Scottish Parliament Region: North East Scotland

Case 200802067: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Accident & Emergency, staffing, record keeping and hospital transport

Overview

The complainant (Mrs C) raised a number of concerns about the care and treatment provided to her by Accident and Emergency (A and E) staff which resulted in her being misdiagnosed and discharged only to be readmitted hours later suffering from bacterial meningitis and septicaemia.

Specific complaints and conclusions

The complaints which have been investigated are that following her admission to A and E on the morning of 11 January 2008 Grampian NHS Board failed to:

(a) properly monitor and record Mrs C's condition (*upheld*);
(b) supervise the actions of junior staff (*upheld*); and
(c) provide Mrs C with appropriate transport at discharge (*not upheld*).

Redress and recommendations

The Ombudsman recommends that Grampian NHS Board:

(i) undertake an audit (or provide evidence of a recent audit) of the quality of clinical documentation in A and E, with particular reference to discharge documentation;
(ii) review their practice in relation to patient call buzzers being removed and consider how patients can summon assistance from staff when required;
(iii) use events of this case to remind frontline staff of the importance of early diagnosis of meningitis and use in teaching for new junior doctors and nursing staff; and
(iv) stress the importance of documenting consultation outcomes and requests for senior review to all grades of staff in the A and E department.

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

Main Investigation Report

Introduction

1. On 10 November 2008 this office received a complaint from the complainant (Mrs C) that Grampian NHS Board (the Board) had failed to provide her with all appropriate care and treatment during her visit to Accident and Emergency (A and E) at Aberdeen Royal Infirmary (the Hospital) on 11 January 2008 and that as a consequence there was a crucial delay of nine hours in the diagnoses of her meningococcal septicaemia and considerable added pain and distress.

2. The complaints from Mrs C which I have been investigated are that following her admission to A and E on the morning of 11 January 2008 the Board failed to:

(a) properly monitor and record Mrs C's condition;
(b) supervise the actions of junior staff; and
(c) provide Mrs C with appropriate transport at discharge.

3. During local resolution of this complaint Mrs C received an explanation and an apology from the Board for the failure by the junior doctor (Doctor 1) in his misdiagnoses of her illness. Mrs C accepted that apology and explanation but remained concerned about other related aspects of her care that night which she brought to this office. I have not investigated the junior doctor's decisions as the fact of his misdiagnosis is accepted by all parties.

Investigation

4. Investigation of this case involved discussions with Mrs C, reviewing Mrs C's clinical record and obtaining the views of medical and nursing advisers (the Medical Adviser and the Nursing Adviser) to the Ombudsman who are both specialist in A and E care.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Background

6. Mrs C was admitted to A and E by ambulance shortly after midnight on 11 January 2008, following contact with NHS24. She was generally unwell with headache, sore throat, feeling hot and shaky, muscle spasms, stiff neck and

suffering throat spasms, abdominal spasms and a rash. Doctor 1 who reviewed her condition felt it was probably a viral flu-type illness and discharged her. Later that morning she was found in a semi-conscious state at home and at 09:00 was readmitted by ambulance to the Intensive Therapy Unit where meningococcal septicaemia was diagnosed. Mrs C was successfully treated for this life-threatening illness but has a number of on-going health problems such as vertigo and loss of balance as a consequence and has required treatment for post-traumatic stress. All this has impacted adversely on her long-term health and quality of life.

7. Mrs C met with staff following these events and received a number of apologies on behalf of the A and E department but remained concerned about the care she had received. She complained to the Board on 6 May 2008 and received a response on 14 July 2008 with a further apology from the consultant in charge of Emergency Medicine. A meeting was arranged on 15 October 2008 with relevant NHS staff following which Mrs C felt that while she could accept the explanation of the failure to diagnose she was still concerned that a lack of proper oversight of junior staff and access to other staff had allowed her to be inappropriately discharged with adverse consequences to her health. She complained to the Ombudsman's office on 10 November 2008.

(a) Following her admission to A and E on the morning of 11 January 2008 the Board failed to properly monitor and record Mrs C's condition

8. On her admission at 00:25, Mrs C was assessed by a Triage Nurse (the Nurse) as a category 3 (moderately urgent) case. Her temperature and respiration were noted as normal and her pulse was recorded as slightly raised. The possibility of an allergy rash was noted. Mrs C was reviewed within 20 minutes of triage by Doctor 1 and discharged at 03:20.

9. Mrs C complained that she had been left alone unmonitored and unobserved for up to 75 minutes and was unable to call for assistance. She also told me that while she was waiting for her husband to arrive to take her home, her condition had deteriorated but this went unobserved because she was left alone and unmonitored.

10. During local resolution of the complaint the Board told Mrs C at a meeting with staff and an advocacy worker, recorded by the advocacy worker, that the call buzzers had been removed from the rooms because of misuse by other patients. They suggested that members of staff were probably engaged in

other areas of A and E. The Board also advised that once a patient has been discharged they are no longer responsible for that patient even where they remain in the department awaiting collection by relatives. Finally the Board advised that a new department is to be built which will allow for better visibility of patients for nurses.

11. The Nursing Adviser told me that she considered the triage assessment of '3' as reasonable but she had concerns about the recording of the assessment. The Nursing Adviser noted there was no subjective or objective assessment by the Nurse, only a note of physiological observations which the Nursing Adviser considered inadequate. The allergy section contains the word 'drug' which she considered not terribly helpful. The Nursing Adviser also noted that no pain score was taken at any time during Mrs C's first admission and she would consider this poor practice. The Nursing Adviser told me that there are no further nursing records for Mrs C's three hour admission other than incomplete discharge information comprising a note at 02:10 that her treatment was complete. There is no record of any monitoring following the administration of paracetamol (prescribed at 01:20). The record indicates verbal advice was given but with no indication what this advice was. The Nursing Adviser felt that the lack of recording of any monitoring or interaction fell short of the professional standards expected by the Nursing and Midwifery Council in their Guidelines for Records and Record Keeping (published 2005).

12. The Nursing Adviser also expressed concern that the view of the Board appeared to be that once a patient was discharged and awaiting transport they were their own responsibility. The Nursing Adviser felt that if a patient was awaiting transport then nursing staff should be ensuring that person is comfortable and not forgotten. If this occurs then any deterioration should be noticed and reported back to the doctor who saw them.

13. The Nursing Adviser told me that she understood the challenges from disruptive patients in an A and E department but removing the buzzers without providing an alternative for patients or relatives to legitimately attract attention was not acceptable. If no other solution can be found then observation by staff must be increased to compensate. The Nursing Adviser stressed that this would be the case even in the new department as increased visibility will still mean patients are sometimes left alone or cannot be seen.

14. The Medical Adviser found no entry in the medical record of any discussion by Doctor 1 with a senior colleague and advised me that if such discussions did occur they should have been recorded. The Medical Adviser also noted that the discharge information in the clinical record was incomplete.

(a) Conclusion

15. The Medical Adviser and the Nursing Adviser have both told me that there were failures in the recording of Mrs C's condition and treatment. There is no evidence of adequate monitoring and there was insufficient scope for patients to summon assistance if needed. For all these reasons I uphold this aspect of the complaint.

(a) Recommendations

16. The Ombudsman recommends that the Board undertake an audit (or provide evidence of a recent audit) of the quality of clinical documentation in A and E, with particular reference to discharge documentation. The Ombudsman also recommends that the Board review their practice in relation to patient call buzzers being removed and consider how patients can summon assistance from staff when required.

(b) Following her admission to A and E on the morning of 11 January 2008 the Board failed to supervise the actions of junior staff

17. Mrs C complained that while she accepted the Board's apology for the error in diagnosis by Doctor 1 she was concerned that the misdiagnosis had not been picked up at the time given the relatively junior status of the doctor. Mrs C noted that Doctor 1 had had difficulty in finding another, more senior doctor, and seemed unsupported.

18. The Medical Adviser told me that Doctor 1 reviewed Mrs C within 20 minutes of arrival and that this was reasonable. The Medical Adviser noted that Doctor 1 recorded a reasonable thorough history of Mrs C's illness and noted a few scattered non-blanching spots (typical of meningococcus) as well as other blanching spots (not typical) and that the level of medical cover that night was reasonable for the case load. I have previously noted that there is no record of a discussion by Doctor 1 of Mrs C's case with a senior colleague.

19. During my investigation the Board supplied me with a statement, made from memory several months later, from the senior doctor (Doctor 2) on duty during Mrs C's first admission. This statement confirmed he had discussed

Mrs C's case with Doctor 1 and had asked for some further checks to be performed to eliminate liver disease as a possible cause of her illness. When he returned later Doctor 1 advised that all the checks had been normal and he had now discharged Mrs C. Doctor 2 noted that Mrs C had been ambulant when she left the department and her condition had apparently settled so he saw no reason to recall her. Mrs C has told me that she does not recall any further tests being carried out and that Doctor 1 had simply told her that her condition was not acute enough to warrant admission. She also told me that her husband had needed to find a wheelchair to help her out to the car as she could not walk and that as Doctor 2 had not seen her he could not say she was ambulant or not.

20. The Medical Adviser noted that much of Doctor 2's non-contemporaneous note of his understanding of Mrs C's condition diverges from Doctor 1's notes taken at the time and also from Mrs C's account. Unfortunately it is not possible to clarify now whether Doctor 2's account of events stem from poor recollection or a failure by Doctor 1 to convey the correct information to him at the time.

21. The Medical Adviser told me that in her view a young doctor's uncertainty about the nature of a rash and the possible significance of other symptoms alongside a lack of repeated observations and examination by a more senior doctor may have resulted in a missed opportunity to pick up Mrs C's life threatening condition at an earlier stage.

(b) Conclusion

22. I am concerned that a series of failures; in monitoring, recording and understanding all contributed to Mrs C's missed diagnosis. Doctor 2's note of events provides evidence that there was senior support available to Doctor 1 but also indicates that this level of support was inadequate as he was not given an adequate account of Mrs C's condition on which to base his own conclusions. I, therefore, uphold this aspect of this complaint.

(b) Recommendations

23. The Ombudsman recommends that the events of this case are used to remind frontline staff of the importance of early diagnosis of meningitis and used in teaching for new junior doctors and nursing staff. The Ombudsman also recommends that the importance of documenting consultation outcomes and requests for senior review should be stressed to all grades of staff in the A and E department.

(c) the Board failed to provide Mrs C with appropriate transport at discharge

24. Mrs C complained that once she had been discharged, despite her poor health, inability to walk unaided and the time of night, she was not offered transport home but had to arrange her own – this required a lengthy wait for her husband to arrive as they lived at some distance and meant that a further opportunity to observe her deterioration (by hospital or ambulance staff) was lost.

25. The Board apologised that their resources did not permit them to offer taxis or transport home for patients who were able to make their own arrangements.

26. The Medical Adviser told me that the transport policy for the Board which we reviewed was typical of the policy in most areas. Transport can be requested for patients who need it but urgent cases will take priority which in practice will mean long waiting times for anyone not considered urgent and it is usual to encourage patients to arrange their own transport.

27. The Nursing Adviser made similar comments, noting that transport was sadly a finite resource. Her overall view was that the issue here was not the insufficiency of transport available after discharge but rather the appropriateness of the discharge.

(c) Conclusion

28. Based on the views of the advisers that the transport policy is adequate and in-line with reasonable practice elsewhere I do not uphold this aspect of the complaint.

(c) Recommendation

29. The Ombudsman has no recommendation to make.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Grampian NHS Board
A and E	Accident and Emergency
The Hospital	Aberdeen Royal Infirmary
Doctor 1	The Senior House Officer who examined Mrs C
The Medical Adviser	A medical adviser to the Ombudsman
The Nursing Adviser	A nursing adviser to the Ombudsman
The Nurse	The Triage Nurse who first examined Mrs C on arrival at A and E
Doctor 2	The senior doctor – a registrar – who spoke with Doctor 1 about Mrs C's condition

Annex 2

Glossary of terms

Meningococcal Septicaemia	A type of blood poisoning that is caused by the same type of bacteria that cause the most common form of bacterial meningitis
The Nursing and Midwifery Council	An organisation appointed by the UK government to oversee the nursing profession