SPSO decision report

Case: **201508444, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Following a fall, Mrs C attended the A&E department at St John's Hospital with a painful and swollen left arm. X-rays were taken and Mrs C was diagnosed with a dislocated left elbow. Mrs C's elbow was moved back into position (reduced), she was given a plaster cast and further x-rays were taken. An emergency medicine consultant reviewed the x-rays and did not identify any fractures. Mrs C was discharged the same day.

Mrs C's records and x-rays were later reviewed by an orthopaedic and trauma surgeon at the hospital's virtual trauma triage clinic. The surgeon agreed there were no evident fractures. Mrs C was issued with a follow-up appointment to attend the fracture clinic.

In the interim, Mrs C returned to A&E as her cast had become loose and she was in continual pain. An x-ray was taken which showed the elbow had dislocated again and she had a displaced radial head fracture (a fracture of the bone at the top of the forearm). Mrs C was referred the same day to the Royal Infirmary of Edinburgh for surgery.

Mrs C complained that there was an avoidable delay in staff diagnosing she had suffered a fractured arm.

We took independent advice from advisers in emergency medicine and orthopaedics. We found that Mrs C's injury was managed correctly when she first attended A&E and she was appropriately referred to the virtual clinic for review. We also found that the x-rays taken before Mrs C's elbow was reduced showed a fracture which was missed on review. We noted that the x-rays taken after Mrs C's elbow was reduced were not of sufficient quality to rely upon for a diagnosis and that further x-rays should have been obtained. While the problems Mrs C experienced in terms of her outcome were due to the severity of her injury and not her treatment, if further x-rays had been ordered, it is likely the severity of the injury could have been diagnosed and the injury treated sooner. We therefore upheld Mrs C's complaint.

We accepted the advice we received that the board should give consideration to the implementation of hot reporting (where a report of an x-ray of a suspected fracture is delivered by a radiographer before the patient is discharged from the emergency department). This would be in-keeping with the National Institute for Health and Care Excellence (NICE) guidelines on the assessment and management of non-complex fractures. We also considered the board should review the relevant patient advice sheet given at discharge and the process of scheduling fracture clinic appointments to minimise the risk of administrative errors which we found had occurred in this case. We therefore made recommendations to address this.

Recommendations

We recommended that the board:

- apologise to Mrs C for the delay in diagnosing her fractured arm;
- ensure that the advisers' comments on the failure to observe the x-ray abnormalities in this case and to

order further x-rays of a diagnostic quality are brought to the attention of relevant staff and report back on the action taken;

- give consideration to the implementation of hot reporting as per the NICE guideline (NG38) on the assessment and management of (non-complex) fractures;
- review the relevant patient advice sheet given at discharge to ensure it sets out the process for orthopaedic follow-up and contains appropriate contact details for any concerns the patient may have and provide us with evidence of this; and
- review the process of scheduling fracture clinic appointments to minimise the risk of administrative errors as occurred in this case.