Scottish Parliament Region: Highlands and Islands

Case 200700092: Western Isles NHS Board

Summary of Investigation

Category

Health: Hospital; podiatry

Overview

The complainant (Mr C) raised a number of concerns about the podiatry treatment which he had received from a podiatrist (the Podiatrist) of Western Isles NHS Board (the Board) on 7 December 2006.

Specific complaint and conclusion

The complaint which has been investigated is that the Board failed to provide Mr C with appropriate podiatry treatment (*not upheld*).

Redress and recommendation

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 10 April 2007, the Ombudsman received a complaint from the complainant (Mr C) about the podiatry treatment which he had received from Western Isles NHS Board (the Board) on 7 December 2006. He complained that the podiatrist (the Podiatrist) cut a toe on his left foot and that he contracted Methicillin resistant staphylococcus aureus (MRSA) because the Podiatrist failed to apply a dressing to his wound. His toe was now deformed. Mr C complained to the Board but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaint from Mr C which I have investigated is that the Board failed to provide Mr C with appropriate podiatry treatment.

Investigation

3. In writing this report, I have had access to Mr C's clinical records and complaint correspondence with the Board. I obtained advice from the Ombudsman's professional medical adviser (the Adviser) regarding the clinical aspects of the complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board failed to provide Mr C with appropriate podiatry treatment

5. Mr C complained that the Podiatrist did not exercise sufficient care when they treated his left foot on 7 December 2006. During a home visit, the Podiatrist had cut Mr C's toenails and removed a corn from the second toe on the left foot. The Podiatrist did not apply a dressing to the foot. Several days later, Mr C noticed blood in the shower which he believed came from his left foot and he experienced pain and severe discomfort in the toe the corn had been removed from. A nurse examined his foot and told him that there was a hole in the toe and that the bone was visible. A swab was taken of the wound and Mr C was informed that the toe was infected with MRSA. He was prescribed antibiotics to clear the infection and received home visits from a district nurse to check his toe and change dressings.

6. In considering the complaint, the Board asked the Podiatrist for their account of what happened. The Podiatrist said that, in line with their usual practice, they had used sterile pre-packed instruments to cut and file the toenails and a scalpel to reduce the hard corn. The Podiatrist said that there were no breaks in the skin before, during or after treatment. When the Board became aware of Mr C's problems, another podiatrist made a home visit to assess the toe and sent a swab to the laboratory. While the Podiatrist could not say what went wrong with Mr C's toe, Mr C did not have an open wound when they had completed their treatment. If there had been an open wound then the Podiatrist would have supplied a dressing and contacted the district nurse to provide any further treatment required. They accepted that Mr C suffered an ulcer on his toe and was sorry that Mr C felt dissatisfied with the treatment they had provided.

7. The Board said it did not uphold Mr C's complaint. It appeared appropriate measures regarding infection control were carried out by the Podiatrist on 7 December 2006. The Board also said that the result of a swab taken from the toe on 3 January 2007 was negative for MRSA. A further swab taken on 11 January 2007 showed a heavy growth of MRSA, but the Board noted that Mr C had been colonised with MRSA in 2004 and believed it highly probable that this was the source of the infection.

Medical background

8. Mr C received routine podiatry treatment at a clinic until 2005 when he began to receive treatment at home at the request of his general practitioner. Mr C suffered from a number of chronic illnesses and prescribed extensive medication.

Clinical advice

9. In his review of Mr C's clinical records and of the response to the complaint, the Adviser found the Podiatrist's account reasonable in saying that normal hygiene aseptic procedures had been followed. It was the Adviser's view that had there been a breach of the skin, there would almost certainly have been some bleeding which would have been noticed by both the Podiatrist and Mr C. The fact that Mr C only noticed bleeding several days after treatment indicated it was not caused directly by the treatment provided by the Podiatrist. The Adviser said it had not been necessary to apply a dressing in the absence of a breach, and the lack of a dressing did not contribute to the infection in the toe.

Conclusion

10. Mr C complained about the standard of podiatry treatment which he received from the Podiatrist. In particular, he is concerned that the Podiatrist cut his toe and that failure to apply a dressing resulted in the toe becoming infected with MRSA.

11. The records show that Mr C was previously infected with MRSA. The Adviser has told me that hygiene procedures described by the Podiatrist to the Board were acceptable in the circumstances. The crucial question I have to decide is whether there is evidence that the Podiatrist did breach the skin on Mr C's toe, and, if he did so, failed to treat that breach properly.

12. The Podiatrist in their note of the treatment did not record any breach of the skin, and they said in their account to the Board that there was no breach. Mr C did not notice any problem until some days later. I accept the Adviser's advice that any bleeding would almost certainly have been visible sooner had there been a breach on 7 December 2006. Therefore, on balance, I do not uphold the complaint.

Recommendation

13. The Ombudsman has no recommendations to make.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Western Isles NHS Board
The Podiatrist	A podiatrist who provided treatment to Mr C
MRSA	Methicillin resistant staphylococcus aureus
The Adviser	A medical adviser to the Ombudsman

Annex 2

Glossary of terms

Methicillin resistant staphylococcus aureus (MRSA)	A form of the bacteria Staphylococcus Aureus which is resistant to the antibiotic Methicillin