SPSO decision report

Case: **201400049, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, no recommendations

Summary

Mr C was Mrs A's carer, and complained on her behalf that a community health partnership did not identify that she had an infected leg wound. Mr C said that district nurses did not maintain the dressings appropriately, and an ulcer became infected. He also said that Mrs A's GP failed to diagnose the infection. Mrs A was later admitted to hospital, where she developed sepsis (a serious blood infection).

We took independent advice from two advisers; one a GP and the other a specialist in district nursing. Our GP adviser noted the condition of Mrs A's leg ulcer when she was examined by the GP, and said there was no evidence at the time of the examination, or when Mrs A was admitted to hospital, that her ulcer had become infected. Our adviser also clarified that the source of Mrs A's sepsis was never identified when she was in hospital.

Our district nursing adviser reviewed the care and treatment Mrs A was given by district nursing staff prior to her admission to hospital. This adviser explained the expectations around treatment of leg ulcers, and said that it was appropriate for staff to replace Mrs A's dressings every two days. She said that Mrs A's care and treatment was in line with national guidance and good clinical judgement, and our decision reflected this advice.