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PUBLIC SERVICES OMBUDSMAN FOR WALES
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The investigation of a complaint

By Mrs B

against Aneurin Bevan University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201704489

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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 Mrs B.

Summary

Mrs B complained about the care and treatment given to her son ("Mr C"), by the Podiatry Service and during two hospital admissions, when he suffered foot problems associated with diabetes. Mrs B said the Podiatry Service was inadequate, Mr C was discharged from his first admission too soon and the Health Board failed to provide adequate protection for Mr C against Deep Vein Thrombosis (DVT)[1] or Pulmonary Embolism (PE)[2] following an operation to amputate an infected toe during his second admission to hospital, and that this resulted in Mr C suffering a PE 12 days later, from which he sadly died.

The investigation found that earlier referral, by the Podiatry Service, to a specialist team might have resulted in earlier treatment of his condition and might have prevented the need to amputate Mr C's toe. The investigation found that further steps should have been taken before Mr C was discharged, following his first hospital admission, and had these steps been taken Mr C's care might have been managed differently.

The investigation also found that Mr C was at increased risk of DVT/PE and that protection against DVT/PE should have continued after he was discharged from his second hospital admission. Had Mr C received medication to reduce the risk of DVT/PE it might have prevented Mr C from developing the PE which caused his death. It follows that Mr C's death might have been avoided.

The Health Board agreed to implement the following recommendations:

(a) Apologise, in writing, to Mrs B for the failings identified in this report.

(b) Make a payment of £4000 in recognition of the failings identified in the report.

[1] A blood clot which forms in a deep vein in the body, usually the leg
[2] A sudden blockage of the artery in the lung, usually by a blood clot

(c) Arrange for the clinicians involved in Mr C's first discharge from hospital to review this case with their supervisors and examine what lessons can be learned from the failures identified in the report.

(d) Undertake a root cause analysis investigation of this case to establish why no assessment was undertaken of Mr C's risk of developing DVT/PE once he had been discharged. An action plan should be created to prevent this situation arising again. The findings and action plan should be shared with the Ombudsman.

(e) Arrange for the staff involved in Mr C's care during and following the amputation of his toe to review the case and the results of the root cause analysis investigation with their supervisors.

(f) Ensure that the Podiatrist involved in Mr C's care reviews the case with their supervisor and receives further training on the use of the referral pathway.

(g) Remind complaints team staff of the importance of providing timely and regular updates to complainants.

The Complaint

1. Mrs B raised the following complaints about the service provided by Aneurin Bevan University Health Board ("the Health Board") to her son Mr C:

- The Podiatry Service did not provide adequate treatment.
- Mr C was prematurely discharged from hospital in October 2016.
- The Health Board failed to provide adequate protection for Mr C against Deep Vein Thrombosis (DVT)[3] or Pulmonary Embolism (PE)[4] as it did not administer appropriate doses of anticoagulant (blood thinning) medication.
- VAC therapy[5] (used to clean and protect the wound) was stopped prematurely.
- There was a delay in receiving a complaint response and the response was incomplete.

Investigation

2. I obtained comments and copies of relevant documents, including Mr C's clinical records, from the Health Board and considered those in conjunction with the evidence provided by Mrs B. I also obtained advice from three of the Ombudsman's Professional Advisers. The First Adviser, Richard Leigh is an experienced Podiatrist,[6] the Second Adviser, Leslie Ala is an experienced Consultant Physician and the Third Adviser, Kathryn King is an experienced District Nurse. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

[3] A blood clot which forms in a deep vein in the body, usually the leg
[4] A sudden blockage of the artery in the lung, usually by a blood clot
[5] Vacuum Assisted Closure is a medical device used in the management of acute and chronic wounds which is often indicated for use by diabetic patients
[6] Specialist in the treatment of conditions affecting the foot

3. Both Mrs B 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 and policies

4. The Advisers and I have had regard to a number of regulatory and good practice documents in considering this case, including the following:

- Aneurin Bevan University Health Board – Podiatry Service Diabetic Foot Care Pathway ("the Pathway") allows for diabetics with active foot ulceration (open wounds on the skin of the foot, common in diabetic patients) to be referred to the Multi-Disciplinary Foot Team ("MDFT") for both new and chronic (persistent) ulceration.

- The NICE Guidelines CG92 (2010) on anticoagulation prophylaxis (medication to prevent DVT or PE) say that patients are considered to have an increased risk of DVT/PE if they:

  - are medically obese (overweight to a degree it may cause medical complications)

  - are expected to have a significant reduction in mobility for at least 3 days or more

  - have undergone a surgical procedure

  They also say that patients undergoing orthopaedic surgery (except knee or hip replacements) should continue to receive anticoagulation prevention medication until they no longer have any significantly reduced mobility.

- The Nice Guidelines NG19 (2016) Diabetic foot problems state that clinicians should:

  - Start antibiotic treatment for suspected diabetic foot infection as soon as possible. Take cultures and samples before, or as close as possible to, the start of antibiotic treatment.

- Choose the antibiotic treatment based on the severity of the diabetic foot infection, the care setting, and the person's preferences, clinical situation and medical history

- The British National Formulary (BNF)[7] states that, for anticoagulation prophylaxis, the first dose of Dalteparin (a type of anticoagulation prophylaxis) should be given the evening before surgery; the second 24 hours after surgery and, subsequently, every 24 hours until it is no longer required.

Relevant background information and events

5. On 8 January 2016, Mr C, who was 41 years old and a diabetic, presented at the Podiatry clinic. No concerns were raised, and he was advised to return in six weeks. An appointment was booked for 24 March, but Mr C did not attend. On 26 August, Mr C attended the Podiatry clinic complaining that he had a problem with his right big toe. An ulcerated area was noted. A Podiatrist dressed the area and raised a request with Mr C's GP practice ("the Practice") for antibiotics. The Practice issued a prescription which was collected by Mr C on 30 August; staff at the Practice also redressed the wound.

6. Mr C was seen in the Podiatry clinic weekly between 2 September and 23 September. The wound did not heal and on, 23 September, an appointment was made for 11 October at the Community Podiatry Tissue Viability Clinic (a service which supports patients with wounds such as ulcers, bed sores or wounds that have failed to heal over time) with a Podiatrist who specialised in diabetic foot management. During that period, the Practice issued further antibiotics, firstly on 2 September, following a telephone call with Mr C and then again on 9 September, following a planned diabetic review.

7. On 3 October, Mr C attended the Practice. It was noted that Mr C was well with no temperature but the area on the toe had become red again, so further antibiotics were given.

[7] The UK's pharmaceutical reference book

8. On 6 October, Mr C was admitted to Ysbyty Ystrad Fawr Hospital ("The First Hospital") under the care of a Consultant Physician ("the First Doctor"). It was considered that Mr C's likely diagnosis was osteomyelitis (infection of the bone) with sepsis (a serious complication of an infection where bacteria from the infection have entered the bloodstream) owing to poorly controlled diabetes. Mr C was given intravenous (directly into the vein) antibiotics for 8 days. On 7 October, it was agreed that test results would be discussed with the Trauma and Orthopaedic ("T&O") doctors at Royal Gwent Hospital ("the Second Hospital").

9. On 11 October an urgent referral was made for Mr C to the T&O team. He was also referred to a wound clinic. It was noted that Mr C needed six weeks of antibiotics. Later that day an MRI scan (that uses radio waves to produce images) and X-ray confirmed the presence of osteomyelitis.

10. On 13 October, Mr C was seen by a Tissue Viability Nurse ("the TVN"). It was noted that the wound needed daily dressing and the TVN suggested that Mr C should be transferred to the Second Hospital to be cared for by the T&O team. The First Doctor noted an improvement and discharged Mr C from hospital on 14 October to await an appointment with the T&O team. During his stay at the First Hospital Mr C was given Dalteparin.

11. Between 17 October and 22 November, Mr C was visited regularly by District Nurses to dress the infected toe. He was reviewed by a Podiatrist on 24 October and 8 November, with no change to his treatment. Subsequent reviews by a District Nurse noted that the infection was not settling, and on 22 November, a Podiatrist noted that there was some bone protruding through the wound and arranged for Mr C to be admitted to the Royal Gwent Hospital (the Second Hospital) under the care of a vascular surgeon.[8]

12. On admission, it was noted that Mr C had ongoing osteomyelitis of his foot and intravenous antibiotics and Dalteparin were given. The following day it was decided that his toe would be amputated that day, but the operation was cancelled. Mr C was not given Dalteparin that evening.

[8] A surgeon that specialises in care related to the vascular system (arteries and veins)

13. On 24 November, Mr C was again booked for the amputation and again it was cancelled. He did not receive Dalteparin that evening. On 25 November, the infected toe was amputated. Mr C received three more doses of Dalteparin on 26, 27 and 28 November. The records reflect that Mr C was able to go to the toilet using crutches.

14. Mr C was discharged on 29 November with a Vacuum Assisted Closure (VAC) dressing. There are no records of the involvement of Physiotherapy or Occupational Therapy staff prior to discharge; the discharge documentation is blank and there is no information in the nursing notes to reflect how mobile Mr C was on the ward, only that he had been able to walk with the VAC, and the clinical notes do not mention Mr C's mobility. There was no record of a discussion between staff or with Mr C regarding the risks of DVT or PE or to reflect whether an extended period of anticoagulation prophylaxis was considered necessary.

15. Mr C was visited frequently by the District Nurses to change the dressing. The records reflect that, despite early problems with the VAC machine alarm, it was working. However, on 10 December, Mr C asked the District Nurse to attend as the VAC machine did not appear to be functioning correctly and there was oozing from the VAC. The District Nurse removed the machine, cleaned and dressed the wound.

16. On 13 December Mr C attended an Orthopaedic Clinic at the First Hospital. No issues were raised, and Mr C was advised he would need a review at the Second Hospital.

17. On 19 December, the District Nurse arrived to find Mr C was breathless, pale and clammy. Mr C collapsed, and paramedics were called. Sadly, Mr C died; the records show he had suffered a PE.

18. Mrs B made a complaint to the Health Board on 31 January **2017**. A response was due on 3 March. Mrs B's advocate sought an update and was advised on 22 March there would be a delay owing to the complexity of the complaint. The response was provided on 27 June.

Mrs B's evidence

19. Mrs B said that the Health Board did not keep her updated in relation to her complaint and that her advocate had to chase the Health Board for news.

The Health Board's evidence

20. The Health Board said that the timeline of events reflect that Mr C was in receipt of high intensity appointments appropriate with his presentation and in line with best practice guidance. The Health Board said the Podiatry Service indicated that the wound was healing and there was no evidence to suggest infection at the time of the appointments.

21. The Health Board said, in relation to Mr C's first hospital visit, that once Mr C had converted to oral antibiotics and a referral had been made to the T&O team there was no clinical indication to keep him in hospital. The First Doctor said the T&O team had arranged an outpatient appointment for Mr C and he could not arrange an intra-hospital transfer without the permission of that team. The First Doctor said that he did not disagree with the TVN advice to refer Mr C to the T&O team, but he had already made a referral on 11 October.

22. The Health Board said that, although there was no assessment undertaken of Mr C's risk of developing DVT/PE, he was appropriately prescribed Dalteparin. It also said that whilst two doses of Dalteparin were omitted, it did not cause any harm.

23. The Health Board said that NICE guidance recommends the continuation of anticoagulation prophylaxis until a patient no longer has significantly reduced mobility. The Health Board said that, at the point of discharge, Mr C was noted to be mobilising with crutches and half weight bearing to his right foot. Based on this level of mobility, it was therefore considered appropriate that Mr C should be discharged without continued provision of anticoagulation prophylaxis.

24. The Health Board said the VAC was removed after the District Nurse assessed the VAC therapy. It said the District Nurse felt the VAC was making the surrounding skin wet and there was also a rash present around the healthy skin surrounding the wound. The Health Board said that the District Nurse's clinical judgement was that she needed to assess the wound and surrounding skin daily as, possibly, the VAC therapy had caused the rash; therefore, the VAC was removed at this time and the wound was packed with suitable dressings.

The Health Board's comments on the draft report

25. The Health Board said the Pathway applies to external referrals into the service and not the management of patients known to the service. It said its practise is that patients will be managed in the community team unless specific concerns are identified and "All Wales" guidance is being developed.

26. The Health Board said the Podiatrist considered that their action at the first two appointments was reasonable, based upon Mr C's presentation. The Health Board said additional tests at the earlier appointments were not indicated (in accordance with NG 19) as there was no indication that the wound had reached the tendon or bone, but it also said it did not know which antibiotics were prescribed by the Practice. The Health Board acknowledged that when it did escalate Mr C's treatment there would have been an 18 day wait and this was longer than should be expected. The Health Board said that the Podiatry Service has created an action plan on reading the draft of this report.

27. The Health Board said that it was standard practice that concerns raised would be shared with clinicians at their appraisals and that the Health Board would undertake a root cause analysis investigation into the care provided to Mr C at both hospitals.

Professional Advice

The First Adviser – Podiatry

28. The First Adviser said that, when Mr C presented to the Podiatrist on 26 August, a swab of the infected area should have been taken to determine what should be appropriate treatment. The First Adviser said the Podiatrist should have requested an X-ray of the toe to determine if osteomyelitis was present and requested blood tests to determine the level of infection. The Adviser said that, if these options were not available to the Podiatrist, a referral should have been made to the hospital MDFT.

29. The First Adviser said there should have been an urgent referral to an MDFT. The First Adviser said that, had Mr C had earlier intervention by a specialist team (i.e. the MDFT), the treatment might have been better targeted, preventing the need for intravenous antibiotics and, ultimately, amputation of the toe.

The Second Adviser – Consultant Physician

30. The Second Adviser said that Mr C was appropriately risk assessed for anticoagulation prophylaxis to prevent DVT/PE on admission to the First Hospital and Dalteparin was appropriately prescribed.

31. The Second Adviser said that, before the decision to discharge Mr C from the First Hospital on 14 October was made, at the very least, another discussion should have taken place with the T&O team at the Second Hospital, as agreed on 7 October, to inform them of the MRI findings. The Second Adviser said that there was nothing in the records to suggest that such a discussion took place following the test results. The T&O team, as experts in osteomyelitis, would have been better placed to advise the medical team at the First Hospital on whether Mr C should have been transferred to the Second Hospital; whether if he went home, he should have oral antibiotics or longer term intravenous antibiotics and, if he was discharged, whether an urgent review was required.

32. The Second Adviser stated that there was no evidence of a risk assessment to consider the need for anticoagulation prophylaxis to prevent DVT/PE on admission to the Second Hospital. However, the failure to formally document a risk assessment had no bearing on Mr C's treatment, as he was appropriately prescribed Dalteparin. The Second Adviser also said that he agreed with the Health Board that it is unlikely that the omitted dose of Dalteparin on 24 November would have caused any harm and that it was appropriate that Mr C did not receive Dalteparin on 25 November as it should not be received until 24 hours after surgery.

33. The Second Adviser noted that there was no documented discussion between the medical and nursing staff, or with Mr C and his relatives regarding Mr C's risk of DVT/PE, neither was there any evidence of consideration of Mr C's increased risk of DVT/PE after discharge. The Second Adviser said Mr C was a medically obese patient who had just had foot surgery, therefore, his mobility would have been significantly reduced. NICE Guidelines recommend continuing anticoagulation prophylaxis for DVT/PE until the patient no longer has significantly reduced mobility.

34. The Second Adviser said that Mr C's increased risk of DVT/PE after discharge, and while his treatment continued at home, was not considered and so measures to reduce this, such as continuing the Dalteparin for an extended period, were not instigated. The Second Adviser said that, as Mr C was obese, he was at a significantly increased risk of DVT/PE and, given that his mobility would have been significantly reduced after surgery, at least for a fortnight or more, his risk would have remained high after discharge. Therefore, he should have been given extended anticoagulation prophylaxis against DVT/PE at home and, had he had this, it would have reduced the risk of (and might have prevented) DVT/PE.

35. The Second Adviser said that there is a risk of bleeding when using the VAC machine if a patient is on anticoagulation prophylaxis, but the risks of bleeding are small compared to the risks of developing a blood clot. The Second Adviser said that if this was a concern to the Health Board, the risks should have been communicated to Mr C so he could make an informed decision regarding whether he should have anticoagulation prophylaxis.

The Second Adviser said anticoagulation prophylaxis should **not** have been avoided just because Mr C was being put on the VAC machine. In other words, Mr C being on a VAC machine is not an absolute contraindication for anticoagulation prophylaxis.

The Third Adviser – District Nurse

36. The Third Adviser said the District Nurse was called to see Mr C on 10 December as there was 'oozing from the VAC'. The Third Adviser said it was evidenced that the District Nurse was unable to 'leave or patch up'. Also, the District Nurse observed a rash on Mr C's foot which may have been an indication of a developing infection. The Third Adviser said the District Nurse made a clinical decision following assessment of the wound that it would be safer to discontinue the therapy and replace with an appropriate dressing and provide daily visits as possibly the VAC therapy had caused the rash. Mr C was visited daily hereafter and there was evidence that the wound responded well to the applied dressings.

37. The Third Adviser said there is no evidence within the records that instructed or advised the District Nursing Team to leave the VAC therapy in place for 14 days. VAC therapy should be discontinued after a Registered Healthcare Professional has assessed the wound and concluded that the treatment objective has been achieved. Alternatively, VAC therapy should be stopped when a patient is assessed by a Registered Healthcare Professional as not being suitable to continue with the treatment. The District Nurse assessed the wound and her clinical decision was made following the assessment. She applied an appropriate dressing on removing the VAC and communicated with the District Nursing team to allocate daily visits for assessment of the wound. The Third Adviser said this was appropriate treatment and there is nothing in the records to suggest this decision caused Mr C any harm.

Analysis and conclusions

38. Mrs B complained that the Podiatry Service did not provide adequate treatment to her son, Mr C. I **uphold** this complaint. The First Adviser said that steps were not undertaken to determine the appropriate treatment and there was no urgent referral to the MDFT (as indicated by the Pathway). The Health Board said the Pathway is for new referrals into the service, not

the management of patients already known to the service, and its practise would be to manage the patient in the Podiatry clinic for four weeks. Mr C was managed by the Podiatry clinic for four weeks, but by the time Mr C would have received his appointment with the MDFT, once the referral was made, it would have been six and a half weeks; the Health Board has acknowledged this was too long to wait to see the MDFT.

39. The Health Board also said that in accordance with NG 19, earlier tests were not indicated. However, NG 19 states that cultures should be taken as close as possible to the start of antibiotic treatment and no cultures were taken in this case, which supports the view of the Adviser that steps were not undertaken to determine the most appropriate treatment. In any event, The First Adviser said that earlier intervention by the MDFT, as should have been indicated for patients new to the service, would have been appropriate and might have prevented the additional treatments and eventual amputation. This uncertainty is an injustice for Mrs B.

40. With regard to Mrs B's complaint that Mr C was prematurely discharged from the First Hospital in October **2016**, I **uphold** this complaint. Mr C's management included a decision that test results would be referred to the T&O team at the Second Hospital; this did not happen. The TVN also suggested that the patient should be referred to the T&O team, after the tests results had been received but, because the First Doctor had already made a referral a few days before, he deemed a second referral to be unnecessary. The Second Adviser said that, at the very least, a referral to the T&O team should have been made, after the results were received. As experts in his condition, the T&O team could have taken a decision on an appropriate management plan, including whether transfer to the Second Hospital was necessary, the best antibiotic and whether further urgent review was necessary.

41. Failing to refer the test results to the T&O team, as had been agreed, was a service failure. It is not possible to know now whether, had the agreed referral taken place, Mr C would have been managed in the same way. This uncertainty amounts to an injustice for Mrs B.

42. Mrs B complained that the Health Board failed to provide adequate protection for Mr C against DVT or PE as it did not administer appropriate doses of anticoagulant medication. I **uphold** this complaint.

43. The Adviser said the omitted doses of Dalteparin in the Second Hospital did not cause any harm. However, the Health Board subsequently failed to risk assess Mr C's need for further anticoagulation prophylaxis following discharge from hospital and did not arrange for anticoagulation prophylaxis; neither was there any evidence that reducing the risk of DVT/PE was discussed with Mr C.

44. The Health Board said that Mr C was mobile on the ward. However, this is not an accurate reflection of the records. The records reflect that, on discharge, Mr C was able to walk with the VAC attached. There are no other references to him mobilising except on three occasions it was recorded that he was able to use crutches to go to the toilet. In any event, there is no record that due consideration was given to this issue prior to Mr C being discharged.

45. The advice is clear; Mr C was at increased risk of DVT/PE owing to his weight and his reduced level of mobility following his foot operation; anticoagulation prophylaxis against DVT/PE should have continued. Failing to provide it amounts to service failure. There is a significant injustice arising from this service failure. Had the anticoagulation prophylaxis been given, it would have reduced the risk of DVT/PE so might have prevented Mr C from developing the PE which caused his death. It follows that Mr C's death may have been avoided.

46. Mrs B complained that VAC therapy (used to clean and protect the wound) was stopped prematurely. I **do not uphold** this complaint.

47. The Third Adviser concluded that the District Nurse provided the correct assessment of Mr C's wound and applied an appropriate replacement dressing once the VAC was removed. Therefore, I am of the view that this was the appropriate action for the District Nurse to take and that she was an appropriately qualified person to make that decision.

48. With regard to the complaint that there was a delay in receiving a complaint response and the response was incomplete. I **partially uphold** this complaint. It is noted that the Health Board was prompted by the Advocate to provide an update. Failing to provide a timely update is a service failure, which will have caused Mrs C some injustice. That said, whilst the response took longer than originally intended, this was a complex complaint with a number of elements. Therefore, I do not consider the length of time taken to provide a response, to have been unreasonable. The Health Board did respond to all of the complaints raised by Mrs B, albeit that the responses did not give the answers Mrs B was looking for. Therefore, I would take the view that the final response was complete.

Recommendations

49. I **recommend** that within **one month** of the date the final report is issued, the Health Board should:

(h) Apologise, in writing, to Mrs B for the failings identified in this report.

(i) Make a payment of £4000 in recognition of the failings identified in this report.

50. I **recommend** that within **three months** of the date the final report is issued, the Health Board should:

(j) Arrange for the clinicians involved in Mr C's first discharge from hospital to review this case with their supervisors and examine what lessons can be learned from the failures identified in this report.

(k) Undertake a root cause analysis investigation of this case to establish why no assessment was undertaken of Mr C's risk of developing DVT/PE once he had been discharged. An action plan should be created to prevent this situation arising again. The findings and action plan should be shared with the Ombudsman.

(l) Arrange for the staff involved in Mr C's care during and following the amputation of his toe to review this case and the results of the root cause analysis investigation with their supervisors.

(m) Ensure that the Podiatrist involved in Mr C's care reviews this case with their supervisor and receives further training on the use of the referral pathway

(n) Remind complaints team staff of the importance of providing timely and regular updates to complainants

51. 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 10 October 2018
Ombudsman

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