SPSO decision report

Case: **201905360, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C attended at Perth Royal Infirmary after falling and injuring their wrist. C complained that the care and treatment they received was unreasonable and as a result, they had been left with continuing pain and loss of function in their wrist for which they are awaiting surgery.

We took independent advice from a senior nurse practitioner, a consultant radiologist (a doctor who specialises in diagnosing and treating disease and injury through the use of medical imaging techniques such as x-rays and other scans) and a consultant orthopaedic surgeon (a specialist in the treatment of diseases and injuries of the musculoskeletal system).

In relation to C's initial attendance at A&E where they were seen by a nurse practitioner (NP), we found that the NP recognised from their clinical assessment that C may have sustained a fracture to their wrist and appropriately had the wrist x-rayed. However, it was recorded in C's clinical notes that the x-ray showed no bony injury, which indicated the NP had wrongly interpreted the x-ray as being normal. However, the discharge letter from A&E to C's GP stated a different diagnosis suggesting that the fracture was identified. We only received an explanation from the board for the conflicting diagnoses, which was that the NP had made a mistake in recording there was no bony injury, at a late stage in our investigation. We noted that the treatment the NP provided to C in referring them for an x-ray and making a referral to the virtual fracture clinic was appropriate.

We found that the doctor who later reviewed C's case at a fracture clinic correctly identified that C had sustained a fractured wrist. However, the board accepted that C should have been referred to see an orthopaedic consultant at an earlier stage. We noted that the board had apologised to C for this and taken action to address what occurred.

Finally, we found that given C's medical history and their significant medical co-morbidity, it was reasonable to take a conservative approach and to not perform surgery at the time.

Taking into account all of the evidence and the advice we received, on balance, we upheld C's complaint.

It was clear from our investigation of C's complaint that the board's own complaint investigation did not address the issue of the interpretation of the x-ray in relation to C's attendance at A&E. This was despite C raising this specifically in their complaint to the board. We also considered that it was a failure in complaint handling that A&E only learned about C's complaint after this office issued the draft decision on the complaint, and we were only provided with an explanation for the conflicting diagnoses recorded in C's clinical records at a late stage in our investigation. We made a complaint handling recommendation to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the conflicting diagnoses recorded and the failure by the board in their complaint handling in relation to C's attendance for a wrist fracture. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Information regarding a patient's diagnosis should be accurately recorded in their clinical records.

In relation to complaints handling, we recommended:

- The board's complaint handling monitoring and governance system should ensure that failings (and good practice) are identified and that learning from complaints is used to drive service development and improvement. The board should comply with their complaint handling guidance when investigating and responding to complaints.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.