Management of shoulder dislocation
15HDC01723, 20 February 2018

District health board ~ Emergency department consultant ~ Clinical nurse specialist ~ Dislocation ~ Sedation ~ Right 4(1), 6(1)(f)

A man dislocated his right shoulder in an accident. He attended the Emergency Department (ED) at a public hospital, arriving at 1.48pm.

The triage nurse arranged for the man to have an X-ray. At 3.15pm, nursing staff gave the man ibuprofen and codeine for pain relief. A Clinical Nurse Specialist (CNS) and a registered nurse (RN) assessed the man at 4.15pm. After reviewing the X-ray, the CNS proceeded to attempt to reduce (relocate) the man's shoulder, but this was stopped as the procedure became too painful.

The CNS attempted reduction on two further occasions after requesting intravenous opiate pain relief from the consultant. 25mcg IV fentanyl was administered before both of these reductions, but both were stopped at an early stage due to pain.

The CNS then contacted the consultant to provide procedural sedation which was administered, and the CNS reduced the man's shoulder at 5.10pm. The CNS then ordered a post-reduction X-ray for the purpose of ensuring that the reduction had been successful. At 6.15pm, the man was discharged from the ED with advice to follow up with his GP, and was given copies of his X-rays and medical notes.

The day after discharge, the X-rays were reported on formally. The pre-reduction X-ray report stated that there was a 1 x 0.2mm bone fragment posterior to the humeral head on the lateral view, and the post-reduction X-ray report queried subtle deformities, and stated "if indicated this area can be better evaluated by CT."

The consultant viewed and signed both of the X-ray reports, and noted that no action was required. The reports were not sent to the man. The man's GP's details were not recorded in the clinical records, so the reports were not sent to the GP either.

Findings
The man's triage documentation was incomplete, his pain was not managed adequately, no secondary survey was undertaken, and his GP's details were not captured on the DHB's system. These deficiencies indicated a pattern of poor care by staff, and systems issues, for which the DHB is responsible. For these reasons, it was held that the DHB did not provide reasonable care and skill, and breached Right 4(1).

The Commissioner was critical that the consultant did not inform the man of the abnormality seen on the X-ray, especially in light of the fact that the reports were not copied to his GP. For failing to do so, the consultant breached Right 6(1)(f).

Adverse comment was made about the CNS's documentation.

Recommendations

The Commissioner's recommendations included requesting that the DHB provide updates on improvements made since this case; provide training to staff on the use of the IV opioid pain relief protocol; and provide an apology.

The Commissioner also recommended that the consultant provide an apology.