Scottish Parliament Region: North East Scotland

Case 200701937: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency

Overview

The complainant (Mrs C) raised a number of concerns about the treatment she received for a fractured arm at her community hospital (Hospital 1), following a fall on 24 October 2006. Mrs C attended Hospital 1 from 24 October 2006 to 12 December 2006 but remained unhappy with the treatment she received and eventually referred herself to a major hospital (Hospital 2) for treatment.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) further to Mrs C's attendance at Hospital 1, from 25 October 2006, staff failed to arrange a follow-up x-ray (*upheld*); and

(a) the management of Mrs C's injury was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that Grampian NHS Board (the Board):

(i) apologise to Mrs C for the failure to carry out a repeat x-ray; and

(ii) develop a protocol for the management of patients who attend community hospitals with fractures, as suggested by the professional medical adviser.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 5 November 2007 the Ombudsman received a complaint from Mrs C about the treatment which she received for a fractured arm at her community hospital (Hospital 1), following a fall on 24 October 2006. Mrs C attended Hospital 1 from 24 October 2006 to 12 December 2006 but remained unhappy with the treatment she received and eventually referred herself to a major hospital (Hospital 2) for treatment. Mrs C complained to Grampian NHS Board (the Board) but was dissatisfied with their responses and subsequently complained to the Ombudsman.

1. The complaints from Mrs C which I have investigated are that:

(a) further to Mrs C's attendance at Hospital 1, from 25 October 2006, staff failed to arrange a follow-up x-ray; and

(b) the management of Mrs C's injury was inadequate.

Investigation

2. In writing this report I have had access to Mrs C's clinical records and the complaints correspondence from the Board. I obtained advice from one of the Ombudsman's professional advisers (the Adviser), who is an Accident and Emergency Consultant, regarding the clinical aspects of the complaint. I also made an enquiry of the Board.

3. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical History

4. According to Mrs C's clinical records, she attended Hospital 1 as follows:

24 October 2006: '… complaining of painful L[eft] wrist. Unsure how she landed. Very slight swelling. No bruising ROM [range of movement] good. Painful on palpitation in distal radius area + ASB area L[eft] elbow slightly sore … return 9am 25.10.06 for x-ray to exclude # Please reassess L[eft] elbow'

*25 October 2006***:** '… xr[ay] ? undisplaced # L[eft] radius (head) … see 1/12 1/11/06 9 am for x-ray result.'

1 November 2006: '… cont[inue] pop [plaster of paris] … see3/52 -?x-ray then …'
9 November 2006: '… increased pain in POP. POP removed … paraestheia in hand and tenderness … wrist splint applied – more comfortable. Review as previously arranged or earlier if required'
22 November 2006: 'some pain at wrist but good ROM continue splint for 2 weeks.'
6 December 2006: 'Feels much improved FC [Final Certificate] to 20 December 2006 wrist injury see prn (when required)'
12 December 2006: 'still swollen and painful'

(a) Further to Mrs C's attendance at Hospital 1, from 25 October 2006, staff failed to arrange a follow-up x-ray; and (b) the management of Mrs C's injury was inadequate

5. In correspondence with the Board, Mrs C said that she attended Hospital 1 on 25 October 2006 and the doctor told her that it appeared she had suffered a fracture in her radius but the diagnosis would need to be confirmed at Hospital 2, where orthopaedic staff were located. (Note: A community hospital is a rural hospital which has a reduced range of medical services available but is conveniently placed for the local population. In community hospitals patients are normally treated by their GPs, however, if specialist advice is required then this can be obtained from the nearest major hospital.) Mrs C was told the result would be back at Hospital 1 the following week. The diagnosis was confirmed as a fracture on 1 November 2006 and Mrs C continued to attend Hospital 1 for follow-up treatment. On 6 December 2006 Mrs C said she was told by a doctor that the splint could be removed but retained should she feel it was required. Mrs C questioned whether an x-ray and/or physiotherapy was required but she was told it would only show that the bone was healing and, with use, her wrist would be alright.

6. Mrs C saw her GP on 3 January 2007, as she had been due to start back at work, but she was still concerned about the pain and swelling from her wrist. The GP referred her back to Hospital 1 for an x-ray. This was carried out on 4 January 2007 and again the x-ray was sent to Hospital 2 where it would be reported on by orthopaedic staff and the result sent back to Hospital 1. Mrs C thought perhaps she should have been advised to attend Hospital 2 in the first instance, as she believed she would have received an improved service and wondered if patients in rural areas received a lesser service than those who lived in the city.

7. The Board's Chief Executive (the Chief Executive) responded to Mrs C on 6 March 2007 that it was felt that staff at Hospital 1 had treated the injury appropriately. If Mrs C had attended Hospital 2 on the first visit she may have received a cast straightaway but, more likely, she would have been asked to call back later to have the cast applied when the swelling had subsided and this would have necessitated two journeys. The Chief Executive explained that Mrs C would have received the same treatment in either Hospital 1 or Hospital 2 and, although the treatment had been appropriate, it was unfortunate that the healing process had not been as straightforward as expected.

8. Mrs C wrote back to the Board as she subsequently learned that there was a video-link between Hospital 1 and Hospital 2 and that, when she queried whether there was a need for an x-ray or physiotherapy on 6 December 2006, staff at Hospital 1 should have contacted Hospital 2 for advice.

9. The Chief Executive responded that it was noted in the clinical records on 6 December 2006 that Mrs C 'feels much improved' and it was assumed that this was why the doctor decided to issue a final medical certificate and not seek an alternative opinion or investigate further.

10. The Adviser reviewed Mrs C's clinical records and noted that she had sustained a fracture of her left radial styloid (the lower end of the long forearm bone on the 'thumb side' of the wrist) on 24 October 2006. She attended the casualty unit at Hospital 1, where a nurse assessed her to have a probable fracture, but Mrs C had to attend the following morning for an x-ray. Follow-up treatment continued until 6 December 2006, when Mrs C was discharged to return 'as needed'. However, due to Mrs C's ongoing pain, she attended her GP who arranged for a further x-ray to take place on 4 January 2007, which was reported as being an un-united fracture of the radial styloid. There were also changes in the joint, although it was not clear if they were new. This x-ray result precipitated an urgent orthopaedic referral but, as this appointment was not planned for some months, Mrs C sought assistance from NHS24 and she attended the orthopaedic team in Hospital 2 on 14 February 2007. At that time, the orthopaedic team appeared to have said there were no signs of a fracture in the wrist and follow-up treatment was arranged by the hand clinic and physiotherapy.

11. The Adviser said that Mrs C had sustained a significant fracture which, although not displaced, had the clear potential to be quite troublesome, involving the joint surface as it did and having the potential for complicating associated injuries. The Adviser felt that it was reasonable, in the absence of gross swelling or deformity, for Mrs C to have returned initially to Hospital 1 for an x-ray on 25 October 2006 and then for her arm to be placed in a plaster of paris. However, the Adviser would have expected orthopaedic follow-up for this type of injury. The Adviser said the records indicated that Mrs C had attended for follow-up at Hospital 1's casualty unit for the fracture up until 6 December 2006 and the responsibility was then transferred to the GP surgery. The Adviser said that during this time she would have expected, at the very least, a check x-ray and, ideally, onward referral to the orthopaedic department at Hospital 2 whilst Mrs C was attending the casualty unit at Hospital 1. In particular, the Adviser believed that when problems with the plaster occurred, necessitating its removal on 9 November 2006, after only two weeks in plaster (see paragraph 5 – clinical history), it was unwise to continue treatment with only a splint and without an x-ray to check the progress and the position of the fracture and despite Mrs C's reports of continued pain.

12. The Adviser felt the clinical notes for 22 November 2006 and 6 December 2006 lacked information and, although no real problems were noted, satisfactory progress seemed unlikely in light of the entry on 12 December 2006 which stated 'still swollen and painful'. At some stage between discharge and January 2007, the Regional Pain Syndrome (also known as Sudek's Atrophy, a painful condition that develops following some fractures - this is an unpredictable complication which can cause swelling, discolouration and loss of function of a limb) established itself and, although the fracture remained relatively stable, it seemed that Mrs C continued to have problems which might be attributable to more damage within the joint than first expected.

13. The Adviser told me that the assessment and decisions made on 24 and 25 October 2006 were acceptable, within the confines of a local service. It was not the sort of injury which warranted the use of the video-link and had appropriate follow-up been correctly managed then Mrs C would not have benefited from being transferred to a larger Accident and Emergency Unit. However, thereafter the communication, record-keeping and assessment at the follow-up in Hospital 1 fell short of what the Adviser would have expected for the type of injury Mrs C sustained, especially given the lack of progress. The

Adviser said that there was a failure to repeat the x-ray at any stage prior to discharge. The Adviser did not think the record entry of 6 December 2006, 'feels much better', was an adequate assessment upon which to base discharge, especially when the entry for 12 December 2006 read 'still swollen and painful'. The Adviser added that the omission of x-ray and poor documentation of progress, probably representing a lack of appreciation of the risks of complication and severity of the developing problems, contributed to the general delays in seeking expert opinion for Mrs C's troublesome injury.

14. The Adviser noted that the entry for 1 November 2006 did say that an x-ray should be considered in three weeks and this would have been an acceptable plan had it been carried out then, or on 6 December 2006, prior to discharge. The delay in healing would have been picked up and appropriate onward referral could have been organised. The Adviser noticed that there were two GP practices which provided medical cover for the casualty unit's patients and, coincidently, Mrs C's practice was one of them. In this instance, the supervising GPs elected for Mrs C to return not to her own GP surgery but to the casualty unit for follow-up until 6 December 2006. The Adviser thought it was possible doctors at the surgery would have known about Mrs C's progress to date and may have seen her in the casualty unit. If this was the case, it could have meant that the continuity of care was maintained and that there was not a lack of communication, although this was not explicit from the records.

15. Nevertheless, the Adviser noted that Mrs C did return un-bidden to the casualty unit on 12 December 2006, where she was prescribed anti-inflammatory analgesics, and was reviewed at the GP surgery on 20 December 2006. As Mrs C was still experiencing pain, an urgent physiotherapy referral was made. Although the Adviser was somewhat assured that there was an ongoing attempt by the GPs to control Mrs C's pain and get the injury resolved, the Adviser still felt that the failure to repeat x-ray until ten weeks after the injury, despite continued pain, delayed appropriate specialist follow-up.

16. In response to my enquiry, the Board provided me with a copy of the agreed protocols which are applied by Minor Injuries Trained Nurses in Minor Injuries Units across the Board area. There is no written guidance, as such, for GPs who hold casualty contracts in community hospitals. However, they have a level of professional training and competence to allow them to make judgements on treatment of fractures, gained through both under-graduate and

post-graduate training and through experience gained over the years. For patients presenting to community hospitals, judgement is made on whether the condition merits immediate referral to the Accident and Emergency Department at major hospitals.

17. The Adviser reviewed the protocols and told me they comprised of simple algorithms for dealing with suspected fractures, which guide the user to make the decision whether to x-ray or not. There was no guidance about what to do once a fracture had been diagnosed and she had hoped to see guidance on which fractures could be simply managed (for example, by plaster cast for a certain set time and local casualty follow-up) and those which needed specialist referral and after what interval. The Adviser accepted that GPs have a level of training and competence, although she believed that, in this instance, the GPs covering the casualty unit worked outside that level of training and competence, as there was a delay in them recognising complications in a fracture that, although it looked on x-ray to be fairly trivial, had the potential for significant complications. The Adviser believed that most major Accident and Emergency Departments, whilst managing the initial x-ray, diagnosis and immobilisation in the same way, would have specifically agreed protocols for radial styloid fracture and Sudek's Atrophy and she would have expected urgent referral for specialist follow-up in an orthopaedic clinic. The Adviser suggested that the Board should develop a protocol which would include a schedule of recommended management, follow-up options, repeat x-ray intervals and onward referral requirements for common fractures. This would give guidance to GPs covering the casualty unit, in order to avoid unnecessary referral where facilities do exist for simple treatment and follow-up but reduce the risk of delay to referral where management may be more complex or have a higher risk of complication.

(a) Conclusion

18. Mrs C wondered whether the level of treatment she received at Hospital 1 was inferior to that which would have been provided at Hospital 2. In particular, whether she should have been referred earlier for a specialist opinion and whether that would have avoided her suffering from ongoing pain. Mrs C had also inquired whether there was a need for her to have an x-ray or physiotherapy but was told it was not required. While there is no doubt that the range of specialist services which would be available at a community hospital will be less than a major hospital, procedures have to be in place which allow staff at the community hospitals to seek advice and refer patients for specialist

opinion when required. The advice which I have received and accept is that the initial treatment which was provided at Hospital 1 was appropriate and there was no requirement for Mrs C to be referred to Hospital 2 for either a specialist opinion or to discuss matters via a video-link. However, as time progressed, and it became apparent that there was a problem with the injury, staff failed to arrange for a repeat x-ray to take place, which would have alerted them to the fact that the injury was not healing as expected. Accordingly, I uphold this complaint.

(a) Recommendation

19. The Ombudsman recommends that the Board apologise to Mrs C for the failure to carry out a repeat x-ray.

(b) Conclusion

20. Mrs C believed that the management of her injury should have been transferred to the orthopaedic team at Hospital 2 by Hospital 1 and that it only took place because she attended Hospital 2 by her own referral. The Adviser has pointed out that, although she felt the GPs at Hospital 1 had attempted to resolve Mrs C's injury, it was clear that, due to the length of time since the injury occurred and the continued pain suffered by Mrs C, referral for a specialist opinion was required. While I have no reason to doubt that the GPs involved were acting to the best of their ability, an earlier referral to the orthopaedic department of Hospital 2 was required, as has been alluded to earlier in this report. Matters may have been hampered by a lack of clear protocol about the procedures which should be followed when a patient attends local casualty units with a fracture. Such a protocol would give advice on what action to take should such an injury occur and where there are noticeable complications which indicate the injury is not responding to treatment. In the circumstances, I uphold the complaint that the management of Mrs C's injury was inadequate.

(b) Recommendation

21. The Ombudsman recommends that the Board develop a protocol for the management of patients who attend community hospitals with fractures, as suggested by the Adviser.

22. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Hospital 1	Mrs C's community hospital
Hospital 2	A major hospital in the Board area
The Board	Grampian NHS Board
The Adviser	Professional medical adviser
The Chief Executive	Chief Executive of the Board