Shoulder Dislocation in Adults

Background.

Dislocated shoulders are a common problem faced by emergency physicians. They are often extremely painful injuries and require prompt attention if they are to be managed well. The vast majority (>95%) of dislocations are anterior dislocations as shown below.

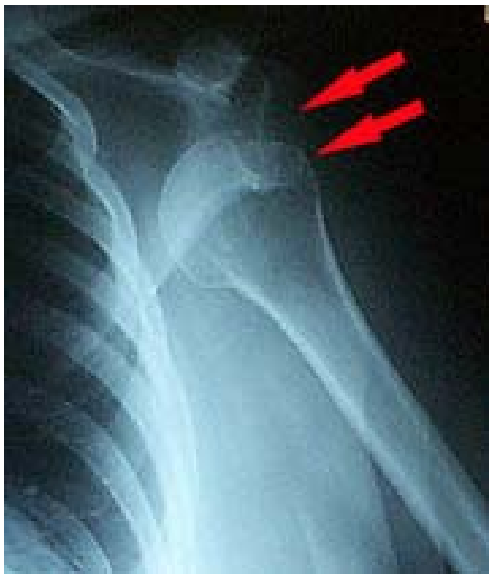
Shoulder dislocation is documented in Egyptian tomb murals as early as 3000 BC, with depiction of a manipulation for glenohumeral dislocation resembling the Kocher technique. Hippocrates detailed the oldest known reduction method still in use today and advocated treating chronic shoulder instability with cauterization of the deep tissues of the anterior shoulder.

The shoulder dislocates more than any other joint. It moves almost without restriction, but pays the price of vulnerability. The shoulder's integrity is maintained by the glenohumeral joint capsule, the cartilaginous glenoid labrum (which extends the shallow glenoid fossa), and muscles of the rotator cuff. Anterior dislocations account for more than 95% of dislocations, with posterior dislocations making up 4% and inferior dislocations (luxatio erecta) about 0.5%. Superior and intrathoracic dislocations are extremely rare.

A Dutch study estimated the incidence of shoulder dislocation at 17 cases per 100,000. In a random sample of people in Sweden, 1.7% reported a history of shoulder dislocation.

Distribution is bimodal, with peak incidence in men aged 20-30 years (with a male-to-female ratio of 9:1) and in women aged 61-80 years (with a female-to-male ratio of 3:1).

In many ways the management of shoulder disclocation is a good indicator of orthopaedic care in the ED. This audit is designed to tell us how well we deliver care to patients with shoulder dislocations



Special points of interest:

- Pain control is important
- The timeliness of care affects patient morbidity
- It often requires sedation to achieve reduction
- Most patients are discharged directly from the ED
- There are a number of controversies in manageme

Methods

Retrospective audit

Sample: 30-50 Emergency Department patient records

Criteria

Inclusions: All shoulder dislocations in patients aged 16 or over

Exclusions: Dislocations associated with greater tuberosity fractures, humeral and/or clavicular fractures, and children

Please ensure you register the audit with your Trust Clinical Audit Department

Notes can be obtained by computer search of the ED database. The coding system on the back of the ED cards should be searched using the terms :

The search should extend over a sufficient period to include the 30 most recent obtainable events as a minimum. Contact the ED information manager to obtain a list of case notes matching these criteria.

Cards may only be physically kept in the department for a couple of weeks and then sent for scanning and archiving electronically. This can take up to 4 weeks.

Once you have the cards for the relevant patients then you need to record the data in an accessible way. This should be entered into the excel spreadsheet that contains all the relevant cells and formulae. For some of the items on the spreadsheet you may want to include a number of options. To maintain a consistency between rolling audits we ask that you stick to the approved list of criteria.

Work plan

Week 1-2, background reading and ordering case notes

Week 3-4, accessing records and entering data onto spreadsheet

Week 5-6, preparing the Powerpoint presentation of your findings

Presentation of findings

The data should be collated and then presented using the associated PowerPoint presentation with the new data entered.

Data **MUST** then be uploaded onto www.stemlyns.org.uk/admin as instructed. Please obtain the username and password from your audit lead.

Further Information contact:

How to upload the audit data

- www.stemlyns.org/admin
- Username and Password
- Select Appropriate Audit Title
- Select EDIT RESULTS next to appropriate date
- Enter results and CONTINUE
- FINISH
- LOG OUT

Traffic lights within 5% of target within 6-15% within 16%+

Criteria	Standard (%)	Standard achieved Locally (%)	Standard Achived Regionally (%)	Standard Met?	Status
Pain relief within 20 mins of arrival	100				
Neurovascular examination (including axillary nerve) documented	100				
X ray taken within 60 mins of arrival	100				
Two medical staff involved, one for reduction and one for sedation	100				
X-ray post reduction	100				

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Clinical scenario

Dislocated shoulders are a common problem faced by emergency physicians. For patients they are often extremely painful injuries that they consequently require prompt attention if they are to be managed well. The vast majority (>95%) of dislocations are anterior dislocations.

Audit question

Are shoulder dislocations managed appropriately according to best practice guidelines?

Method

Retrospective audit of 30-50 Emergency Department patient records

Criteria

Inclusions - Shoulder dislocations in patients aged 16 or over

Exclusions: Dislocations associated with greater tuberosity fractures, humeral and/or clavicular fractures, and children

Results

Date	Patients	Measured	Results	Standard	Regional avg.
1st August 2006	Patients attending the ED with a shoulder dislocation	Management of patient according to criteria	Pain relief within 20 mins of arrival	100 %	-
			Neurovascular examination (including axillary nerve) documented	100 %	-
			X ray taken within 60 mins of arrival	100 %	-
			Two medical staff involved, one for reduction , one for sedation	100 %	-
			X-ray post reduction	100 %	-

Comment

To be completed

Audit Bottom Line

To be completed