Scottish Parliament Region: Highlands and Islands

Case 200802376: Highland NHS Board

Summary of Investigation

Category

Health: Hospital; accident and emergency, triage and diagnosis, record-keeping

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment he received during three Accident and Emergency admissions at Campbeltown Hospital (Hospital 1) on 24 and 26 August 2008.

Specific complaint and conclusion

The complaint which has been investigated is that Highland NHS Board (the Board) failed to provide Mr C with adequate care and treatment at Hospital 1 on 24 and 26 August 2008 (*upheld*).

Redress and recommendation

The Ombudsman recommends that the Board apologise to Mr C in writing for the failing identified in this report and their failure to provide him with adequate care and treatment on 24 and 26 August 2008.

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

Main Investigation Report

Introduction

1. On 9 December 2008, the Ombudsman received a complaint from the complainant (Mr C). Mr C complained that staff at the Accident and Emergency Department (A&E) of Campbeltown Hospital (Hospital 1) failed to respond appropriately to his symptoms which led to a delay in diagnosing appendicitis and caused him increased pain and anxiety. Mr C complained to Highland NHS Board (the Board) on 26 September 2008 and received a written response from them on 13 November 2008.

2. The complaint from Mr C which I have investigated is that the Board failed to provide Mr C with adequate care and treatment at Hospital 1 on 24 and 26 September 2008.

Investigation

3. Investigation of this complaint included obtaining and reviewing Mr C's clinical records and the complaints file from the Board. I have sought the opinions of a specialist emergency nurse adviser (the Nurse Adviser) and a medical adviser (the Medical Adviser). I have also made further written enquiries of the Board. 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.

Complaint: The Board failed to provide Mr C with adequate care and treatment at Hospital 1 on 24 and 26 August 2008

4. Mr C attended A&E at Hospital 1 at 19:45 on 14 August 2008. At that time his symptoms related to cuts on his left foot. There was no record of any abdominal pain or other related symptoms. Mr C returned to A&E at 22:10 the same evening at which time he was reviewed by an emergency nurse practitioner (Nurse 1) at which time symptoms of vomiting and abdominal pain were recorded. Mr C was given an injection to combat his nausea and as he was noted to be feeling better he was discharged home at 22:50.

5. Mr C next attended A&E on 26 August 2008 at 09:00 with symptoms of nausea and back pain. Mr C was assessed by a second emergency nurse practitioner (Nurse 2) and reviewed by the A&E doctor (the Doctor). Mr C was noted to have a high temperature and abnormally fast pulse although urinalysis

was normal. Mr C complained that Nurse 2 and the Doctor were rude, uncaring and unprofessional towards him at this time and did not listen to his concerns.

6. Mr C attended his GP on the evening of 26 August 2008 with progressively worse abdominal pain and was referred to the surgical team at the larger area hospital (Hospital 2), which was some distance from Mr C's home, where an appendicectomy was performed on 27 August 2008. Because of the distance involved, Mr C's journey to Hospital 2 was an uncomfortable and distressful one. Mr C complained to the Board that the attitude of Nurse 2 and the Doctor had precluded them properly diagnosing the cause of his pain and prompt referral to Hospital 2 in an ambulance.

7. In the Board's response both the Doctor and Nurse 2 refuted Mr C's allegations about their conduct and the Board concluded that the care and treatment provided during Mr C's attendances at Hospital 1 were appropriate in the circumstances.

8. The Nurse Adviser told me that an emergency nurse practitioner (ENP) is a registered nurse who has undertaken advanced training to allow him or her to act as an autonomous practitioner who can assess, diagnose and treat without referral to a doctor, although ENPs work at different levels according to the training undertaken. The Nurse Adviser reviewed the records for Mr C's A&E appointments and commented that the documentation available was incomplete in that it contained little or no evidence of an attempt being made to find a cause for Mr C's pain and vomiting and no evidence of clinical history taking. The Nurse Adviser also noted that she would have expected an ENP to offer some pain relief medication and medication to reduce temperature. The Nurse Adviser concluded that the standard of care offered by Nurse 1 and Nurse 2 was not reasonable for an ENP as there was no evidence of history taking or diagnosis. The Nurse Adviser was not able to comment specifically on the attitude of Nurse 2 as there is no reference to this in the records which she reviewed, however, she noted that there is reference in the records to Mr C being described as an anxious person which may have affected how staff perceived his reported symptoms.

9. The Medical Adviser reviewed Mr C's medical records for the A&E appointment on 26 August 2008 and told me that the medical notes for this attendance were very brief. The note contained no record of any examination of anything other than the abdomen. An ECG was undertaken but the

interpretation of the results are not obviously recorded. The Medical Adviser noted that Mr C was discharged with no explanation attempted for his raised heart rate and temperature which were all important clues to Mr C's underlying condition which should have prompted further clinical management. The Medical Adviser noted that staff attitude is not normally written down in casenotes thus making it difficult to confirm inadequate or unprofessional attitude without having been present at the time of the events. The Medical Adviser concluded though that the actual lack of documentation of Mr C's history, failure to obviously undertake a full examination or relevant investigations as well as not explaining Mr C's symptoms or abnormal vital signs satisfactorily all led to a level of clinical management which was below the standard expected of a doctor in A&E, irrespective of attitude present.

10. Both the Nursing Adviser and the Medical Adviser provided me with a number of suggested recommendations for the Board covering implementation and monitoring of pain management guidelines, management of common abdominal emergencies and quality control of A&E documentation. I put these matters along with the advice received from the Nursing Adviser and the Medical Adviser to the Board on 6 May 2009. The Board reviewed this information and the issues raised by the advisers and provided me with the further information and comment.

11. In their response the Board acknowledged that the standard of note taking in Mr C's case record was inadequate and fell short of the standard expected by the Board for both ENPs and doctors. The Board advised me that in light of the advisers' comments they have undertaken a number of actions as follows:

- Pain management guidelines have been implemented within the department and will be audited before December 2009.
- Common Abdominal Emergency guidelines would be introduced soon and would be audited following implementation.
- Other areas for review had been identified including staff skill levels for each shift, triage systems, training and supervision of staff.

The Board also noted that whilst there was no excuse for the gaps in practice identified, it was important to reflect that Hospital 1 is in a remote and rural location and a full range of tests and immediate access to clinical expertise is not practically possible as it might be in an urban district hospital.

Guidance

12. The Nursing and Midwifery Council (NMC) issued guidelines for record-keeping in 2005. These guidelines state that 'The quality of your record keeping is also a reflection of the standard of your professional practice. Good record keeping is a mark of the skilled and sage practitioner, whilst careless or incomplete record keeping often highlights wider problems with the individual's practice'.

13. The NMC code issued in 2008 states 'You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been. You must complete records as soon as possible after an event has occurred'.

14. The General Medical Council (GMC) guidance, Good Medical Practice 2006, states that good clinical care must include:

> '2a. adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient
>
> 2b. providing or arranging advice, investigations or treatment where necessary'

Conclusion

15. The Nursing Adviser and the Medical Adviser have told me that the standard of care provided to Mr C fell below that which he was entitled to expect. I also note that the standards set by the NMC, the GMC and the Board were not met. I, therefore, uphold Mr C's complaint that the Board failed to provide him with adequate care and treatment on 24 and 26 August 2008.

16. The initial investigation of this complaint by the Board failed to identify the shortfalls identified by the advisers. However, the action taken by the Board subsequent to receiving the advisers' reports has been prompt and comprehensive and demonstrates willingness by all staff concerned to learn lessons from complaints and as such is to be commended.

Recommendation

17. The Ombudsman notes the actions already proposed and undertaken by the Board and has no further clinical recommendation to make but asks that the

Board notify him of progress towards achieving these changes and the outcome of the associated audits.

18. The Ombudsman recommends that the Board apologise to Mr C in writing for the failing identified in this report and their failure to provide him with adequate care and treatment on 24 and 26 August 2008.

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

Annex 1

Explanation of abbreviations used

Mr C	The complainant
A&E	Accident and Emergency
Hospital 1	Campbeltown Hospital
The Board	Highland NHS Board
The Nurse Adviser	A nursing adviser to the Ombudsman
The Medical Adviser	A medical adviser to the Ombudsman
Nurse 1	The emergency nurse practitioner who reviewed Mr C on 24 August 2008
Nurse 2	The emergency nurse practitioner who reviewed Mr C on 26 August 2008
The Doctor	The A&E doctor who reviewed Mr C on 26 August 2008
Hospital 2	The District Hospital where Mr C had his appendicectomy
ENP	Emergency nurse practitioner
NMC	Nursing and Midwifery Council
GMC	General Medical Council

Annex 2

Glossary of terms

Appendicectomy	Surgical removal of the appendix

Annex 3

List of legislation and policies considered

Guidelines for Records and Record-Keeping, NMC 2005 (subsequently reviewed July 2009)

The Code, NMC 2008

Good Medical Practice, GMC 2006