SPSO decision report

Case: **201508027, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C attended Raigmore Hospital with an injury to her ankle. She complained about the care and treatment provided, in particular that there was an unreasonable delay in providing her with orthopaedic treatment.

During our investigation we took independent advice from a consultant radiologist and a consultant trauma and orthopaedic surgeon.

The consultant radiologist considered that an abnormality on Mrs C's first x-ray was missed, and as a result there was a delay in being referred to an orthopaedic surgeon and in a diagnosis being made. In addition, the consultant radiologist considered that the abnormality was also missed on an x-ray taken 15 months later and that had this been noticed, Mrs C may have been referred for imaging earlier than she was.

We found that there were no long-term orthopaedic consequences for Mrs C's ankle as a result of the delays. However, we were concerned that the delays added to Mrs C's distress and that she had continued to suffer pain and discomfort when this could possibly have been avoided.

We considered that a delay between Mrs C being placed on the waiting list for an orthopaedic appointment and being advised four months later that she would not be offered an appointment within the target timescale was unreasonable.

We also found that the delay between Mrs C attending hospital for her injury and being seen in an orthopaedic clinic was unreasonable. However, we noted that action was being taken by the board to address the delays. We upheld Mrs C's complaint.

Recommendations

We recommended that the board:

- apologise for the failure to report and act on the abnormality shown in
- x-rays of Mrs C's ankle and for the prolonged waiting time between being referred to orthopaedic services and receiving an orthopaedic appointment;
- consider the adviser's comments on the failure to observe the radiological abnormalities in this case and identify any action which could be taken to minimise the occurrence of such errors;
- ensure patients are advised in a timely manner that they may not be seen within waiting-time targets; and
- provide us with evidence that the action taken to reduce waiting times is having the desired effect.