SPSO decision report

Case: **202207499, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that the board failed to provide C with appropriate treatment for a shoulder fracture. C was admitted to hospital suffering from alcohol related seizures. It became apparent that C had also suffered a shoulder fracture. C was discharged 12 days later with an orthopaedic referral (specialists in the treatment of diseases and injuries of the musculoskeletal system) for the following week. C was then scheduled for surgery to realign the fracture. This was subsequently cancelled. When C was seen again the following week a different consultant determined that C’s fracture had now healed to the extent that surgery was no longer a viable option.

C complained that the shoulder is now misaligned, causing discomfort and a reduced range of motion affecting day-to-day life and their ability to work. C believes that opportunities were missed to prevent this outcome. The board’s response stated that C was initially too unwell for surgery, and that the cancelled procedure was because of an emergency admission that had to be prioritised. They also noted that there was reason to suspect that the injury was older than C had stated upon admission.

We took independent advice from an orthopaedic consultant. We found that there had been some challenges for the board in providing care and treatment to C. However, it had been evident from three days before C was initially discharged that the fracture was healing out of alignment. We also found that there was insufficient evidence on which to conclude that the injury was older than stated. We noted that various opportunities were missed for earlier surgical intervention and that there was a lack of ownership of C’s case from an orthopaedic perspective, contributing to a series of small delays which ultimately led to the window of opportunity for effective surgery passing. This amounted to unreasonable care and treatment. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Discussions about patient care should be documented.
- Upper / lower limb expertise should be obtained promptly where this is appropriate. In addition, where patient care is being transferred, the board should ensure that there is effective communication and that delays are avoided / minimised.

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.