SPSO decision report

Case: **201608303, A Health Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of her client (Mrs B). Ms C raised concerns that the board did not take appropriate action in relation to an ulcer on Mrs B's daughter (Ms A)'s heel. Ms A had a number of complex health conditions, including diabetes, and Ms C complained that neither the podiatrist that saw Ms A, nor the surgeon that saw her, raised any alarm about the fact the heel wound was getting worse.

We took independent advice from a podiatrist and from a surgeon. We found that Ms A should have been seen by the lead podiatrist at an earlier point and that this may have resulted in a swifter referral to a specialist team. We also found that the podiatry team failed to appropriately use diabetic foot screening tools. We further found that the surgeon that saw Ms A recommended a treatment that would not be normal practice and did not document any reason for this. We found that whilst they reasonably arranged a scan for Ms A's foot, this should have been done at an earlier point, and a management plan should have been made. We also found that the board's own complaints investigation did not identify or address the failings in the care provided to Ms A.

We upheld this complaint. However, since the events of this complaint, the board had implemented a detailed and comprehensive action plan to improve the care pathways for diabetic feet, which we found reasonable. We, therefore, limited our recommendations to areas which we felt had not been covered by the board's action plan.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs B for failing to take appropriate action in relation to Ms A's heel wound and for failing to identify these issues in the complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Patients with diabetic foot ulcers should be referred to the lead podiatrist or the vascular service as appropriate in a timely manner, and diabetic foot ulcers should be assessed in line with diabetic foot screening tools.
- In similar cases, surgeons should be aware of what action to take.

In relation to complaints handling, we recommended:

- The board's complaints handling procedure should ensure that failings (and good practice) are identified, and should enable learning from complaints to inform service development and improvement.

We have asked the organisation to provide us with evidence that they have implemented the recommendations

we have made on this case by the deadline we set.