SPSO decision report

Case: **201905253, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C attended A&E at Perth Royal Infirmary following a knee injury. They were diagnosed with a soft tissue/tendon strain and advised to attend their GP for follow-up. C said that their knee did not settle and attended the hospital again six months later. C was then told that they had a meniscal tear (a partial or full tear in the cartilage of the knee). As their condition did not improve, C underwent an operation. C said that they experienced no relief following the operation and their GP made a further referral to orthopaedics (specialists in the treatment of diseases and injuries of the musculoskeletal system). They were advised that further surgery would be unlikely to help and, therefore, there was no clinical reasons to operate further.

C complained about the care and treatment they were given by the board. C said that there was a delay in providing appropriate treatment and diagnosis, that their care was poor and that the board did not deal reasonably with their complaints about this.

The board said that C's initial care and treatment had been appropriate and although they were aware of C's view that they should have been x-rayed when they first attended the hospital, to have done so would not have shown the subsequent diagnosis they received. The board added that scans and x-rays were not routinely carried out for knee injuries and that C had been given appropriate advice.

We took independent advice from consultants in emergency medicine and in orthopaedics. We found that, overall, C's care and treatment had been reasonable. However, there was a failure to carry out an x-ray when they first attended hospital which was contrary to accepted guidance regarding when an x-ray of a knee should be undertaken following trauma. For this reason, the complaint was upheld.

In relation to complaint handling, we found that C was kept fully apprised of the progress of their complaint and given a new target date for a response which was met. We did not uphold this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to x-ray their knee in accordance with the Ottowa knee rules. 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:

- When presented with knee injuries in A&E, clinicians should take into account the relevant guidance (in this case the Ottowa knee rules).

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.