SPSO decision report

SCOTTISH PUBLIC SERVICES OMBUDSMAN

Case: **201905939, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment the board provided to their parent (A) after they stepped on a rusty nail and it penetrated their foot. A was initially seen at their GP practice and was then referred to the board. We took independent advice from a consultant orthopaedic surgeon (a specialist in the treatment of diseases and injuries of the musculoskeletal system).

C said that the board failed to provide A with appropriate care and treatment at Woodend Hospital for their painful toe. We found that A should have been seen in hospital within 12 weeks of referral, but was not seen until nearly eight months later, and after a second referral was sent by A's GP. C also said that the surgeon planned to amputate A's fifth toe during surgery, when it should have been their fourth toe. While the decision to amputate the fourth toe was reasonable, we noted that there was nothing in the medical records recording the misunderstanding about which toe was to be amputated. We also found that the specific risks of the amputation surgery were not mentioned to A at the clinic appointment at which the proposed surgery was discussed. Therefore, we upheld this part of the complaint.

C also complained that the board failed to provide A with appropriate care and treatment after their toe surgery. They said that, when A's surgical wound was not healing, the consultant failed to carry out a pulse test (test of the peripheral vascular system) on A and failed to refer them to the vascular surgeons (specialists in the treatment of diseases affecting the vascular system including diseases of the arteries, veins and lymphatic vessels) sooner. We found that A's pulses should have been assessed at the clinic appointment at which amputation surgery was discussed, and this should then have led to investigations and vascular input prior to surgery, if an abnormality had been detected. We considered that the failure to carry out this assessment was unreasonable and we, therefore, upheld this part of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for failing to deal with the referral from A's GP in a reasonable manner and see A within 12 weeks of that date; mention the specific risks of the surgery to A at the clinic appointment; record the misunderstanding about which toe was to be amputated in A's medical records; and assess A's pulses at the clinic appointment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients' pulses should be assessed and recorded at clinic appointments, in cases where foot and ankle surgery is being considered.
- Patients should be informed of the specific risks of surgery at clinic appointments where surgery is discussed and this should be documented.

- Relevant details, including where appropriate, misunderstandings about surgery should be recorded in patients' medical records.
- The board should have appropriate systems in place to assess GP referrals in cases such as this and ensure that patients are seen within an appropriate timescale.

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.