. This omission in their investigation only came to light after Mrs L received the Trust's response letter of 17 November 2010. In response to this investigation, the Trust said it was regrettable that the issue of the grade 4 pressure ulcer was not fully investigated and they would have tried to resolve it by offering Mrs L a meeting to discuss the matter further. By that time, however, Mrs L had lost faith in the local complaints process, declined a meeting, and pursued her complaint with the Ombudsmen.

84. Mrs L raised concern about the sharing of information in her complaint with Mr M's wife. The Trust said they shared with her an acknowledgement to Mrs L dated 11 November 2010 and their substantive response to the complaint

of 17 November 2010. They said they did not share Mrs L's complaint letter with Mr M's wife. Community Services did not check with Mrs L before sharing this information, as the Trust would normally do. The Trust told us that they informed Mrs L they would be sharing their response with Mr M's wife but it would have been courteous to have asked her first whether she was happy about this.

85. I conclude that although the Trust delegated the investigation to Community Services, they retained responsibility for the quality of investigation and the response. Community Services had a separate complaints department that was not acting in line with the Trust's procedures. The Trust's investigation did not provide a robust and reasonable explanation that was supported by the evidence. They did not get it right in terms of the thoroughness of their investigation, and they acted unfairly by not asking Mrs L if they could share their complaint response with Mr M's wife. I consider that the failings in the Trust's investigation meant their complaint handling fell so far below the applicable standards that it amounted to maladministration.

Injustice

The Local Government Ombudsman's findings regarding the Care Home

86. I have found that the Care Home did not deal adequately with Mr M's pressure area care and that, as a result, his existing pressure ulcer deteriorated to such an extent that it was assessed by the Hospital at his admission on 13 October as grade 4. Given the state of Mr M's health more generally, I do not know if the delay in recognising a grade 4 pressure ulcer caused him more pain and discomfort than he would otherwise have suffered, but the deterioration in the pressure ulcer was, itself, an injustice arising from the Care Home's failure to follow the care plan. Mrs L believed that the Care Home's failure to adequately treat her father's pressure ulcer led to him contracting septicaemia, which in turn led to his death. A grade 4 pressure ulcer is serious, and can be life-threatening if it leads to septicaemia. The pressure ulcer could have been the source of Mr M's septicaemia. However, it seems far more likely that Mr M's urinary tract problems were the cause of his septicaemia. He had a history of persistent bladder or urine infections; he required a catheter change on 13 October, which may have led to bacteraemia (paragraph 155), which may, in turn, have precipitated his collapse that day. The diagnosis of urinary sepsis when he was admitted to hospital indicates that doctors there suspected urinary tract infection to be the cause of the sepsis. Importantly, Mr M was treated for urinary sepsis on his admission to hospital and his condition improved. That suggests that he did not die as a result of the infection that led to his admission to hospital: he died from another urinary tract infection six weeks after he was admitted to the hospital. In the light of all this, I cannot conclude that the pressure ulcer was the probable cause of Mr M's deterioration on 13 October 2009 or of his death on 23 November 2009.

The Health Service Ombudsman's findings regarding the Nurse's actions

87. Mrs L said that the Nurse failed in her '*duty of care*' to Mr M in that she did not notice his grade 4 pressure ulcer, and as a result of her actions, he did not get help quickly enough and was left in a '*dangerously ill*' condition. The term 'duty of care' has an everyday meaning but it is also a legal concept. We do not make legal

determinations, but we do make findings about injustice in terms of the impact on the individuals affected by service failures we find. It is the everyday meaning of the term that we are using here. In order for us to uphold a complaint, we have to be persuaded, on the balance of probabilities, that any injustice arises from the service failure we have found, and so we will only uphold a complaint if we have evidence that this is so.

88. I have found service failure in the actions of the Nurse when she saw Mr M on 13 October 2009. I have found that she did not act in line with established good practice or give care in accordance with the district nurse care plan; and that she delayed following up Mr M's pressure area care needs to the next day. However, I do not find that there was any injustice to Mr M from this service failure. Grading the pressure ulcer and following the care plan on the morning of 13 October would have made no difference because this damage had already been occurring over time, and Mr M was admitted to hospital later that day for a reason unrelated to his pressure ulcer.

89. I also cannot conclude that the Nurse failed in her duty of care to Mr M. She was called out to the Care Home to deal with his blocked catheter. The Medical Adviser said that the procedure she used appears to have been appropriate. To that extent, her actions were in accordance with the applicable guidance set by the NMC. The Medical Adviser said the catheter change '*may have disturbed the situation leading to bacteraemia*' and this may have precipitated Mr M's collapse on 13 October 2009. However, this appears to have been an unfortunate consequence of the necessary and correctly performed procedure to deal with the blockage. I have explained already that there are no grounds to say that the pressure ulcer was probably the cause of Mr M's septicaemia on 13 October or his later death. I therefore cannot conclude that Mr M's death occurred in consequence of the service failure by the Nurse.

The Ombudsmen's finding regarding the Council's and the Trust's complaint handling

90. Mrs L said that the story from the complaints responses was '*garbled*' and she highlighted many discrepancies in the answers she received from both the Council and the Trust. We have found maladministration in the way both these organisations investigated Mrs L's complaints. We find that this caused distress and inconvenience to Mrs L, who had to make repeated and protracted attempts to get the answers and explanations she was seeking.

The Ombudsmen's conclusions

91. Having studied the available evidence and taken account of the advice provided by the Nurse Adviser, we find that the care provided for Mr M by the Council (at the Care Home) and by the Nurse fell significantly below the applicable standard. This was service failure. We have concluded that the injustice to Mr M (that his existing pressure ulcer deteriorated to a grade 4 pressure ulcer) arose in consequence of the service failure by the Care Home. However, we have not found that Mr M's pressure ulcer deteriorated as a consequence of the Nurse's service failure. We have found shortcomings in the way the Council and the Trust handled Mrs L's complaint and that these shortcomings amounted to maladministration. We have concluded that the distress and inconvenience to her arose in consequence of this maladministration.

92. We therefore uphold Mrs L's complaint about the Council and partly uphold her complaint about the Trust.

Recommendations

93. In making our recommendations we have taken account of the Health Service Ombudsman's Principles for Remedy, in particular:

    - '*Being customer focused*' – which includes quickly acknowledging and putting right cases of maladministration or poor service that have led to injustice or hardship; and
    - '*Seeking continuous improvement*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action, or financial compensation).

94. The Council and the Trust should, therefore, within a month of the issue of this final report:

    (i) write to Mrs L to acknowledge the service failures and maladministration we have identified (paragraphs 50 to 85);

    (ii) apologise to Mrs L for the injustices (paragraphs 85 and 91) that Mr M and Mrs L and her family suffered as a result; and

    (iii) each pay financial redress of £250 for the impact (distress and inconvenience) of the Council's and the Trust's poor complaint handling that Mrs L suffered as a result of the maladministration we have identified.

    A copy of the apology and notification that payment has been made should be sent to both Ombudsmen.

95. In order to ensure the appropriate lessons are learnt, we recommend that the Council and the Trust should also, within three months of the date of this final report, prepare action plans that:

    - describe what they have done to ensure they have learnt the lessons from the failings identified by this upheld complaint; and
    - details what they have done and/or plan to do, including timescales, to avoid a recurrence of these failings.

96. The Council and the Trust should send copies of the action plans to:

    - Mrs L
    - both Ombudsmen
    - the Care Quality Commission, and
    - NHS North of England.

    The Trust should ensure that the Care Quality Commission and NHS North of England are updated regularly on progress against the action plan.

    On 31 March 2013 the Trust was abolished in accordance with the NHS reforms. From 1 April 2013 liability for those services complained about that were provided by the Trust transferred to Wakefield Clinical Commissioning Group (the CCG). The CCG have agreed to implement the recommendations we made to the Trust.

    On 31 March 2013 NHS North of England (a strategic health authority) was also abolished.

Section 4: Final remarks

97. In this report we have set out our investigation, findings, conclusions and recommendations with regard to Mrs L's complaint about the care and treatment Mr M received from the Council and the Trust and the way in which they handled her complaints.

98. We hope this report will provide Mrs L with the explanations she seeks. We reassure her that lessons will be learnt and the learning shared as a result of her complaint so that others are now less likely to suffer the same experiences as Mr M and Mrs L and her family. We also hope that this report will draw what has been a long and complex complaints process to a close.

Dame Julie Mellor DBE
Health Service Ombudsman for England

Dr Jane Martin
Local Government Ombudsman

June 2013

Annex A: Legislation

99. The *Care Standards Act 2000* makes provision for the registration and regulation of care homes. Part 1 of the Act established the (former) National Care Standards Commission (now the Care Quality Commission) with its inspection and regulation functions of care homes. Part 2 provided for the registration and inspection of establishments and agencies, including care homes, by the Care Quality Commission. It also provided powers for regulations governing the conduct of establishments and agencies (paragraph 100). The Act defines a care home as any home that provides accommodation together with nursing or personal care for any person who is or has been ill (including mental disorder), is disabled or infirm, or who has a past or present dependence on drugs or alcohol. Personal care in the context of care homes can include assistance with bathing, dressing and eating for people who are unable to do these things without help.

100. *The Care Homes Regulations 2001* (the Regulations) were made under the *Care Standards Act 2000* and came into force on 1 April 2002 in England only. These Regulations are mandatory. Part 3 – '*Conduct of Care Home*' – states that:

'12. – (1) The registered person[22] shall ensure that the care home is conducted so as –

(a) to promote and make proper provision for the health and welfare of service users;

(b) to make proper provision for the care and ... treatment ... of service users.

...

'13. – (1) The registered person shall make arrangements for service users –

(a) to be registered with a general practitioner of their choice; and

(b) to receive where necessary, treatment, advice and other services from any health care professional ...'.

'Assessment of service users

'14. – (1) The registered person shall not provide accommodation to a service user at the care home unless, so far as it shall have been practicable to do so –

(a) the needs of the service user have been assessed by a suitably qualified or suitably trained person;

(b) the registered person has obtained a copy of the assessment;

(c) there has been appropriate consultation regarding the assessment with the service user or a representative of the service user;

(d) the registered person has confirmed in writing to the service user that having regard to the assessment the care home is suitable for the purpose of meeting the service user's needs in respect of his health and welfare.

(2) The registered person shall ensure that the assessment of the service user's needs is –

(a) kept under review; and

(b) revised at any time when it is necessary to do so having regard to any change of circumstances.

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[22] That is, any person who is the registered provider or registered manager of a care home.

'Service user's plan

'15. – (1) Unless it is impracticable to carry out such consultation, the registered person shall, after consultation with the service user, or a representative of his, prepare a written plan ("the service user's plan") as to how the service user's needs in respect of his health and welfare are to be met. ...

'Records

'17. – (1) The registered person shall –

(a) maintain in respect of each service user a record which includes the information, documents and other records specified in Schedule 3[23] *relating to the service user ...*

(2) The registered person shall maintain in the care home the records specified in Schedule 4.[24]

(3) The registered person shall ensure that the records referred to in paragraphs (1) and (2) –

(a) are kept up to date; and

(b) are at all times available for inspection in the care home by any person authorised by the Commission to enter and inspect the care home ... .'

National guidance

101. The Department of Health (DH) issued *Care Homes for Older People: National Minimum Standards* (the national minimum standards) in February 2003. The national minimum standards are core standards that apply to all care homes providing accommodation and nursing or personal care for older people. They apply to homes for which registration as care homes is required. Standard 8 includes:

'8.3 Service users are assessed, by a person trained to do so, to identify those service users who have developed, or are at risk of developing, pressure sores and appropriate intervention is recorded in the plan of care.

'8.4 The incidence of pressure sores, their treatment and outcome, are recorded in the service user's individual plan of care and reviewed on a continuing basis.

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[23] Schedule 3 sets out the records that must be kept in a care home for each service user. These include: the service user's assessment; the service user's plan; a photograph of the service user; the service user's name, address, date of birth, marital status; contact details for next of kin; name of service user's general practitioner and any social worker; date of entry to and departure from the care home; a record of all medicines kept in the care home for the service user, and the date on which they were administered to the service user; a record of any accident affecting the service user in the care home and of any other incident in the care home that is detrimental to the health or welfare of the service user; a record of any nursing provided to the service user, including a record of his condition and any treatment or surgical intervention; details of any plan relating to the service user in respect of medication, nursing, specialist health care or nutrition; a record of incidence of pressure ulcers and of treatment provided to the service user.

[24] Schedule 4 is a list of other records to be kept by the care home. These include the duty roster of persons working at the care home, and a record of whether the roster was actually worked; and records of the food provided for service users in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition and otherwise.

'8.5 Equipment necessary for the promotion of tissue viability and prevention or treatment of pressure sores is provided ... .'

Professional guidance

102. The Nursing and Midwifery Council (the NMC – the organisation responsible for the professional regulation of nurses) publishes the Nursing and Midwifery Council code of professional conduct (the Code of Conduct), which contains general and specific guidance on how nurses should approach their work. This represents the standards that the NMC expects nurses to meet. The relevant version was published in 2008. It states that nurses must '*provide a high standard of practice and care at all times*' and that they must:

    '... deliver care based on the best available evidence or best practice

    '... keep clear and accurate records of the discussions [they] *have, the assessments* [they] *make, the treatment and medicines* [they] *give and how effective these have been ...'*

103. The Royal College of Nursing (RCN) and the National Institute for Health and Clinical Excellence (NICE) collaborated in 2005 to produce '*The management of pressure ulcers in primary and secondary care*'. This contains recommendations for good practice based on the best available evidence of clinical and cost-effectiveness. Under the heading '*Key recommendations*' it states:

    'The following recommendations have been identified as priorities for implementation.

    - *Record the pressure ulcer grade using the European Pressure Ulcer Advisory Panel Classification System.*
    - *All pressure ulcers graded 2 and above should be documented as a local clinical incident.*
    - *Patients with pressure ulcers should receive an initial and ongoing pressure ulcer assessment. Where a cause is identified strategies should be implemented to remove/reduce these. Ulcer assessment should include:*
        - *cause of ulcer*
        - *site/location*
        - *dimensions of ulcer*
        - *stage or grade*
        - *exudate*[25] *amount and type*
        - *local signs of infection*
        - *pain*
        - *wound appearance*
        - *surrounding skin*
        - *undermining/tracking (sinus or fistula)*[26]
        - *odour, and*
        - *involvement of clinical experts – e.g. tissue viability nurse.*

[25] Exudate is any fluid that filters from the circulatory system into lesions or areas of inflammation.

[26] A sinus is an abnormal track that originates or ends in one opening. A fistula is an abnormal canal between two anatomical spaces or a pathway that leads from an internal cavity or organ to the surface of the body.

'This should be supported by tracings and or photography (calibrated with a ruler).

- *Patients with pressure ulcers should have access to pressure-relieving support surfaces and strategies – for example, mattresses and cushions – 24 hours a day, and this applies to all support surfaces.*
- *All individuals assessed as having a grade 1-2 pressure ulcer should, as a minimum provision, be placed on a high-specification foam mattress or cushion with pressure-reducing properties combined with very close observation of skin changes, and a documented positioning and repositioning regime.*
- *If there is any perceived or actual deterioration of affected areas or further pressure ulcer development, an alternating pressure (AP) (replacement or overlay) or sophisticated continuous low pressure (CLP) system – for example low air loss, air fluidised, air flotation, viscous fluid – should be used ...*
- *Depending on the location of ulcer, individuals assessed as having grade 3-4 pressure ulcers – including intact eschar*[27] *where depth, and therefore grade, cannot be assessed – should, as a minimum provision, be placed on an alternating pressure mattress (replacement or overlay) or sophisticated continuous low pressure system – for example low air loss, air fluidised, viscous fluid).*
- *If alternating pressure equipment is required, the first choice should be an overlay system, unless other circumstances such as patient weight or patient safety indicate the need for a replacement system.*
- *Create the optimum wound healing environment by using modern dressings for example hydrocolloids, hydrogels, hydrofibres, foams, films, alginates, soft silicones – in preference to basic dressing types – for example gauze, paraffin gauze and simple dressing pads.'*

104. Under a separate section entitled '*Recommendations: pressure-relieving support surfaces*' it states: '*Decisions about choice of pressure-relieving support surfaces for patients with pressure ulcers should be made by registered health care professionals*'.

Complaint handling

105. *The Local Authority Social Services and National Health Service Complaints (England)* Regulations (the Complaints Regulations) came into force on 1 April 2009. Under the heading '*Investigation and response*' it states:

'14. – (1) A responsible [organisation] to which a complaint is made must –

(a) investigate the complaint in a manner appropriate to resolve it speedily and efficiently; and

(b) during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation.

[27] Eschar – brown or black necrotic, devitalised tissue; can be loose or firmly adhered, hard, soft or soggy.

(2) As soon as reasonably practicable after completing the investigation, the responsible [organisation] *must send the complainant in writing a response, signed by the responsible person, which includes –*

(a) a report which includes the following matters –

(i) an explanation of how the complaint has been considered; and

(ii) the conclusions reached in relation to the complaint, including any matters for which the complaint specifies, or the responsible [organisation] *considers, that remedial action is needed; and*

(b) confirmation as to whether the responsible [organisation] *is satisfied that any action needed in consequence of the complaint has been taken or is proposed to be taken ... .'*

Annex B: The Care Home records

106. At the start of our investigation in October 2010 a Resident's Register for the Care Home was provided. It shows that Mr M stayed in the Care Home for the following dates: 1 September to 7 September 2008; 2 November to 9 November 2008; 7 March to 15 March 2009; 23 June to 1 July 2009; 19 September to 25 September 2009; 6 October to 13 October 2009. The last entry did not record when Mr M was discharged or to where. However, when the Ombudsmen's investigators attended the Care Home to conduct interviews in October 2011, this document was made available and it had been completed.

107. On 15 July 2008 a care co-ordinator for the Council's Older People's Team provisionally booked a period of respite for 1 to 7 September at the Care Home for Mr M. This was in response to the Older People's Team agreeing that Mr M needed to come into respite to give his wife a break from caring for him. The care co-ordinator noted that Mr M would be taken to the Care Home for an assessment to be carried out. On 30 July 2008 the Care Home Manager completed a form entitled *City of Wakefield Metropolitan District Council Family Services – Initial Respite Care Profile*. Following this, in March 2009, an updated service plan by the Older People's Team named the Care Home as the provider of respite breaks for Mr M.

108. An assessment and care plan for Mr M was drawn up on 2 November 2008 by the Care Home Manager. On 15 March 2009 (at the end of an admission) the Care Home Manager completed a Waterlow pressure ulcer prevention/treatment policy form. This showed a score of 11, indicating that Mr M was assessed as being '*at risk*' of developing a pressure ulcer at that time. There was a handwritten annotation at the bottom of the form stating: '*on pressure cushion for sitting. Checked* [sic] *areas am and pm. Cavilon to apply*'. The care plan relating to personal care (which includes washing, bathing and skin care) was amended by the Care Home Manager for the next admission on 23 June 2009 to state: '*Catheterised. Needs leg bag changing weekly and night bags, refer to DN* [District Nurse] *if problems*'. The Care Home Manager amended this sheet again on 19 September 2009 to say '*Sacral area very sore on discharge from hospital. Staff to apply creams twice daily and report and record any changes*'. On Mr M's admission in October 2009, the Care Home Manager made additions and alterations to the '*Mobility*', '*Moving & Handling*' and '*Sleep Pattern*' sections of the care plan, and the care plan monthly review sheet stated on 7 October 2009 '*Care plan updated where necessary*'.[28]

109. Staff at the Care Home told the Ombudsmen's investigators that whenever Mr M came into the Care Home for respite care, his wife provided information sheets including details of his medication and personal possessions. At the start of the investigation, the Ombudsmen were provided with a copy of one such information sheet that was erroneously dated '*23 June 1909*'. It stated: '*Cavilon cream to sore bottom*' and next to it was a handwritten annotation stating *'am and pm please*'. Below that it states: *'Has a*

[28] This suggests that the care plan for personal care did not need to be amended on admission in October, so the instruction to apply cream twice daily was still valid.

catheter insitu ... 9 night bags + 1 day bag ... (day bag was changed Tuesday 23rd June) ... emergency catheter pack for use if catheter needs changing'.[29]

110. At interview in October 2011, a number of staff at the Care Home confirmed the procedure for completing the daily log, which is used to record detailed regular everyday care given to residents. They explained that, towards the end of a shift, all the care staff sit together around a table and take a resident's file from a box or pile. This may or may not be a resident they have had any contact with during the shift. Staff then tell each other verbally what has been done and a record is made. Some staff sign their initial next to the entries (though this means only that they have written the record, not that they provided the care). Some staff do not sign or initial entries at all.

111. The daily log for the penultimate stay on 19 September 2009 afternoon shift records ' ... s*acral area sore* ... ' and for the night shift it states ' ... *Bottom very sore cream ... applied*'. The log for 20 September records ' ... cream applied to bottom ... '. On 22 September it records ' ... [Mr M] *sat on pressure cushion*'.

112. On his last admission, the daily log for the night shift on 10 October 2009 states '*cream applied to* [Mr M's] *bottom it is very sore* ... '. The daily log for 11 October morning shift states '*bottom creamed am*'. At interview, some staff said that if they applied cream they would definitely record it in the daily logs and if there was no reference to such action, then it will not have been done. Others said that a lack of recording did not mean it had not happened.[30]

113. At interview with the Ombudsmen's investigators in October 2011, the Social Worker had copies of Mr M's Care Home records which she obtained on 20 October 2009 when visiting the Care Home in connection with the safeguarding investigation. The Ombudsmen's investigators noted instances where the set of records provided to the Ombudsmen in October 2010 included information not present in the copies held by the Social Worker: for example, the entry dated 11 October 2009 which states '*bottom creamed am*' and an entry on 12 to 13 October which states '*sacral area washed and creamed*'. In the copy held by the Ombudsmen, the additional note for 12 October is written in a different handwriting from the rest of the note. The carer who made the note for that shift (the first Carer) explained at interview that she had forgotten to record this information at the time and so had later asked a colleague to do so. However, the annotation is not on the copies held by the Social Worker, so it must have been made at least a week after the event.

114. Handover sheets are used to record which staff are on duty at each shift and any information about individual residents that needs to be passed on to the next shift. There is a space for each resident, which is completed three times a day at shift handover. Managers or senior carers

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[29] This suggests that the information sheet was supplied when Mr M went into the Care Home on 23 June 2009.

[30] This made it very difficult for the Ombudsmen's investigators to identify the authors of the entries. Staff suggested the name of a colleague who might have made a particular note, but this was denied by the individual concerned.

pass on the information from these sheets verbally to the next shift of carers. On the handover sheets for the period in question, the only references to Mr M receiving care for his sacral pressure area or similar are (i) the morning shift of 9 October 2009 which states: *'creams applied to groin areas very reddened*'; (ii) the afternoon shift of 9 October, where '*creamed*' is noted; and (iii) the night shift of 10/11 October, which records '*changed bottom creamed very sore*'. At interview most staff recalled information being handed over to them about the need to monitor Mr M's catheter, rather than about monitoring his pressure ulcer, though some staff made vague and generic references that '*it* [that is, pressure ulcer care] *would be handed over* [that is, always]'.

115. The night shift daily log for 12 October 2009 recorded that Mr M's catheter was '*bypassing*'[31] and that he might need a visit from a district nurse in the morning. The morning shift daily log for 13 October recorded: '[District nurse] v*isit requested ... catheter changed slight blood loss if doesn't settle down to contact DNs*'. The afternoon shift records: '[Mr M] *fine. Nurse been to see him. Eaten well at both meal times. Had drinks. Been changed, incontinent of faeces*'. On the afternoon shift it is noted:

    '[Mr M] has been asleep in the reception area. He hasn't eaten much at tea time. All fluids encouraged'. A separate entry made later in the shift states: '[Mr M] was unable to wake ... '. The Communications Book is used to record information about calls in or out of the Care Home for the residents and their care needs. On 13 October 2009 it states '[District nurse] visit requested for [Mr M] catheter bypassing'. Later in the evening it is recorded: '[Mr M] unable to wake all evening ... '. Telephone records supplied to the Ombudsmen by the Council show that on 13 October 2009 the Care Home made a call to the 'single point of contact' (this is a telephone system manned by clerical staff who take calls and pass them on to the correct group of district nurses) at 9.40am requesting the attendance of a district nurse. A further call was made to the single point of contact at 8.41pm that evening following which a call was made at 8.45pm to the West Yorkshire urgent care services line. An ambulance attended the Care Home (at about 9pm) and took Mr M to hospital.

116. On 14 October 2009 the assistant manager completed a statutory notification form relating to a 'notifiable event' about Mr M. It stated that:

    'from lunchtime onwards [he] *was sleepy, but this was not unusual. However, through the course of the evening staff found that they could not rouse* [him] *at all and his breathing was shallow and he felt clammy to touch also the catheter bag looked as if it contained blood. ... .'*

    There was mention of his catheter change that morning, but no mention of the pressure ulcer.

District nurse records

117. The district nurse records show that Mr M had had a catheter in place since May 2009 because of incontinence. The district nurse care plan for the catheter showed that it was due to be changed every 10 to 12 weeks or '*when blocked*'.

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[31] When a catheter is blocked urine can drain down the outside of the catheter rather than down the tube and into the collection bag.

118. A district nurse visited Mr M at home on 26 September 2009 and drew up a care plan (care plan 8), which referred to a wound on the left sacrum. An identical plan (care plan 9) refers to a wound on the right sacrum. Both care plans describe the maximum length, width and depth of the wounds as 2cm x 1.5cm and 1mm. The district nurse did not grade the pressure ulcer. The dressing prescribed was Mepilex[32] to be changed twice weekly (Tuesdays and Fridays) and it was recommended that Mr M be reviewed every two weeks.

119. The district nurse records show that the next day, 27 September (a Sunday), Mr M's '*dressing was rumpled and soaked in urine*'. It was recorded that the dressing was changed '*as plan*'. On 29 September (a Tuesday) a district nurse attended again and redressed the ulcer in accordance with the plan. She also carried out a Waterlow assessment for Mr M and noted the score to be 22, indicating that he was at '*very high risk*' of developing a pressure ulcer.[33]

120. On 3 October a district nurse made an emergency visit to Mr M because his catheter was blocked. It was recorded that Mr M's urine was '*very offensive smelling ... '*. A further emergency visit was made on 5 October to deal with a possible blocked catheter. There was no record for a change of dressing on 2 October (a Friday) in accordance with the plan and there were no entries on 3 or 5 October relating to pressure area care.[34]

121. On 13 October the Nurse recorded in the district nurse records (which were brought into the Care Home with Mr M) that she changed the catheter. She further recorded that he '*seemed uncomfortable, bleeding on removal and insertion, urine now draining clearer, advised to push fluids ... '* and to contact the district nurses if there were any further problems. She also made two entries in the records relating to Mr M's pressure ulcer on care plan 9 which stated *'1100hrs Sacrum checked scuffed only no dressing in situ left exposed advised carers to use cavilon*'.[35] On care plan 8 she recorded '*see care plan 9*'.

Hospital records

122. Mr M was recorded to have arrived in Accident and Emergency at the hospital at 9.21pm. At 10.45pm he was noted to be confused, had blood in his urine and it was offensive-smelling. It was recorded that he had poor mobility but had been mobilising with a walking frame before admission to respite care, and that he had

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[32] A dressing used to absorb oozing from wounds.

[33] The district nurse records show earlier Waterlow scores for Mr M between September 2007 and May 2009. There was no score below 20 in all of that time.

[34] Mr M had visiting carers provided by the Council who attended him in his own home each day to wash and dress him and assist him with toileting needs. On 1 October 2009 they visited at lunchtime and recorded that Mr M's wife had changed the dressing on his bottom. This is therefore the last documented reference to a dressing being in place.

[35] Cavilon is a cream used to protect unbroken skin against bodily fluids for example, oozing from wounds or urine.

been '*unwell for a few days*'.[36] A registrar (a middle grade doctor) assessed Mr M and recorded his impression that Mr M had urinary sepsis,[37] a chest infection; renal impairment;[38] and possibly having had a stroke. Mr M was transferred to the medical assessment unit at midnight.

123. In the medical assessment unit the nursing notes for 14 October (timed at 12.05am) include a pressure ulcer risk assessment score of 25,[39] and a grade 4 pressure ulcer is noted on the sacrum. The ulcer is recorded as measuring 6cm x 5cm. An Allevyn dressing was applied.[40] Mr M's pressure ulcer was reported as an incident on 17 October.[41] The pressure area care records made on this date clearly show that there was one wound but it was depicted in a diagram in the records as being across both buttocks.

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[36] It is not clear where this information came from. The Care Home's records show that Mr M was accompanied to the hospital by one of the carers (the fifth Carer) but she said at interview with the Ombudsmen's investigators that she had no recollection of what happened at the attendance (Annex B).

[37] The body's response to infection in vital organs, in this case the kidneys.

[38] Kidneys not working properly.

[39] This is the Waterlow score (a well-known risk assessment tool used throughout hospitals in the UK) and denotes that a person is at '*very high risk*' of developing pressure ulcers.

[40] A dressing used for the management of chronic wounds that are oozing.

[41] This is a requirement if a person is admitted, or discharged, with a pressure ulcer (according to RCN and NICE guidance – Annex A, paragraph 103).

Annex C: The evidence from interviews

124. Two years had passed since the events complained about and the recollections of staff were limited. The following are the most relevant points from the interview.

The Care Home Manager

125. The Care Home Manager said that staff visit a prospective respite resident before they are admitted to ensure that the facility can meet their needs. When residents arrive, staff carry out an overview and specific assessments. On any subsequent admission, staff consult the social worker and family to see if there has been any deterioration.[42] The Care Home Manager said that the Care Home formulates care plans and makes additions as appropriate. She said that Mr M brought in an electronic cushion from home so the Care Home staff were aware of his pressure area problem.[43] She said staff knew that they had to apply cream because Mr M's wife had brought it in and explained. The Care Home Manager said Mr M did not arrive at the Care Home with a pressure ulcer, just a red area. She said she saw Mr M's sacral area a couple of days before 13 October and it was just red, not broken. The Care Home Manager said that if Mr M had had a grade 4 pressure ulcer on 13 October, they would have been able to smell it.

126. The Care Home Manager said that practice varied among staff members in the way they recorded care given but most have had training. She said staff do not record that someone is washed and had cream applied every day because this is standard and repetitive. The Care Home Manager was asked about the apparent alterations made to the notes after the event. She said she was unaware of this and could not recall it, even though she acknowledged that the alterations had been made in her handwriting.

127. The Care Home Manager said staff had asked the Nurse to look at Mr M's pressure area. She said there was no specific log to record instructions given by district nurses, and they would be recorded in the care plan.[44] When asked about the monitoring of Mr M's catheter bag after the Nurse's visit on 13 October, the Care Home Manager said such monitoring was probably not recorded anywhere, but it would have been observed. She had seen the catheter bag herself that day.

128. The Care Home Manager said there were no concerns about Mr M's eating and drinking leading up to his hospital admission. Most staff agreed with that, but it was generally agreed that Mr M had not eaten much of his tea that evening.

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[42] There is no evidence that a social worker was consulted in respect of Mr M's stay at the Care Home in October 2009.

[43] Some Care Home staff made reference to Mr M having a pressure cushion, though not all.

[44] There are no references in Mr M's care plan following the Nurse's visit on 13 October 2009. The only record of the action taken was made by the Nurse herself in the district nursing notes.

The assistant manager at the Care Home

129. The assistant manager said that when Mr M arrived at the Care Home, they were informed that he had a reddened area that required having cream applied twice a day. She confirmed that it was she who had telephoned for a district nurse on 13 October 2009 to look at Mr M's catheter. The assistant manager said the Nurse advised that Mr M be monitored for more blood loss (there had been some bleeding when the catheter was changed) and, if significant, to contact her again. The assistant manager said that this advice was given to her downstairs by the Nurse before she left. The assistant manager could not recall any mention of Mr M having any reddened areas at the time. She said that when a district nurse gives instructions, this would probably be recorded in the Communications Book.[45] The assistant manager could not explain why there was no such record in this case.

A carer who saw Mr M on 11 October 2009 (the second Carer)

130. The second Carer recalled that she had helped to get Mr M up on 11 October 2009 and remembered that his bottom was a little bit sore at that time. She applied cream and said they would keep an eye on it and if the next day it was any worse, they would call a district nurse. She reiterated that it was only a little bit red. She could not recall how big it was, just that it was '*red skin*'.

A carer who was present during the Nurse's visit on 13 October 2009 (the third Carer)

131. The third Carer said that a colleague had told her on the morning of 13 October that Mr M's catheter was bypassing. She and a colleague went to get him up and it was still bypassing. This information was passed to managers, who telephoned for a district nurse. The third Carer said she could not remember who, but someone also handed over the information that Mr M's bottom was a bit sore and that when the Nurse came she should be asked to look at that as well. When the Nurse attended, the third Carer and her colleague told her about the soreness and the Nurse said she would have a look. The third Carer said she saw the pressure ulcer, which was the size of a 20 pence piece and looked like a carpet burn, with just the first layer of skin off. She recalled that the Nurse advised them to apply Cavilon cream and monitor the ulcer, and if there were any changes she would come back. When asked at interview what happens when advice is provided by a district nurse, the third Carer said that whoever receives that advice will pass it on to the office staff and then it is shared with colleagues. The third Carer said it was usual practice for district nurses to collect the district nursing notes before seeing a service user. However, she could not remember the Nurse writing anything in the notes at the time.

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[45] This point was endorsed by one of the senior carers. However, there is no reference in the Communications Book to any advice from the Nurse who attended.

Another carer present during the Nurse's visit on 13 October 2009 (the fourth Carer)

132. The fourth Carer said she had been called in with a colleague to see to Mr M with the Nurse. The fourth Carer said that, in Mr M's bedroom, the Nurse asked the care staff to clean Mr M before she looked at his pressure area. The fourth Carer thought there was a dressing on the area and she did not see the ulcer. She could not recall the Nurse giving any advice in relation to Mr M's catheter or pressure ulcer at the end of the visit. The fourth Carer could not remember the Nurse writing any notes at the time.

A carer who accompanied Mr M to hospital (the fifth Carer)

133. The fifth Carer was on duty and travelled with Mr M to hospital in the ambulance, but was unable to recall any detail of Mr M's visit to hospital.

The Nurse

134. The Nurse explained that she is a community nurse, not a qualified district nurse. She said that service users coming into the Care Home who did not normally live in the local area had to temporarily register with one of two local GP practices. She was regularly called out to the Care Home but she did not know Mr M. The Nurse said that on 13 October 2009 she was called to attend Mr M at the Care Home through the 'single point of contact' system. The Nurse said it was not clear at that stage to which GP practice Mr M was to be allocated and so she attended him as an emergency because he had a problem with his catheter. As Mr M had a catheter fitted, he would have had an ongoing district nursing need. It would have been the Care Home's responsibility to notify the district nurses when a service user came in who required such input.

135. When the Nurse arrived at the Care Home, one of the carers told her that Mr M's catheter had been bypassing overnight. She looked through his district nursing records and noted that he had required previous regular changes of his catheter for the same reason. She noted that Mr M seemed confused. However, as she had never met him before, it was difficult to know if this was more or less than usual. She remembered asking staff about his normal levels of communication. She talked to him as she carried out the procedure to explain what was happening but she was not sure he understood what she was saying. Having re-catheterised Mr M, the Nurse noted that the new catheter did not flow particularly freely and there was some blood in the catheter bag. She told the carers they should monitor the catheter, encourage Mr M to take fluids, and contact her if further problems occurred.

136. The Nurse said at interview that she did not recall whether anyone at the Care Home had said anything to her about a pressure ulcer. However, she had noticed that the carers brought Mr M into his bedroom in a wheelchair. This meant that he had mobility problems and so she was alerted to the possible risk of pressure area problems. She observed that he did not have the correct equipment in place for pressure management; there was no pressure cushion in his wheelchair. She checked his sacrum and noticed a '*scuffed*' area. She advised staff to use Cavilon cream and then she completed care plan 9, which related to a pressure ulcer on the left sacrum. She also cross referenced this information onto care plan 8 (which referred to a right-sided pressure ulcer).

She said at interview that there was only one pressure ulcer and it was about a grade 2 according to EPUAP (Annex D). She said grade 2 pressure ulcers were superficial with scuffed or broken skin but they did not always need a dressing, as these can sometimes cause more damage. In Mr M's case, she did not advise a dressing. She told staff she would be back in touch about an air mattress for Mr M's pressure care.

137. The Nurse said she telephoned the Care Home later that day (she could not remember the time but it would have been before she went off duty at around 4.30pm).[46] The Care Home staff told her that Mr M had gone into hospital. She had by that time found out which GP practice Mr M was temporarily registered with and so she advised the Care Home that they should contact that practice when he came out of hospital.

138. When asked at interview about the hospital's finding that Mr M had a grade 4 necrotic pressure ulcer, the Nurse said she had seen documentation that indicated that Mr M's pressure ulcer was grade 1 on 29 September 2009.[47] She also pointed to the district nursing notes for 5 October 2009 (the day before Mr M went into the Care Home) which did not imply that his pressure ulcer required dressing, as he had been seen that day for a catheter change and no record was made of any need to dress his pressure ulcer. She said she had definitely not seen a grade 4 pressure ulcer when she saw Mr M that morning. She said '*you don't see many grade 4s*'. If there had been an ulcer of that grade, a risk management plan and incident procedures would have had to have been followed. Looking at the hospital notes, the Nurse commented that on 14 October staff wrote that they were going to apply 'Sudocrem'[48] to the pressure ulcer. She said '*you would not be applying cream to a grade 4 pressure ulcer*'.[49]

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[46] After the interview, the Nurse informed us that she had since established that she telephoned the Care Home on 14 October, not 13 October. She also said that, on return from the visit the previous day, she told a district nurse colleague about the pressure ulcer but this was not recorded anywhere.

[47] The Nurse was referring to the minutes of the case conference in October 2009 based on evidence from the district nurse who attended Mr M at home on 29 September 2009. However, this district nurse did not include a grading of the ulcer in the records.

[48] An antiseptic ointment that can be used as protective barrier on vulnerable skin.

[49] In view of this apparent discrepancy, we rechecked the hospital records. The handwritten entry timed at 5.30am on 14 October 2009 is difficult to read but it says, '*Scrotum area sore – hygiene cares* [given] *sudocrem applied*'. There is a separate reference in the same note to the grade 4 pressure ulcer to the sacrum.

Annex D: Clinical advice

The Nurse Adviser

139. The Nurse Adviser provided some background information about pressure ulcers.

'A pressure ulcer (previously known as a bedsore or pressure sore) is an area of localised damage to the skin and underlying tissue caused by the effects of shear[50] and compression, or a combination of these on the skin over time, in association with a number of other factors which vary from individual to individual.

'The European Pressure Ulcer Advisory Panel (EPUAP) and National Pressure Ulcer Advisory Panel (NPUAP) published a Pressure Ulcer Classification System in 2009. It categorises four stages (or grades) of pressure ulcer severity:

Stage or grade I

Intact skin with non-blanchable redness[51] of a localised area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler compared with adjacent tissue.

Stage or grade II

Partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed, without slough.[52] May also present as an intact or open/ruptured serum-filled[53] or sero-sanguinous[54] filled blister.

Stage or grade III

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunnelling.

Stage or grade IV

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunnelling.'

140. The Nurse Adviser listed the factors likely to increase a person's risk of developing a pressure ulcer:

- extremes of age
- immobility/reduced mobility
- medical condition, for example, stroke/ paraplegia
- medical interventions, for example, drug therapy prescribed

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[50] Shear forces occur when a part of the body tries to move but the surface of the skin remains fixed.

[51] This is redness that does not disappear when pressed.

[52] Dead skin tissue.

[53] A clear fluid that comes from the blood.

[54] A combination of blood and serum.

- peripheral vascular disease (PVD)[55]
- nutrition – in particular, low protein or carbohydrate intake
- the type of support surfaces being used
- the type of care setting
- nursing/carer interventions, for example, not initiating regular repositioning
- social factors, for example, smoking/ alcohol intake.

141. The Nurse Adviser said there were a number of factors that put Mr M at increased risk of developing a pressure ulcer. These included:

    - his medical conditions – long-term angina, atrial fibrillation, pernicious anaemia, Parkinson's disease and possible Alzheimer's disease. The Nurse Adviser said:

      'Alzheimer's, depending on its progression, could certainly have an impact on a person's risk of developing a pressure ulcer as it is not unreasonable to assume that associated mood changes may affect a person's willingness to co-operate with requests such as to move or eat.'

    - taking multiple medications for a prolonged period of time to stabilise these medical conditions. The Nurse Adviser said '*this could have a negative effect on a person's skin tolerance to pressure*'.
    - prolonged periods of immobility/ prolonged sitting. The Nurse Adviser said '*It is widely accepted that the majority of pressure ulcers are likely to develop when people are seated, due to the effects of shearing forces*'.
    - inappropriate provision of pressure reducing/relieving equipment.

142. The Nurse Adviser explained how quickly a pressure ulcer can develop. He said:

    'While there is evidence in the literature to suggest that damage caused by pressure can start within two to four hours of immobility, this is primarily at circulatory level and would not usually be noted on a person's skin on day one, except by someone with a very trained eye who is both assessing the person's skin at frequent intervals throughout the day and who is able to identify and recognise the progression of non-blanching hyperaemia (Collier 1999).[56] *In general, the only other situations in which you might expect rapid skin deterioration or development of visible pressure ulcers or skin damage would be: (a) where a person has persistent undiagnosed systemic sepsis over time, though the resulting skin changes will occur at a certain time point, not usually within twenty four hours; and (b) when a person is known to be terminally ill and in the last stages of life, or if they are suffering from "total system shutdown", in particular, the circulation (Kennedy ulcers). Neither of these situations had been diagnosed in relation to Mr M while he was in the Care Home or following his initial admission to hospital.'*

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[55] A condition of the blood vessels that leads to narrowing and hardening of the arteries that supply the legs and feet. This leads to decreased blood flow, which can injure nerves and other tissues.

[56] Hyperaemia is the increase of blood flow to various tissues in the body.

Comment on the development of Mr M's pressure ulcer

143. The Nurse Adviser noted that Mr M was said to have a grade 1 pressure ulcer on discharge from hospital in August 2009. He noted that at home on 26 September Mr M was recorded as having a pressure ulcer on his sacrum measuring 2cm x 1.5cm x 1mm. He noted there was no grading of the ulcer but said it was likely to have been a grade 2/3. The Nurse Adviser said *'the ulcer was managed with Mepilex Border, which is an interactive foam dressing that provides the ideal wound healing environment, while at the same absorbing any exudate*'. He noted the instruction to change the dressing twice a week.

144. The Nurse Adviser said:

'Mr M would have been at high risk because of all of the risk factors highlighted above'.

He noted that there was little evidence of any assessment or reassessment of Mr M's risk of developing pressure damage, or that preventative actions were identified and put in place, or that Care Home staff were given any additional advice on this admission.

145. The Nurse Adviser said:

'where pressure-relieving equipment is used, it should be in place for all twenty-four hours of each day, and seating equipment (cushions) should match the function (pressure reducing/ relieving) of any equipment used on a person's bed, in accordance with NICE guidelines (2003/2005).'

146. The Nurse Adviser asked the Ombudsmen's investigators to make some specific enquiries of the Care Home about the equipment they had available. The standard mattress in use at the time for all service users was a divan. If service users were identified as being at high risk of developing pressure ulcers, there were some Propad (pressure reducing) mattresses available. The Nurse Adviser said:

'these are "toppers" only, not high specification mattress replacements, and would normally be used for people at low risk primarily to encourage greater comfort and therefore encourage more independent movement – if applicable – while on the bed.'

It was noted that Mr M used a divan mattress during his stay and had brought his pressure-reducing cushion with him from home.

147. The Nurse Adviser said:

'It would appear that throughout his stay in respite care Mr M used a divan mattress and there is no evidence to suggest that any pressure reducing or pressure relieving support surfaces were utilised on his bed throughout his time in the Care Home. Although Mr M had his own pressure reducing cushion, there is no record to suggest this was used at any point during his stay.'

148. Turning to the events on 13 October, the Nurse Adviser noted that the Nurse observed a scuffed area on Mr M's sacrum. He said:

'It is unclear whether there was a broken area because the Nurse did not categorise the damage. I would have expected her to apply an interactive dressing if the skin was broken at all (grade 2 or above damage) to promote healing and prevent further deterioration. She advised using Cavilon skin protectant only.'

149. The Nurse Adviser went on to say:

'It is reported that Mr M was taken down to the day room around lunchtime and spent the rest of the day. I would have expected to see evidence that he was offered pressure relief by way of a cushion or assisted standing/change of position. The pressure cushion was not mentioned as having been used during this time. I would also have expected to see evidence that the damaged skin was further inspected at points during the rest of the day until Mr M was taken to hospital. There was no evidence of this either.'

150. The Nurse Adviser noted that in the early hours of 14 October at the hospital, Mr M was found to have grade 4 pressure damage to his sacral area.

151. The Nurse Adviser cited a statement that appeared on the DH website in 2009 and was subsequently incorporated into *Nurse Sensitive Outcome Indicators for the NHS and commissioned car*e published by the DH in 2010:

'For patients admitted or transferred to a healthcare setting without any obvious signs or symptoms of pressure area skin damage, the development of a pressure ulcer of stage three or four within 72 hours is likely to be related to pre-existing damage incurred prior to admission or transfer of care. For any pressure area damage arising thereafter, the most likely cause will be related to care within the health care setting the patient is in; this must be regarded as a new event.'

The Nurse Adviser said this is relevant in this case because the Nurse said she saw only minor skin damage (a scuffed area) on the morning of 13 October 2009.

152. In considering whether Mr M's pressure ulcer could have developed after he left the Care Home on 13 October, the Nurse Adviser said:

' ... this is unlikely in view of the DH statement above ... Additionally it could be surmised that if a grade 2/3 pressure ulcer was identified and was being managed on Mr M's sacrum on 26 September, it would be unlikely to have "healed" by the time of his admission to the Care Home on 6 October due to a number of factors that would have compromised his healing potential to some extent – such as his medical conditions, circulation, nutritional factors, immobility etc. Additionally, if the management plan (use of Mepilex foam dressings and twice weekly dressing changes) was not maintained as prescribed (and there is no evidence to show that it was), it could be surmised that Mr M's skin condition would have deteriorated (not healed) to some extent while in the Care Home and that the Nurse most likely misclassified – or failed to appreciate the extent of – his skin damage when she assessed this on 13 October 2009. Furthermore, in view of Mr M's risk factors and the lack of evidence to show that he was frequently moved or assisted to change position, it must be concluded that he spent long periods of time in the same position – be that in a chair or on a bed whilst in the Care Home – exacerbating his already compromised skin condition as reported on 26 September.'

153. The Nurse Adviser concluded:

' ... Mr M's pressure damage was, in all probability, already present at the time of his admission to hospital. Due to the severity of his illness at that time (not recognised by the Care Home staff earlier

that day or at any other point in his stay previously), when the skin in his sacral area did completely break down, this simply revealed the true extent of the damage (grade 4) which is most likely to have occurred over time.'

The Medical Adviser

154. The Medical Adviser noted from the district nurse records that Mr M had urinary overflow problems requiring urinary catheter changes on 27 June, 4 August, 2 September, 27 September, 3 October, 5 October and 13 October 2009. The records showed that Mr M's urine smelt strongly on 27 September and was noted to be '*offensive smelling*' on 3 October. He said '*This would indicate that the urine was infected*'. He further commented that given the seven changes of catheter from June to October '*it would appear that Mr M had persistent infection of his urine*', although there are no urine culture results from that period to confirm this.

155. The Medical Adviser said the procedure by the Nurse to change Mr M's catheter appears to have been appropriate. He said '*It is probable that Mr M was suffering from a bladder/urine infection prior to the catheter change, and the procedure may have disturbed the situation leading to bacteraemia*'.[57]

156. The Medical Adviser noted that, after the catheter change, Mr M was admitted to hospital with a reduced level of consciousness (his Glasgow coma score was between 9 and 11 out of a possible 15). The Medical Adviser noted from the hospital records that Mr M was diagnosed with urinary sepsis.[58] He had a white cell count of 58.2[59] and impaired kidney function. There was evidence of lactic acidosis[60] and septic shock.[61] The Medical Adviser said '*Gram negative bacilli*[62] *were cultured from the blood indicating the urine as the most likely cause for Mr M's septicaemia*'. He said this type of bacteria is more likely to be linked to urinary tract infections, although it can be associated with pressure

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[57] Bacteraemia occurs when bacteria enter the bloodstream. This may occur through a wound or infection, or through a surgical procedure or injection. Bacteraemia may cause no symptoms and resolve without treatment, or it may produce fever and other symptoms of infection. In some cases, it can lead to septic shock (footnote 61).

[58] Urinary sepsis is bacterial infection of the blood. In Mr M's case, this was probably due to a urinary tract infection.

[59] A high white blood cell count is an indication of infection. The figure of 58 is very high; the normal level is about 5.0.

[60] Lactic acid is produced when oxygen levels in the body drop. Lactic acidosis is when lactic acid builds up in the bloodstream faster than it can be removed. This can be caused by, among other things, kidney failure, respiratory failure, or sepsis.

[61] Septic shock is a serious condition that occurs when an overwhelming infection leads to life-threatening low blood pressure.

[62] A type of bacteria with an outer membrane that protects it from a number of antibiotics, making it resistant to treatment.

ulcers. However, looking at Mr M's history of repeat possible urinary tract infections, foul-smelling urine, and the change of catheter, the Medical Adviser said it was highly likely that the urinary tract was the source of Mr M's urinary sepsis. The Medical Adviser said that urinary sepsis is different from urinary tract infection: he explained that sepsis is usually defined as *'a clinical situation involving infection and evidence of organ or tissue damage*'.

157. The Medical Adviser said it was important to note that Mr M was treated effectively with intravenous antibiotics in hospital and his condition improved. Mr M then succumbed to another urinary tract infection from which he died some six weeks later. As such, he concluded that Mr M's death on 23 November 2009 could not have been caused by the same infection that he originally came into hospital with (urinary sepsis resulting from the catheter change that day) on 13 October 2009.

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