SPSO decision report

Case: **201508880, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the treatment she received for her injured hand following a fall. Mrs C attended A&E at Caithness General Hospital. An x-ray was taken the next day and no bone injury found. Further x-rays were taken after Mrs C attended her GP. However, a fracture was only identified seven months later, following a scan. Mrs C complained that she had not been provided with reasonable treatment and that she had not been referred to a specialist within a reasonable timescale.

The board had accepted that they were not meeting the 48-hour target for a formal report to be issued in relation to x-rays and had taken action. They also accepted and apologised for the delay in diagnosing the fracture Mrs C suffered.

During our investigation we took independent advice from three advisers: a consultant in trauma and orthopaedic surgery (adviser 1), a consultant radiologist (adviser 2) and a consultant musculoskeletal physiotherapist (adviser 3).

Adviser 1 noted that the overall orthopaedic treatment Mrs C received was correct but that access to treatment was not as timely as it could have been. This related to the delay in a scan being carried out. However, the adviser also said that the delays experienced by Mrs C would not have altered the treatment or long-term outcome from an orthopaedic point of view.

Both adviser 1 and adviser 2 were of the view that the board's decision to delay carrying out an x-ray until the day after the injury was sustained was not reasonable. Adviser 2 did not agree with the board's policy of waiting on a formal report of an x-ray before taking a further x-ray. The advice we received from adviser 3 was that overall the physiotherapy treatment Mrs C received was reasonable.

The board accepted that they were not meeting the 12-week target for out-patient appointments and apologised that the specialist in this case had been unable to prioritise Mrs C and for the delay in being seen by the specialist. While the board outlined the action being taken, adviser 1 was concerned about the approach being taken by the board to restrict urgent appointments in the orthopaedic clinic and on referring patients to other board areas.

Recommendations

We recommended that the board:

- use the findings of this complaint to develop a multi-disciplinary (orthopaedic, radiology and A&E) action plan;
- feed back the findings of this investigation to the relevant staff;
- consider adviser 1's comments in relation to the approach being taken to restrict urgent appointments in the orthopaedic clinic and on referring patients to another board; and

- provide details of the steps taken/action plan to address how the 12-week target will be met in future.