Scottish Parliament Region: North East Scotland

Case 200602983: Tayside NHS Board

Summary of Investigation

Category

Health: Hospital; Accident and Emergency

Overview

The complainant Mr C complained on behalf of his wife (Mrs C) about what happened when she attended the Accident and Emergency Department at Perth Royal Infirmary (Hospital 1).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C was inappropriately referred to the out-of-hours service (*not upheld*);

(b) Hospital 1 failed to diagnose Mrs C's condition (*not upheld*); and

(c) Mrs C was treated rudely and uncaringly by the Emergency Nurse Practitioner (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board review the completion of triage documentation in the Accident and Emergency Department of Hospital 1 to ensure the reasons for the triage assessment are documented.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. Mrs C developed symptoms of earache and sickness on 27 June 2006. She attempted to contact her General Practitioner (GP) but the surgery was closed for an in-service training day. Mrs C attended the Accident and Emergency Department at Perth Royal Infirmary (Hospital 1) but was re-directed to the out-of-hours service, which was based at a health centre approximately one mile away. Mr C complained to Tayside NHS Board (the Board) about what happened to Mrs C at the Accident and Emergency Department but he remained dissatisfied with the response and he complained to the Ombudsman.

2. The complaints from Mr C which I have investigated are that:

(a) Mrs C was inappropriately referred to the out-of-hours service;

(b) Hospital 1 failed to diagnose Mrs C's condition; and

(c) Mrs C was treated rudely and uncaringly by the Emergency Nurse Practitioner.

Investigation

3. In order to investigate this complaint I have had access to the clinical records relating to Mrs C's attendances at Hospital 1 and the out-of-hours service and the correspondence in relation to the complaint. I have corresponded with both the complainant and Tayside NHS Board (the Board) and I have obtained information from Mrs C's General Practice. I have obtained clinical advice from the Ombudsman's adviser who is an Accident and Emergency Consultant (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Mrs C was inappropriately referred to the out-of-hours service

4. Mr C complained that Mrs C was not fit enough to go to the out-of-hours service. Following his wife's attendance at the out-of-hours service on 27 June 2006, Mr C said that her condition deteriorated and on 3 July 2006 her GP required to refer Mrs C to Ninewells Hospital (Hospital 2), where Mr C said that she underwent an urgent brain scan and was kept in hospital under observation until 7 July 2006.

5. In response to the complaint, the Consultant in Emergency Medicine (the Consultant), who had been on duty on the day Mrs C attended Accident and Emergency, said that the closure of the GP practices that afternoon had led to a large influx of patients with complaints which would normally - and more appropriately - be dealt with by their GPs. Mrs C, who had attended with symptoms of earache, fell into this category. The Emergency Nurse Practitioner had discussed Mrs C's presentation with the Consultant on duty before referring her to the out-of hours service. The referral had been made in good faith to the place where the Consultant considered that Mrs C would receive the most appropriate treatment.

6. I asked Mrs C's GP Practice for a transcript of the message which was on the Practice's answering machine that afternoon. The message was:

> 'The surgery is now closed. If you require urgent medical advice please call NHS 24 on 08454 242424, I repeat, please call NHS 24 on 08454 242424. If you require a repeat prescription, routine appointment or your call does not require immediate medical attention, please contact the surgery during normal working hours.'

7. I obtained a copy of the call sheet referring to Mrs C's attendance at the out-of-hours service, which stated that Mrs C was seen by a GP and was diagnosed with an ear infection and a burst eardrum. She was prescribed ear drops and a painkiller.

8. The Accident and Emergency records showed that Mrs C attended on 27 June 2006 at 14:58. She was triaged as category four (non-urgent). The only entry was:

> 'Right ear pain, ? infection. Unable to see GP till tomorrow.'

9. The Adviser said that triage is the process by which patients are allocated resources, according to degree of urgency, based upon a brief clinical assessment. The most common triage tool is a five point scale, with one being most urgent. The allocation uses various presenting features and discriminators, such as severity of pain, to decide the category. Unfortunately, in this case, there is no record of any baseline observations or details of the basis for the triage category decision. The records from the out-of-hours service, however, stated that Mrs C gave a history of having had a cold for two weeks and earache for two days. On examination, the eardrum was obscured by the presence of pus in the ear canal. She was said to be

otherwise well. The Adviser said that this information justified the triage score of four and subsequent referral to the out-of-hours service. The Adviser said that if Mrs C had contacted NHS 24, as advised by her own GP surgery, she would probably have been referred to the out-of-hours service. The Adviser was, however, critical that no further details were available from the Accident and Emergency records. The Adviser would counsel the Accident and Emergency Department that the need for documentation of a good triage assessment is paramount.

10. Following Mrs C's discharge from Hospital 2, the Senior House Officer wrote to her GP. He said that, on examination on 3 July 2006, she was found to have mastoid tenderness on the right side (the mastoid bone is located just behind the ears slightly above the level of the earlobe). A scan confirmed the presence of otomastoiditis (infection of the mastoid, usually as a consequence of an ear infection). Mrs C was treated with antibiotics and her symptoms resolved after a few days. In a further letter it stated that, on review on 23 August 2006, it was noted that Mrs C's symptoms had resolved although she was aware of mild dullness of hearing. Mrs C did not attend an appointment for further follow-up and so she was discharged from the out-patients clinic.

(a) Conclusion

11. Mr C was concerned that his wife was inappropriately referred to the out-of-hours service on 27 June 2006. It is unfortunate that Mrs C's symptoms later worsened and she was admitted to Hospital 2 on 3 July 2006 but the Adviser said that a triage score of four justified the decision to refer her to the out-of-hours service at that time. The Adviser confirmed that the triage score was correct from the information in the out-of-hours service's records. Mr C was concerned that his wife was not well enough to make her way to the out-of-hours service, which was located approximately one mile away. There is nothing in the clinical records to suggest that Mrs C said at any time that she could not do so and, based on the advice I have received, I do not consider that it was unreasonable for the Consultant to refer Mrs C to the out-of-hours service. I, therefore, do not uphold this complaint. However, although I have not upheld the complaint, I am concerned about the Adviser's comments about the Accident and Emergency Department's lack of documentation to explain the triage decision and the Ombudsman, therefore, makes the following recommendation.

(a) Recommendation

12. The Ombudsman recommends that the Board review the completion of triage documentation in the Accident and Emergency Department of Hospital 1 to ensure the reasons for the triage assessment are documented.

(b) Hospital 1 failed to diagnose Mrs C's condition

13. Mr C said that Hospital 1 failed to diagnose Mrs C's condition, which resulted in the decision to refer her to the out-of-hours service.

14. I asked Mrs C's GP for a copy of the letter which the Accident and Emergency Department sent to him following Mrs C's attendance. The letter confirmed that Mrs C attended and was redirected to the out-of-hours service. The letter said that the diagnosis was a possible right ear infection. This was supported by the entry in the Accident and Emergency records (see paragraph 8).

(b) Conclusion

15. Mr C thought that the Accident and Emergency Department had not realised what was wrong with his wife. It is clear from the letter which was sent to Mrs C's GP, however, that the Accident and Emergency Department did provide a diagnosis of what they considered to be wrong with Mrs C at that time. This is backed up by the out-of-hours service diagnosis of the same day that Mrs C was suffering from an ear infection and a burst eardrum. I, therefore, do not uphold this complaint.

(c) Mrs C was treated rudely and uncaringly by the Emergency Nurse Practitioner

16. Mr C complained that the Emergency Nurse Practitioner who saw Mrs C when she attended the Accident and Emergency Department treated her in an unfeeling manner and was rude to her.

17. In response to the complaint, the Senior Charge Nurse said that she regretted that Mrs C had felt like that but it would not have been the intention of the Emergency Nurse Practitioner to upset Mrs C in any way.

18. Mr C said that that the fact remained that the Emergency Nurse Practitioner had upset his wife. As stated in paragraph 8, the records show that Mrs C attended on 14 June 2006 at 14:58. She was triaged as category four (non-urgent) and that is the only entry.

19. I asked Mr C what exactly the Emergency Nurse Practitioner had said to Mrs C and if there had been any other witnesses to the remark. Mr C replied that there had been no other witnesses but the Emergency Nurse Practitioner said something like:

'The complaint you have does not qualify you to be seen here at A and E.'

(c) Conclusion

20. Having considered what the Emergency Nurse Practitioner said, I can find nothing rude or uncaring in it. It is essentially a statement of fact. I realise that Mr C was disappointed that the Accident and Emergency Department would not treat his wife. I have reviewed the records relating to Mrs C's attendance at Accident and Emergency and, while the Ombudsman has made a recommendation in relation to documents, there is no evidence that the Emergency Nurse Practitioner treated her in a rude or uncaring manner. Accordingly, I do not uphold this complaint.

21. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

19 December 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
The Board	Tayside NHS Board
Hospital 1	Perth Royal Infirmary
The Adviser	The Ombudsman's adviser, who is an Accident and Emergency Consultant
Hospital 2	Ninewells Hospital
The Consultant	The Consultant in Emergency Medicine at Hospital 1