

DO NOT FORGET · THE SHORT CHECKLIST

Anterior shoulder dislocation: reduction

Closed reduction of an anterior glenohumeral dislocation in the emergency department, with a documented neurovascular examination before and after and a clear list of cases that must not be attempted.

EM Orbit

Patient reference	Date	Time	Completed by

The 13 steps that must not be missed

- [ ] **BEFORE**
  Examine and document the distal neurovascular status before any manipulation: radial pulse, capillary refill, hand temperature and colour.
  Compare with the other side.

- [ ] **BEFORE**
  Test the axillary nerve: sensation over the lateral 'regimental badge' area of the shoulder, and deltoid contraction by palpating the muscle while the patient attempts isometric abduction.
  Active abduction is limited by pain and the dislocation, so test sensation and isometric contraction rather than range.

- [ ] **BEFORE**
  Do not attempt reduction if the films show a displaced fracture-dislocation, or if the dislocation is posterior or inferior, without senior or orthopaedic advice.

- [ ] **BEFORE**
  Do not attempt reduction if there are signs of arterial injury; call vascular surgery and orthopaedics and follow their plan.

- [ ] **BEFORE**
  If sedating, fast per local protocol, apply full monitoring, site IV access and have airway equipment and reversal agents ready before starting.

- [ ] **DURING**
  Insert the needle into the joint space, aspirate (haemarthrosis confirms position), then inject slowly after negative aspiration.

- [ ] **DURING**
  If local anaesthetic toxicity is suspected, stop injecting, call for help, manage the airway and circulation, and give 20% lipid emulsion 1.5 mL/kg IV bolus followed by an infusion per the national LAST guideline.
  Signs: Perioral tingling or numbness, metallic taste, tinnitus, light-headedness, agitation, confusion, seizures, arrhythmia, cardiovascular collapse.

- [ ] **DURING**
  Use slow, steady, gentle movements and allow muscle spasm to settle; do not use sudden jerks.

- [ ] **DURING**
  Stop immediately if the patient reports severe pain, if there is a crunch, or if resistance suddenly increases.

- [ ] **DURING**
  Do not use levering manoeuvres (for example the original Kocher technique) or a foot in the axilla; these carry a risk of fracture and neurovascular injury.

- [ ] **AFTER**
  Reassess and document the neurovascular status: radial pulse, capillary refill, axillary nerve (sensation over the lateral shoulder and deltoid contraction), musculocutaneous, radial, median and ulnar function.
  Compare with the pre-reduction findings; any new deficit is an emergency.

- [ ] **AFTER**
  If a new neurological deficit or pulse loss appears, stop, call senior and orthopaedic or vascular help, and do not discharge.

- [ ] **AFTER**
  If reduction fails after reasonable attempts with adequate analgesia, stop and arrange orthopaedic review; do not continue forceful attempts.



The short list: an aid to memory, not the whole procedure. The full checklist is at the QR code. It does not replace your local protocol or your clinical judgement.