Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health & Social Care Trust

NIPSO Reference: 202001357

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Listed Authority: Belfast Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to the patient between 1 October 2019 and 14 March 2020. In particular, the complainant was concerned the Trust failed to remove or check the patient's plaster cast, which he believed eventually led to the patient's death from infected foot ulcers.

The investigation examined the details of the complaint, the Trust's response and relevant local and national guidance. I also obtained independent professional advice from a Consultant Nurse, specialising in tissue viability, a Consultant Orthopaedic Surgeon and a Consultant Podiatric Surgeon

The investigation established failures in the care and treatment in relation to the following matters: the failure to document any consideration given to the reduced sensation in the patient's leg when applying her cast; the failure to change or inspect the patient's cast for a period of eight weeks; the failure to advise the patient's family of her increased risk of pressure sores under her cast; the failure to review the patient's wounds in a timely fashion and the failure to refer the patient to Podiatry in a timely fashion. I concluded that the Trust's failure to remove her cast caused the patient the injustice of distress. I also concluded that the patient was denied the opportunity for a timely assessment of her wounds by Tissue Viability and for a timely referral to Podiatry. I am satisfied that the failures and losses of opportunity identified contributed significantly towards the patient's premature death. As a result of this I am satisfied that the complainant experienced the injustice of distress and uncertainty about the appropriateness of the care and treatment provided to his wife up until her death

The investigation found that the Trust's decision to move the patient to the Ear Nose and Throat ward was acceptable. It also found that the Podiatry team treated the patient's wound with an appropriate dressing.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements in relation to staff training and record keeping.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment provided to his wife (the patient) between 1 October 2019 and 14 March 2020.

Background

2. The patient was a 67-year-old woman. She suffered a stroke some years previously which left her with limited mobility and reduced sensation in her right side. The patient attended the Emergency Department (ED) at the Royal Victoria Hospital (RVH) on 1 October 2019 after falling at home and fracturing her lower right leg. The hospital fitted the patient with a long leg Plaster of Paris (PoP) cast to treat the fracture and discharged her on 9 October 2019.

3. The patient was due to attend a review at the Fracture Clinic on 22 October 2019. The complainant cancelled the appointment on the patient's behalf as she was unwell. The receptionist in the clinic told the complainant that the next available appointment was 26 November 2019.

4. The patient attended a review at the Fracture Clinic on 26 November 2019. Staff removed her cast and found pressure damage to her right leg and foot. The patient developed pressure ulcers on her foot, which deteriorated over subsequent months and the patient developed sepsis. The patient sadly passed away on 14 March 2020. Her death certificate recorded the cause of death as necrotic foot ulcers.

Issues of complaint

5. The issue of complaint accepted for investigation was:

Whether the care and treatment provided by the Trust to the patient between 1 October 2019 and 14 March 2020 was reasonable and in accordance with relevant standards and procedures.

In particular, this will include consideration of:

- The length of time the patient remained in the Plaster of Paris cast;
- Involvement of the appropriate team;
- The Trust's management of the patient's wounds; and
- The patient's placement in the Ear, Nose and Throat ward.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPAs):

- Consultant Trauma & Orthopaedic Surgeon MBBS, MRCSEd, MRCSGlas, MSc, FRCS(Tr. & Orth.) MBA with over 15 years' experience in clinical orthopaedics. A senior manager in Trauma & Orthopaedics within the NHS for over 10 years. (O IPA)
- Consultant Podiatric Surgeon, Fellowship in Podiatric Surgery, MSC Theory of Podiatric Surgery, BSC Podiatry (Hons). A workload consisting of the management of elective and high-risk foot problems conservatively and surgically. Experience also includes the management of foot ulceration in patients with diabetes and peripheral arterial disease for over 20 years, including the use of dressings and cast immobilisation. (P IPA)
- A Registered General Nurse for almost 30 years with a Doctorate in Nursing, specialist subject "Dressing evaluation"; Over 20 years' experience of working on the Tissue Viability Team for an NHS Trust. A Nurse Consultant for the speciality since 2007. A Clinical Academic Nurse Consultant since 2018 and currently the

professional lead for Tissue Viability/Wound Care within an NHS Trust. (N IPA)

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration

10. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- Belfast Health and Social Care Trust (the Trust) Hospital Podiatry Referrals, undated (Trust Protocol for Referrals to Podiatry)
- British Orthopaedic Association Standards for Trauma and Orthopaedics (BOAST) Fracture Clinic Services August 2013 (BOAST-Fracture Clinic Services);
- European Pressure Ulcer Advisory Panel (EUPAP) Guidelines November 2019 (EUPAP guidelines);
- The General Medical Council's (GMC) Good Medical Practice, as

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

updated April 2014 (the GMC Guidance);

- Health & Care Professionals Council (HCPC) Standards of proficiency Chiropodists/Podiatrists September 2013 (HCPC guidelines)
- Infectious Diseases Society of America (IDSA) Clinical Practice Guideline for the Diagnosis and Treatment of Diabetic Foot Infections 2012 (IDSA guidelines);
- National Institute for Health and Care Excellence (NICE) Guidelines: CG147 Peripheral arterial disease: diagnosis and management August 2012 (NICE CG147) ;
- National Institute for Health and Care Excellence (NICE) Guidelines: CG179 Pressure ulcers: prevention and management April 2014 (NICE CG179);
- Health and Social Care (HSC) NI Wound Care Formulary 3rd Edition January 2020 (NI Wound Care Formulary)
- Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code); and
- Royal College of Podiatry (RCOP): Clinical standards Standard 5 Record Keeping 2020 (RCOP Clinical Standards).

11. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

12. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The Trust stated that the delay in reviewing the patient's wounds was not due to the actions of the Tissue Viability Team. It also stated that it did not miss an opportunity to refer the patient to the Vascular Team at an earlier date.

THE INVESTIGATION

Whether the care and treatment provided by the Trust to the patient between 1 October 2019 and 14 March 2020 was reasonable and in accordance with relevant standards and procedures?

Length of time in a PoP cast

Detail of complaint

13. The complainant said that the patient wore a PoP cast continuously for eight weeks. He said that when clinicians removed the cast, her right heel and knee were badly infected. The complainant said the receptionist in the fracture clinic was aware his wife was wearing a cast because he told him. He said that the receptionist at the Fracture Clinic did not know how dangerous it was to leave a vulnerable person in the same plaster cast for so long. He believed that the Trust's failure to remove the cast led eventually to the patient's death.

14. The complainant also highlighted the patient had previously suffered a stroke and was paralysed on her right side. He believed that if the Trust had given her condition due consideration, the treatment she received might have been different.

Evidence Considered

Legislation/Policies/Guidance

15. I considered the following guidance:
    - BOAST-Fracture Clinic Services;
    - GMC guidance; and
    - NICE CG179

The Trust's response to Investigation enquiries

16. The Trust stated that following her discharge from RVH on 9 October, the patient was due to attend an appointment at the Fracture Clinic on 22 October. It stated the complainant contacted the Fracture Clinic on 21 October and cancelled the appointment as the patient was unwell. The Trust stated, '*the*

family did not phone (sic) *Fracture clinic again until the end of October 2019 to reschedule an outpatient appointment*' and that the next available appointment with the consultant was 26 November 2020.

17. The Trust stated it was '*usual practice*' for reception staff at the Fracture Clinic to confirm if a patient is wearing a cast. If so, the clinic can give the patient an earlier appointment at the daily nurse led plaster clinic. The Trust stated it '*would wish to apologise if this question was not asked on this occasion*'. The Trust stated the receptionist who spoke to the complainant on 31 October had '*no recollection*' of the call, but also admitted that the receptionist was '*not aware they needed to ask this specific question*'.

18. The Trust stated wearing a plaster cast does not affect the blood supply in a limb, however '*a plaster touching the skin can potentially cause pressure sores*'.

19. The Trust stated that following the patient's experience, it highlighted to all reception staff within the Fracture clinic the requirement to check if a patient is in a cast before cancelling their appointment. It stated that it had also placed laminated signs beside every telephone to remind staff to ask this question. It explained that the reminder is also included in the standard operating procedure given to all new members of staff appointed to receptionist posts in Fracture clinic.

Relevant Independent Professional Advice

20. The N IPA advised the patient was '*at very high risk*' of developing pressure sores to her leg and foot. She further advised the patient developed pressure ulcers after the Trust left her cast in situ for '*an inappropriate* (sic) *long period of time without being checked*'. She advised that missed opportunities in the patient's care '*contributed to the development of pressure ulcers, wound infection, sepsis and ultimately, death'*.

21. The O IPA advised the Trust did not remove the patient's PoP cast for a period

of eight weeks. He advised it is usual to change a cast after two weeks, and again four weeks later. The O IPA advised that eight weeks was an '*excessively long*' time to leave the cast in situ without changing it. He advised the Trust '*should definitely*' have changed the cast within the eight-week period. The O IPA advised there was a '*definite failing of bringing the patient back at an appropriate time to have a plaster inspection*'. However, he clarified that this was a '*systems*' failure and could not be attributed to one person.

22. The O IPA advised that due to sensory problems following a previous stroke, the patient was at '*higher risk*' of developing '*silent*' pressure sores under a PoP cast. The O IPA advised that there was no documentation to indicate that the Trust considered this before deciding to apply a cast to treat the patient's injury. He also advised there was no documentation to indicate the patient's Consultant advised his team, or the patient of her increased risk of developing pressure sores under the PoP cast and the '*extra vigilance*' needed to prevent this occurring.

23. The O IPA advised the patient did not have any '*wounds of concern*' when the Trust initially applied the plaster on 1 October. He advised further that as clinicians noted the presence of pressure sores when they removed the cast on 26 November, these sores could be '*attributed to the prolonged and uninspected use of the plaster*'.

24. The O IPA referred to BOAST– Fracture Clinic Services which state '*When the treatment involves cast splintage, slings or appliances, then written care instructions should be provided'.* The O IPA advised that he could not confirm if the Trust provided any instructions to the patient.

25. The O IPA advised if a patient was in plaster, a senior clinician such as a consultant, or registrar should decide on the appropriate deferral time of an appointment rather than a member of the administrative team.

Discussion with the complainant

26. As part of the investigation, the Investigating Officer spoke by telephone with the complainant. He said when the Trust discharged the patient it advised him

to periodically check her circulation by feeling her toes, but he said no one warned him about the patient's increased risk of pressure sores.

Analysis and Findings

27. Clinicians applied a PoP cast to the patient's right leg on 1 October after she fractured it during a fall. The cast remained in place until 26 November, eight weeks from its original application. The complainant was concerned that the Trust's delay in changing the patient's cast caused her to develop foot ulcers, which ultimately led to her death.

28. I examined the patient's medical records which document the Trust fitted her with a long PoP cast on 1 October 2019. Clinicians removed the cast on 26 November 2019 and found pressure sores on the patient's thigh, knee, calcaneus[2] and big toe.

29. I note the O IPA's advice that as the patient had a history of reduced sensation on her right side it was important to consider the possible side effects of the prolonged use of a PoP cast. The IPA advised that the patient would not have had the normal pain response to skin damage and it was therefore important to be aware of the increased risk of '*silent*' pressure sores. The O IPA advised that the consultant did not document any such considerations in the medical records. As such I cannot conclude if the consultant considered the patient's increased risk of developing pressure sores beneath the cast or notified his team of the need for extra vigilance.

30. I refer to the GMC Guidance which states: '*Clinical records should include: the decisions made and actions agreed, and who is making the decisions and agreeing the actions'.* In my view, the clinical records should accurately record the details of any decisions made by clinicians in order to ensure clarity for those clinicians who will later rely on the information recorded in these records. I am satisfied that these actions in relation to record keeping fall below the required standard and constitute service failures. I therefore uphold this

[2] Heel bone

element of the complaint. I will address the injustice to the patient in paragraph 36.

31. The Facture Clinic records document the patient attended a review appointment on 8 October. She was due to attend a follow up review on 22 October, however, I note the complainant rang the clinic on 21 October to cancel the appointment as the patient was unwell. He called the clinic again on 31 October to reschedule the appointment. The receptionist told him the next available appointment was 26 November.

32. The Trust stated it was '*usual practice*' for reception staff at the Fracture Clinic to confirm if a patient is wearing a cast. If so, it is possible to give the patient an earlier appointment in the nurse led plaster clinic if required. I was unable to find a contemporaneous record of the phone call between the Fracture Clinic receptionist and the complainant in the patient's notes. I note the Trust stated that the receptionist '*was not aware they needed to ask this specific question*'. The complainant said he told the receptionist that the patient was wearing a cast. He strongly emphasised this point to the Investigating Officer. There is a clear discrepancy between the complainant's recollection of events and the Trust's explanation. While I cannot verify the details of the conversation between the receptionist and the complainant, it remains the case that the Trust did not consider if the patient was wearing a cast when it rearranged her appointment at the Fracture Clinic. I find this extremely concerning.

33. The N IPA advised the patient was at '*very high risk*' of developing pressure sores. She advised the length of time the Trust left her cast in situ without changing it was '*inappropriate*'. The O IPA also advised that the patient's cast remained unchanged for an '*excessively long*' period. Both IPAs advised that the patient developed pressure sores as a consequence.

34. I note further the complainant said no one from the Trust warned him of the increased risk of pressure sores to the patient due to the impaired sensitivity in her leg. I consider that if the complainant had been aware of this risk, he would have had the opportunity to explain it to the receptionist in the Fracture Clinic when rearranging her appointment, potentially obtaining an earlier review.

35. I consider these actions represent a failure in the patient's care and treatment in that the Trust did not change her PoP cast for a period of eight weeks or warn her family of the need for extra vigilance while she was in the cast. I consider she developed pressure sores as a consequence of these failures. I therefore uphold this element of the complaint.

36. I note the O IPA's advice that he could not confirm if the Trust provided the patient and her family with cast care instructions. I examined the patient's medical records which document that the Trust provided the patient with written and oral instructions on 1 October 2019.

Injustice

37. I acknowledge and accept the advice of both IPAs that the patient developed pressure sores because of the Trust's failure to change or inspect her PoP cast for a period of eight weeks. I am satisfied that because of the failures identified, the patient experienced the injustice of the loss of opportunity to have her PoP cast removed and receive appropriate care to prevent pressure sores developing. I am also satisfied the patient experienced the injustice of distress due to developing sores.

38. In relation to the record failures identified above, I am unable to determine if the complainant suffered an injustice. This is because I cannot conclude if the consultant considered the patient's increased risk of developing pressure sores beneath the cast or notified his team of the need for extra vigilance.

39. I note that following the patient's experience, the Trust has now highlighted to all reception staff in the Fracture Clinic the requirement to check if a patient is in a cast before cancelling an appointment. It has also placed laminated signs beside every telephone as a reminder. However, I note the O IPA's advice that the patient's experience occurred because of a '*systems*' failure and was not attributable to one team or member of staff. I will address this in the recommendations below.

Involvement of the appropriate team

Detail of Complaint

40. The complainant queried if the Trust followed the '*correct protocol of contacting the Tissue Viability Nurse*' as the patient was '*in agony*' from her pressure sores by 17 January 2020. While the complainant did not question if the Trust referred the patient to Podiatry at the appropriate time, the N IPA highlighted the issue in her advice. I consider that the matter is relevant and connected to the Tissue Viability Nurse's (TVN) assessment of the patient's condition. I have addressed each issue separately below

Evidence Considered

Legislation/Policies/Guidance

41. I considered the following guidance:
    - NICE CG179
    - NICE CG147; and
    - NMC Code

The Trust's response

42. The Trust stated the Tissue Viability team received a referral on 27 November, the day after the patient's Consultant identified tissue damage to her leg and foot. It stated a TVN first reviewed the patient on 24 December 2019. It stated that the Podiatry Team first saw the patient on 7 January 2020 following receipt of a referral from the District Nursing Team on 3 December. The Trust stated that the '*TVN team did their best to ensure that any treatment, assistance of care for which they were responsible was delivered without undue delay'.*

Relevant Independent Professional Advice

43. The N IPA advised that nursing staff in the Emergency Department (ED) and the Fracture Clinic, the District Nursing Team, Tissue Viability and Podiatry shared responsibility for the patient's wound care. She advised a Registered Nurse (RN) assessed and graded the patient's pressure ulcers upon removal of her cast on 26 November 2019. She advised the TVN's role was to '*validate the grading and assessmen*t' carried out by the RN. The N IPA advised the Tissue

Viability team's involvement with the patient began on 27 November. She advised the TVN was unable to assess the patient's wounds at the time but arranged to review her on 3 December which she advised was '*acceptable and current practice*'.

44. The N IPA advised that a TVN first assessed the patient's pressure sores on 24 December 2019, four weeks after her consultant first identified them. The N IPA advised Tissue Viability '*missed opportunities*' to review the patient between 26 November and 24 December. She referred specifically to a home visit scheduled for 17 December which the Trust cancelled. However, she advised that as the District Nursing Team provided care for the patient throughout this period, '*it is unlikely that this impacted on the care or the outcome*'.

45. The N IPA advised the Trust missed an opportunity to refer the patient to Podiatry at an earlier stage. She advised that given the patient's comorbidities it was '*predictable*' that she had peripheral arterial disease (PAD)[3] and that she needed a podiatrist's '*expert input*'. She advised the patient's wounds were necrotic[4] by the time Podiatry carried out its first assessment. She further advised that an earlier referral to Podiatry would have led to an earlier referral to the Vascular team[5]. She said that this '*might or might not*' have prevented the patient's death.

46. The P IPA advised a podiatrist first reviewed the patient at home on 7 January 2020. I asked the P IPA if an earlier intervention by podiatry would have resulted in a different outcome for the patient. The P IPA advised from a Podiatry perspective it would not as the patient's wounds did not show any clinical signs of infection '*at the time of the first assessment, or before*'. However, the P IPA advised that an earlier referral to Podiatry would in turn have probably led to earlier referral to the Vascular Team.

[3] a condition where a build-up of fatty deposits in the arteries restricts blood supply to leg muscles which can lead to foot ulcers, among other health issues.
[4] Necrotic tissue means that the tissue has died due to a lack of blood and oxygen. It will turn black in colour and will fall away, leaving an even larger open wound
[5] a team providing diagnosis and surgical treatment of disorders of the blood vessels

Analysis and Findings

47. The N IPA advised that staff from different departments shared responsibility for the patient's wound care. I examined the patient's medical records which document that on 27 November a TVN arranged to review her wounds on 3 December. I note that due to several cancelled appointments, Tissue Viability did not assess the patient until 24 December. I note the N IPA's advice that there were several missed opportunities for Tissue Viability to assess the patient. The patient's records document that a TVN was scheduled to assess the patient in the Fracture Clinic on 3 December and 10 December and at home on 17 December with the District Nurse. The patient was unable to attend the appointments on 3 and 10 December due to issues beyond her control. I note the District Nurse cancelled the assessment on 17 December and rescheduled for 24 December.

48. It is evident from the medical records that neither the Trust nor the patient were responsible for the missed assessments on 3 and 10 December. However, I accept the N IPA's advice that by cancelling the appointment on 17 December the Trust missed an opportunity to review the patient. I acknowledge the Trust's view that the '*TVN team did their best to ensure that any treatment, assistance of care for which they were responsible was delivered without undue delay*'. I also acknowledge the Trust's point that it was the District Nurse who cancelled the appointment on 17 December and not the TVN. However, the fact remains that the Trust first identified that the patient had pressure sores on 26 November and did not review her wounds again until 24 December. I consider that the delay in assessing the patient's pressure wounds was significant. I also consider that the Trust bears responsibility for the delay.

49. The NMC Code requires nurses to '*make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*'. I consider that the Trust's failure to review the patient's wounds on 17 December was a failure in the patient's care and treatment as the Orthopaedic team first documented the patient's wounds over four weeks earlier.

50. I am satisfied that because of this failure, the patient experienced the injustice of the loss of opportunity to have her wounds assessed at the earliest possible

date. Therefore, I uphold this element of the complaint. However, I accept the N IPA's advice that this '*was unlikely to have impacted*' the patient due to the care provided by the District Nursing team during the period.

51. The N IPA advised the Trust missed an opportunity to refer the patient to Podiatry at an earlier date. The N IPA advised that an earlier referral to Podiatry would have led in turn to an earlier referral to the Vascular team. The N IPA advised this '*might or might not*' have prevented the patient's death. I examined the Trust Protocol for Referrals to Podiatry which specifies that a patient without risk factors, should be managed by '*nursing/TVN*'. I note that the protocol includes PAD as a risk factor. The N IPA advised that the patient had not officially been diagnosed with PAD when she was under review by Tissue Viability. However, she also advised that given the patient's comorbidities and lifestyle it was '*predictable*' that she suffered from PAD. I accept the N IPA's advice and I agree the Trust missed an opportunity to refer the patient to Podiatry at an earlier date.

52. I consider these actions represent a failure in the patient's care and treatment. As a result of the failures identified, I am satisfied the patient experienced the injustice of the loss of opportunity to be referred to Podiatry at an earlier date. I therefore uphold this element of the complaint.

53. I consider that it is impossible to be certain if the failure to review the patient's wounds in at the earliest opportunity, or the failure to refer to Podiatry at the earliest opportunity led to the deterioration of the patient's wounds. However, I am satisfied on the balance of probabilities it was the Trust's failure to change the patient's PoP cast for a period of eight weeks that caused the patient to develop the necrotic pressure sores which ultimately led to her death. As a result of this I am satisfied that the complainant experienced the injustice of distress and uncertainty about the appropriateness of the care and treatment provided to his wife up until her death

Wound care

Detail of complaint

54. The complainant questioned the Trust's decision to treat the patient's pressure sores with iodine as he saw no improvement in her condition. He said that when the Podiatry team used honey dressings on her ulcers, the wounds improved. He also asked if the Trust should have given the patient antibiotics when it first discovered the pressure sores in November 2019.

Evidence Considered

Legislation/Policies/Guidance

55. I considered the following guidance:

- IDSA guidelines
- NICE CG179
- NICE CG147;
- NI Wound Care Formulary;
- NMC Code; and
- Trust Protocol for Referrals to Podiatry

The Trust's response

56. The Trust stated that the Podiatry team described the patient's wounds as dry and necrotic. It stated the Podiatry team used Inadine tulle[6] because it provided antimicrobial cover and helped keep necrosis dry, as wet necrosis can increase the risk of infection. It stated the dressing could also be used in the presence of infection as it is non-adherent. It stated *'Inadine tulle was the most suitable choice of dressing*'. The Trust stated that when the Podiatry team identified a possible infection in the patient's heel it contacted the patient's GP who prescribed antibiotics.

Relevant Independent Professional Advice

57. I asked the P IPA if the Trust should have given antibiotics to the patient when clinicians first removed her cast and identified the pressure ulcers. The P IPA

[6] An iodine based dressing

referred to the IDSA guidelines which state that wounds without evidence of soft tissue, or bone infection do not require antibiotics. The P IPA advised that as there was no indication of infection when the consultant discovered the pressure ulcers, it would not have been appropriate to give the patient antibiotics.

58. The P IPA detailed the actions a responsible body of opinion would expect of a podiatrist who was managing a necrotic foot ulcer. He advised that this included dressing the ulcers '*using appropriate dressings and in line with local wound care formulary guidelines*'. The P IPA advised there was '*no evidence to support one dressing over another*' to treat foot ulceration. He referenced the NI Wound Care Formulary which states that necrotic wounds with no blood supply should be kept dry and only provided recommendations for dressings where the necrotic wounds are suitable for debridement. He advised that in the patient's case, the necrotic wounds '*were not suitable for debridement*'.

59. The P IPA advised after reviewing the NI Wound Care Formulary and considering the features of the patient's ulceration, '*the use of Inidine* (sic) *was an appropriate dressing*'.

60. The P IPA advised that the podiatrists responsible for treating the patient accurately documented her wounds and escalated her to an appropriate clinician '*when there was a change in appearance and infection was suspected*'.

61. The P IPA advised that the Podiatry team carried out assessments to determine if the patient was suffering from PAD including '*dopplers*'[7]. However, he advised that in his opinion the Podiatry team should have taken '*a more structured approach to vascular assessment*' such as an '*assessment of foot to femoral pulses*', which he advised was in a podiatrist's '*scope of practice*' and recommended under NICE CG147. However, he clarified that the lack of a structured assessment '*did not materially contribute'* to the deterioration of the patient's wounds. This was because the Orthopaedic team had already referred

[7] a test used to detect blood flow. It shows whether a pulse is present and whether there is blood flow to a limb. It can diagnose or help to manage conditions such as peripheral arterial disease (PAD)

the patient to the Vascular team on 14 January and in addition the Podiatry team had escalated the patient to an appropriate clinician when her wounds deteriorated. The P IPA advised that overall the Podiatry team's approach to treating the patient's wounds '*demonstrated good care*' and that it '*met an acceptable standard*'.

Analysis and Findings

62. The complainant questioned the appropriateness of the Trust's decision to dress the patient's wounds with Inadine Tulle. I note the P IPA advised that given the features of the patient's ulceration, the Trust's decision to dress the wounds with Inadine Tulle was '*appropriate*'. In addition, I note the P IPA's advice that overall the Podiatry team's approach to treating the patient's wounds '*demonstrated good care*' and that it '*met an acceptable standard*'. I accept the P IPA's advice. Therefore, I do not uphold this element of the complaint.

Placement in the Ear, Nose and Throat ward

Detail of Complaint

63. The complainant asked why the Trust moved the patient to the Ear Nose and Throat (ENT) ward at 01.00 on 9 October. He said that it would have made more sense to keep the patient in the ward she was in, rather than move her at 01.00.

The Trust's response to the complainant.

64. The Trust stated that the Patient Flow department made the decision to move the patient to the ENT ward on 9 October. It explained that it did this to allow '*more acutely ill patients to be admitted*' to the ward the patient was in previously. It stated that the demand for acute beds was '*very high at that given time*'. The Trust agreed that it was not acceptable to move patients out of hours and apologised to the patient's family.

Relevant Independent Professional Advice

65. The O IPA advised that the issue of the lack of acute bed spaces was a problem throughout the NHS. He advised that while it was not ideal to transfer

the patient at 01.00, '*in reality, it sometimes happens, to free up bed space for other patients'*. He said that there was no indication in the records that the patient had suffered detriment as a result.

Analysis and Findings

66. The complainant questioned the appropriateness of the Trust's decision to transfer the patient to the ENT ward at 01.00. I acknowledge the complainant's concern and the Trust's apology to the patient's family that that she was moved out of hours. I agree it would have been preferable to transfer her at a more reasonable time. However, I accept the O IPA's advice that it is sometimes necessary to move a patient out of hours, therefore I do not uphold this element of the complaint. I hope the complainant is reassured by the O IPA's advice that the patient did not suffer detriment because of the move.

CONCLUSION

67. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to the patient between 1 October 2019 and 14 March 2020.

68. The investigation found that the Trust's decision to move the patient to the ENT ward at 01.00 was reasonable in the circumstances. It also found that the Podiatry team treated the patient's wound with an appropriate dressing. The investigation was unable to establish if the failure to refer the patient to Podiatry in a timely fashion led to her wounds to becoming infected or her subsequent death. The investigation established failures in the care and treatment in relation to the following matters:

- The failure to document any consideration given to the reduced sensation in the patient's leg when applying the PoP cast;
- The failure to warn the complainant of the increased risk of pressure sores to the patient after her discharge from hospital;
- The failure to change the patient's PoP cast for a period of eight weeks;

- The failure to review the patient's wounds in a timely fashion;
- The failure to refer the patient to Podiatry in a timely fashion

69. I am satisfied that the failure in care and treatment identified caused the patient to experience the injustice of distress and the loss of opportunity for a timely assessment of her wounds and a timely referral to Podiatry. In addition, I am satisfied that the complainant experienced the injustice of upset and uncertainty. In my view the losses of opportunity identified contributed strongly towards the patient's untimely death.

70. I recognise that this report may be distressing for the complainant to read. It must have been very difficult for him to witness his wife's deterioration at home and in hospital. I consider there was uncertainty and upset for the complainant at a stressful time. I acknowledge that this uncertainty will unfortunately continue as he will always question whether things could have been different if the Trust had changed his wife's cast at an earlier stage.

Recommendations

71. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

72. I acknowledge following the patient's experience, the Trust has now highlighted to all reception staff in the Fracture Clinic the requirement to check if a patient is in a cast before cancelling an appointment. It has also placed laminated signs beside every telephone as a reminder

73. I further recommend for service improvement and to prevent future recurrence, that the Trust

- Carry out a random sampling audit of patients' records within the Orthopaedic and Trauma ward from 1 April 2022 to the date of issue of the final report. This is to ensure that staff have documented the risks to vulnerable patients of the long term use of a plaster cast. The Trust take action to address any shortcomings identified;
- Ensure that the families and carers of vulnerable patients wearing plaster casts are advised of the increased risk of pressure sores where appropriate;
- Carry out a random sampling audit of patients' records within the Fracture Clinic from 1 April 2022 to the date of issue of the final report. This is to ensure that staff have asked any patient cancelling an appointment if they are wearing a cast. The Trust should evidence any action taken to address any shortcomings identified;
- Give consideration to placing a '*red flag'* against the computer records of vulnerable patients who have been released from hospital in a plaster cast;
- Discusses the learning identified by the O IPA for making a senior clinician responsible for rescheduling cancelled appointments in the Fracture Clinic at Trust Governance level;
- Raises awareness among relevant staff of the importance of assessing pressure wounds at the earliest available opportunity and the importance of a timely referral to Podiatry if a patient is suspected of having PAD; and
- Arrange for a copy of this report to be shared and discussed with the clinicians involved in the patient's care.

74. I recommend that the Trust implement an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-

declaration forms which indicate that staff have read and understood any related policies).

75. I am pleased to note the Trust accepted my recommendations.

MARGARET KELLY
Ombudsman **June 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.