SPSO decision report

Case: **201302180, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C, who is an advice worker, complained on behalf of her client (Mrs A), who had injured her knee in a heavy fall whilst on holiday. She was taken to a local hospital, where the injury was treated as a sprain. She then returned home and went to the accident and emergency department of Wishaw General Hospital next day. Mrs A was assessed, but the swelling around her knee made a full examination impossible. Mrs A was reviewed there again five days later, and damage to her ligaments was suspected. She was referred to the orthopaedic (dealing with conditions involving the musculoskeletal system) fracture clinic for further assessment.

Mrs A was seen by an orthopaedic consultant, who considered it likely that she had a fracture of her knee cap, so the leg was put in plaster. Mrs A said that she repeatedly returned to the hospital, as the cast was causing her severe discomfort. She also said she repeatedly informed medical staff that her knee felt unstable and 'caved in'. Although Mrs A was first seen in July 2012 it was not until November 2012, when she started physiotherapy, that she was diagnosed with several torn knee ligaments, requiring surgical repair.

Mrs C complained to us that Mrs A's knee was never properly examined and staff ignored her (Mrs A's) concerns. She also said Mrs A had suffered needlessly due to the delay in diagnosing her injury and had lost income as she had to take time off work.

We took independent advice from an expert in orthopaedic and trauma surgery. He said that it was normal to wait until the swelling had gone down before attempting to examine a badly injured knee joint. He said, however, that the record of Mrs A's treatment was inadequate and there was no evidence that her knee was properly examined. Our investigation found that while the initial treatment Mrs A had received was reasonable, overall her care and treatment was not of an acceptable standard. We found that although this did not ultimately affect the outcome of her surgery, she had suffered pain and discomfort due to an avoidable delay in diagnosing her injury.

Recommendations

We recommended that the board:

- remind orthopaedic staff of the importance of a thorough, documented examination of an injury as clinically appropriate;
- apologise for the failings identified in our investigation; and
- remind staff of the importance of clear and detailed clinical record-keeping.