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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

By Mr W

against

Aneurin Bevan University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201707515

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Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr W, and his father as Mr R.

Summary

Mr W complained that the Health Board failed to provide appropriate wound care to his father, Mr R, during his admission to a Community Hospital. Mr R had undergone a total hip replacement following a fall at home and was subsequently discharged to the Community Hospital for rehabilitation. Mr W said that staff at the Community Hospital failed to identify, manage and treat his father's post-operative infection, or arrange for his transfer back to the District General Hospital, for treatment, appropriately. He said that, as a result of the failings in care, Mr R succumbed to further post-operative complications, developed hospital-acquired pneumonia, and sadly passed away.

The Ombudsman found that appropriate dressings were not used at any time throughout Mr R's care and his wound clips remained in situ throughout his admission, which was likely to have exacerbated his infection. In addition, there was no comprehensive review of Mr R or his wound by a doctor after the initial admission assessment, despite clear evidence that infection was present. Senior medical advice should have been sought promptly from the District General Hospital and the failure to do so delayed appropriate treatment for Mr R by at least a week, which made it more difficult to treat the infection, and for Mr R to fight it. The Ombudsman also found that the Health Board failed to ensure that it had fully informed the Welsh Ambulance Services Trust of Mr R's condition, or that appropriate transport was arranged to transfer him back to the District General Hospital.

It was recommended that the Health Board apologise to Mr W, and offer him £2000 in recognition of the failures identified and the repercussions for Mr R. It was also recommended that the Health Board would share the outcome of this complaint with staff at both the Community Hospital and the District General Hospital, highlighting the important learning points including early recognition of signs in the deteriorating patient, comprehensive record-keeping and the sharing of appropriately detailed hand-over information.

It was also recommended that the Health Board ensure its Wound Management Guidelines are up to date and remind all staff of the properties/appropriate uses of the listed dressings, as well as undertake an audit to determine that all staff training on the Principles of Wound Management is up to date. Where training is not up to date, it was recommended that those staff members should be given training as soon as possible. Finally, it was recommended that the Health Board should provide evidence to the Ombudsman that it has robust handover systems in place at both the District General Hospital and the Community Hospital for arranging patient transfers and that it has adequate arrangements in place for senior medical review at the Community Hospital.

The Complaint

1. Mr W complained about the care his father, Mr R, received from the Health Board whilst an inpatient at a Community Hospital following hip replacement surgery. Specifically, Mr W complained that between 20 October and 4 November **2017** the Health Board failed to:

(a) ensure appropriate wound care

(b) identify, manage and treat Mr R's post-operative infection

(c) arrange Mr R's transfer back to the District General Hospital appropriately.

Investigation

2. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr W. I sought advice from Dr Matthew Puliyel, a Consultant Physician and accredited Geriatrician ("the Consultant Adviser"). I also sought advice from Mark Collier, a Nurse Consultant and Associate Lecturer in Tissue Viability ("the Nursing Adviser"). I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Both Mr W and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant legislation

4. The aseptic non-touch technique ("ANTT"), outlines recommended procedure to prevent bacteria or other microorganisms being introduced to a susceptible site, such as a surgical wound. It aims to reduce the risk of surgical site infection.

5. The Health Board's Wound Management Formulary and Guidelines ("the Wound Management Guidelines") provides information on a definitive list of available dressings and guidance on their use. It is applicable to all Primary and Secondary care services throughout the Health Board area, including both district general and community hospitals.

The background events

6. Mr R was 92 when he fell at home and suffered a fractured hip, which was replaced on 14 September **2017** at a District General Hospital. There were no documented complications from the surgery, and Mr R was noted to be well in himself. It was noted, however, that blood tests had shown slightly raised CRP, a protein which indicates inflammation.

7. On 20 September, Mr R was transferred to a Community Hospital for rehabilitation. The discharge documentation from the District General Hospital noted that the clips holding the wound together should be removed in 14 days, and a follow-up appointment made for 6/8 weeks' time. The day after Mr R arrived at the Community Hospital, an Associate Specialist ("the Doctor") assessed Mr R as being clinically stable and appropriate to commence rehabilitation; a referral was made to the Physiotherapy Team. He noted that Mr R's CRP, although still high, had improved slightly and planned to conduct repeat blood tests the following week.

8. Throughout 21 September, Mr R was noted to be well in himself, with good appetite and fluid intake, and was mobilising with his Zimmer frame and the assistance of two people. He was independent in washing and changing his clothes. However, at 11.30pm it was noted that the wound had started oozing and the dressing was changed.

9. On Friday 22 September, Mr R reported to a physiotherapist that although he had pain when the dressing was changed, it had settled now. The physiotherapist noted that Mr R had an altered gait owing to weakness in his left hip, was struggling to fully weight bear and was mobilising with a Zimmer frame and assistance of one person. She recommended strengthening exercises to improve his gait and balance.

10. By Sunday 24 September, nurses noted that the wound was seeping a blood-stained fluid which required the dressing to be changed three times in four hours, and the area around it was very swollen and extremely hard with a small bruise. Swabs were taken and the On-Call Doctor was contacted by telephone. A nurse asked whether removal of the clips would allow the fluid to drain better, but the On-Call Doctor said that the clips should remain in place and a stoma bag (a collection device which is usually stuck to the skin around an opening in the abdomen and used to collect urine and/or faeces) should be placed over the wound to collect the fluid until the ward doctor reviewed Mr R the next day. A wound chart was started to monitor any changes.

11. On Monday 25 September, Mr R was reviewed by the Doctor, and prescribed Doxycycline (an antibiotic that controls bacterial growth and reproduction). The wound dressing was changed twice. The next day, however, the wound dressing required changing three times because it was still oozing blood-stained fluid with hardening of the surrounding skin. The antibiotics were changed to Flucloxacillin (an antibiotic that kills bacteria), blood tests were taken and Mr R was referred for an X-ray. The Doctor telephoned the District General Hospital, but the Trauma and Orthopaedic ("T&O") Surgeon who had conducted Mr R's initial hip replacement surgery was unavailable.

12. On 27 and 28 September, the Physiotherapy Team decided not to continue with mobility exercises owing to concerns about the wound and increased weakness. The Doctor emailed the T&O Surgeon to request advice on further management of the wound. The nursing staff recorded that a Tissue Viability Nurse ("TVN") visited Mr R and recommended to leave the clips in place and to ensure the dressing was changed at least twice a day.

13. During review on Friday 29 September, the Doctor noted that whilst the X-ray did not report any bone destruction, it could not exclude the possibility that infection was inside the bone. The results of the swabs showed significant infection which should be satisfactorily treated by the antibiotic Mr R was already taking (Flucloxacillin). The Doctor therefore noted that no change was required to the prescription, although the blood tests should be repeated after the weekend and the Physiotherapy Team should work with Mr R in the meantime to try to improve his mobility. However, a physiotherapist noted that after walking 5 metres Mr R's gait became increasingly affected, showing continued weakness in his hip.

14. By Saturday 1 October, the nurses recorded that Mr R's wound was weeping "significantly" and they were having to apply secondary dressings of two or three pads to try to contain the leakage. Further swabs were taken, and it was noted that there was a build-up of fluid causing the tissue surrounding the wound to harden.

15. The T&O Surgeon responded to the Doctor on Monday 2 October, by email, explaining that he had been out of the country. Mr R was transferred back to the District General Hospital by a Non-Emergency Patient Transport Ambulance ("the Ambulance") on 4 October. The Welsh Ambulance Services Trust ("WAST") later stated it was not informed that Mr R had recently had a new hip inserted, or that he had an infection in the wound; Mr R was therefore sat in the back seat of the Ambulance. The Ambulance crew offered for him to move to a better seat when they observed his discomfort. Two days later the staples were removed, and the wound was surgically washed out, but by 7 October Mr R's condition had significantly deteriorated. On 8 October Mr R was taken back into theatre and the wound was surgically washed out again. Sadly, Mr R continued to deteriorate; by 20 October he had developed hospital-acquired pneumonia and he died on 24 October.

Mr W's evidence

16. Mr W said that he had no complaint about the care provided at the District General Hospital. He said that at the Community Hospital the wound dressing was not changed often enough and the clips were left in too long, and that these things delayed the wound healing and allowed the infection to accumulate in the wound, making it more difficult to treat. Furthermore, he said that the staff failed to act promptly once the infection was identified, delaying the decision and arrangements to transfer Mr R back to the District General Hospital by more than a week, during which time the infection had spread to Mr R's bone, necessitating further surgery to wash the wound out.

17. Mr W also said that when Mr R was transferred back to the District General Hospital, staff at the Community Hospital did not ensure that the Ambulance crew were appropriately informed of his condition. Mr R was sitting on a seat from which his feet could not reach the floor, and WAST had advised him that the Ambulance crew were only informed that he had an infected recent hip operation by Mr R himself, when they noticed that he was in discomfort.

The Health Board's evidence

18. The Health Board said Mr R's wound was regularly monitored and re-dressed throughout his admission. Swabs were taken and antibiotics were prescribed to treat the infection, which was appropriate, although Mr R's temperature had remained normal and his NEWS (National Early Warning Score, which assesses vital signs and observations to quickly determine the degree of illness of a patient) was nil throughout his admission. It agreed that WAST would have needed to know that Mr R had an open, infected wound prior to his transfer.

19. The Health Board also said that it proactively implements a range of interventions to reduce the risk of surgical site infections, including promotion of ANTT, and that the Wound Management Guidelines and the dressings listed within it should have been available to staff at the Community Hospital. It also said that the Welsh Government is currently working to introduce a new system for monitoring

healthcare-related infection outbreaks, which would require that any wound swab taken for a patient who has undergone an operation in the previous 30 days to be reported. However, this is not yet in place.

Professional Advice

20. The Nursing Adviser said that:

- Wounds that are appropriately dressed should not need changing more than once every 2/3 days. The various dressings used throughout Mr R's stay in the Community Hospital were inadequate and not in keeping with appropriate practice or the Wound Management Guidelines. As such, they were inadequate to control the discharge from the wound, minimise further complications and optimise promotion of wound healing. Consequently, Mr R's dressing frequently needed to be changed because it was saturated. Each time a dressing is removed and changed the risk of infection or contamination increases. In Mr R's case it might also have encouraged more fluid to be produced, and exposing the wound was likely to have exacerbated the infection and delayed healing.

- It was poor practice that the TVN failed to document their attendance at all and, as a consequence of their advice being available only as it was reported within the nursing notes, the rationale for the decision not to remove the clips was not adequately explained or reported. It would usually be considered good practice, once infection was identified, to remove at least every other clip to allow the fluid to drain and to assess whether the clips were in any way exacerbating the situation.

- Despite clear evidence that basic observations and care were recorded through a number of appropriate document bundles and charts, there were occasions when documentation was not fully completed. There was little evidence in the records that the information recorded in the notes was adequately evaluated against previous occasions to prove a complete assessment of

changes in Mr R's condition. Furthermore, there was no evidence that such evaluative, relevant and important information was effectively communicated between nursing staff and doctors.

- It would have been anticipated best practice that Mr R's transfer, and his condition, should have been discussed with WAST on the telephone but there was no record of such a conversation. There was no documented evidence that the hand-over to the Ambulance crew who transported Mr R back to the District General Hospital was appropriate, or that WAST was appropriately informed of Mr R's clinical condition. Furthermore, there was no recorded hand-over sheet which should have been given to the Ambulance Crew when they arrived to collect him.

21. The Consultant Adviser said that:

- The steps taken at the District General Hospital, to prevent post-operative infection, were in line with standard protocol. However, Mr R's CRP level was persistently high and over ten times the normal level throughout his admission there. Whilst CRP is a marker of inflammation (and not necessarily infection), it would be expected to show a downward trend unless there was something else (such as infection) also present, causing it to be raised. Furthermore, it had been noted on 18 September that the wound dressing and bandage were wet. This suggests that the infection might already have been present, and it would have been good practice to remove the dressing and inspect the wound. There is no indication this happened before Mr R was transferred to the Community Hospital, which means that the decision to transfer him was probably based on an incomplete assessment. It is therefore possible that Mr R should have remained at the District General Hospital a bit longer given that the Community Hospital would have only limited access to specialist cover and would not have been able to ensure prompt surgical input, if it was required.

- The discharge notification from the District General Hospital on 20 September was inadequate to provide a complete and meaningful handover of Mr R's care to clinicians at the Community Hospital. It should have identified precisely which blood tests should be checked and explained the rationale behind it, to provide a meaningful picture of Mr R's clinical condition and alert the receiving clinicians to the potential for post-operative infection.

- The Doctor's initial assessment of Mr R, on 21 September, was incomplete because he did not remove the dressing to expose and assess the surgical wound for himself. However, it is not possible to determine conclusively whether doing so would have revealed visible evidence of any developing infection at that time.

- The failure of the On-Call Doctor to visit Mr R on 24 September was significant; it was entirely inappropriate to provide telephone advice suggesting the use of a stoma bag to collect the discharge, without examining Mr R or ordering any further investigations, and to defer action until the ward doctor returned the next day. The On-Call Doctor should have contacted the Surgical or Orthopaedic Team at that point to obtain advice and, ideally, Mr R should have been returned to the District General Hospital that same day. The wound clips should have been removed as soon as the wound began to weep, to allow the infection, and fluids oozing from it, to drain freely.

- There was a complete and demonstrable failure to recognise the seriousness of Mr R's infection and take action to address it. Senior surgical input should have been sought at the earliest sign of infection. By the time the Doctor sought advice from the T&O Consultant, on 28 September, sufficient time had elapsed for the infection to become well-established and by the time he received a response, on 2 October, it is likely that the infection had progressed to the point where it had become harder to eradicate. It was not necessary for the Doctor to contact the particular T&O Surgeon who carried out the initial operation, and the Doctor should not have waited to receive a response

from him; advice could have been appropriately sought from any senior member of the T&O team. The impact of this failure was that the extent of the infection was not identified or understood, and appropriate clinical input was significantly delayed.

- If Mr R's wound infection had been treated sooner, with appropriate antibiotics and surgical input, he might have rallied sooner and been able to sit out of his bed and mobilise which would have helped him to fight off the infection and have been less susceptible to subsequently developing pneumonia. Ultimately, this might have resulted in a different outcome for Mr R.

Analysis and conclusions

22. I find that the Health Board failed to ensure appropriate wound care for Mr R throughout his admission to the Community Hospital. It is unacceptable that, despite being listed in the Wound Management Guidelines, appropriate dressings were not used at any time throughout Mr R's care. I note the Nursing Adviser's comments that use of inappropriate dressings not only resulted in mismanagement of the wound and the discharge from it but might have served to aggravate or exacerbate the infection. In this context, I am concerned that the TVN, who should, because of their speciality, be able to provide appropriate and specialist care to all patients with a wound, failed to document their attendance and recommended twice-daily dressing changes without considering or advising on the types of dressings to be used. I am also particularly troubled by the advice of the On-Call Doctor, to adapt the use of a stoma bag to collect the discharge from Mr R's wound, without recognising or addressing the seriousness of the situation.

23. Furthermore, I accept both the Adviser's comments that the wound clips should have been removed as soon as the infection became evident and I am troubled that, despite both Mr W and the Community Hospital nursing staff raising this issue, both the doctors and the TVN seem to have been unaware of appropriate best practice. It is not possible to say with certainty precisely when Mr R's infection started, or whether appropriate wound care would have precluded the need, eventually, for surgical intervention. Nevertheless, I recognise that, ultimately, the

concerns of Mr W have been confirmed by the advice received – that the failure to provide reasonable and adequate wound care might have enabled the infection to take hold. Moreover, the Consultant Adviser has confirmed that the delays would have made it more difficult for clinicians to treat the infection, and for Mr R to fight it. This leads to a significant uncertainty for Mr W as to whether, had this infection been successfully addressed, Mr R might not have developed the subsequent pneumonia which lead to his death. I **uphold** this element of the complaint.

24. Notwithstanding the shortcomings in the care of the wound, I consider that the nursing staff maintained reasonable and adequate records regarding the care they provided and the progress of the wound and its discharge. I acknowledge the Nursing Adviser's comments that the nursing records were more descriptive than evaluative, but arguably interpretation of that information is, ultimately, the responsibility of the doctors. The records demonstrate that the nurses appropriately reported and escalated their concerns as the infection progressed and I would hesitate to criticise them too severely for failing to recognise the severity of the situation or, perhaps, failing to challenge clinical staff, when advised by doctors, effectively, to continue to "wait and see".

25. I also have a number of concerns regarding the identification, management and treatment of Mr R's infection. I was particularly concerned that there was no comprehensive review of Mr R or his wound by a doctor after 21 September, despite the fact that, by 24 September, the nurses were recording clear evidence that infection was present. The failure of the On-Call Doctor to visit Mr R to assess him meant that he did not receive antibiotics, and his case was not referred back to the District General Hospital until the following day. I cannot understand why the Doctor waited seven days for a response from the T&O Surgeon once he had realised that Mr R's case required more specialist input. Advice could, and should, have been sought from any other member of the T&O team at the hospital and the failure to do so delayed appropriate treatment significantly. Notwithstanding that Mr R appeared well in himself, I accept the Consultant Adviser's opinion

that this inordinate delay in treatment led to complications that might have been avoided, had prompt action been taken. I **uphold** this element of the complaint.

26. I do not believe the Health Board arranged Mr R's transfer back to the District General Hospital appropriately. I accept that WAST should be experienced and practised in transporting patients with a range of needs, including those with open and infected wounds. However, WAST confirmed that the crew were not informed Mr R had an infected hip-replacement and there was no evidence that this information was passed on to WAST by ward staff. Even if the Ambulance was booked orally, there should have been a record of that conversation, and the content of it, within the notes. The lack of any documented hand-over of care suggests that staff did not appreciate the transportation needs of Mr R, or communicate them to the Ambulance crew. The Advisers have both commented that it was inappropriate for Mr R to sit on a high chair in that situation, which would have increased his pain and discomfort. I therefore **uphold** this element of the complaint.

Recommendations

27. I **recommend** that, within **one month** of the date of this report the Health Board should:

(a) Apologise for the failings identified in this report.

(b) Offer Mr W £2000, in recognition of the service failures identified and the repercussions of those failings for Mr R.

(c) Share the outcomes of this investigation with relevant staff in both the Community Hospital and the District General Hospital, highlighting the important learning points including early recognition of signs in the deteriorating patient, comprehensive record-keeping and the sharing of appropriately detailed hand-over information.

28. I **recommend** that, within **three months** of the date of this report the Health Board should:

(d) Ensure all relevant staff are reintroduced to the current Wound Management Guidelines and reminded of the properties and appropriate uses of the listed dressings.

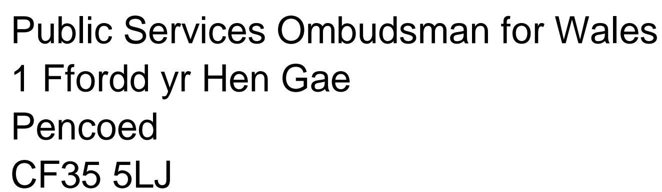
(e) Undertake an audit to determine that all staff training on the Principles of Wound Management and the use of Aseptic Non-Touch Technique ("ANTT") for all wound dressing changes is up to date. Where training is not up to date, those staff members should be given training as soon as possible.

(f) Ensure that it has robust handover systems in place at both the District General Hospital and the Community Hospital for arranging patient transfers, to ensure that WAST is fully informed of the patient's condition when they are moved between settings.

(g) Provide evidence to the Ombudsman that the Health Board has adequate arrangements in place for senior medical review at the Community Hospital.

29. I am pleased to note that in commenting on the draft of this report **Aneurin Bevan University Health Board** has agreed to implement these recommendations.

Nick Bennett 6 November 2018
Ombudsman



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