**Delay in wound assessment**
**15HDC00432, 14 February 2018**

*District health board ~ District nurse ~ Wound care ~ Pain levels ~ Referral ~ Delay ~ Right 4(1)*

A woman attended her general practitioner (GP) for the management of a wound to her foot. The GP referred her to the district health board (DHB), but the referral was returned because the triaging doctor could not read it.

The GP sent the woman to a podiatrist, who also referred her to the DHB. This referral was triaged by a doctor as semi-urgent. The podiatrist also referred the woman to district nurses to care for her wound.

The district nurses visited the woman regularly but the wound continued to deteriorate. One district nurse referred the woman to the DHB and the referral was triaged by another doctor as semi-urgent. The district nurse did not follow up her referral. Another district nurse provided regular care to the woman and observed the deterioration in her condition but took no further action. The woman was eventually diagnosed with critical limb ischaemia.

**Findings**
The district nurses failed to measure the woman's pain levels objectively and to escalate her care to a GP or the DHB. The DHB was ultimately responsible for the woman's care and breached Right 4(1).

By failing to ensure that there were systems in place to allow the individual doctors involved in triaging the woman's referrals access to all relevant information, including recent referral history and previous referral documentation, the DHB breached Right 4(1).

By failing to follow up her referral and by failing to escalate the woman's care to her GP or the hospital, the first district nurse breached Right 4(1). By failing to document objective measures of pain adequately and by failing to refer the woman to a GP or a specialist when the woman's condition deteriorated, the second district nurse also breached Right 4(1).

Adverse comment was made about the GP's record-keeping and his failure to assist the woman to obtain the services she required.

**Recommendations**
It was recommended that the DHB advise on the progress of the new clinical information system, on the new training programme for district nurses, and the results of various audits currently being undertaken.

It was recommended that the DHB and the district nurses apologise to the woman's family, and that the second district nurse provide evidence of further training.