Scottish Parliament Region: Lothian

Case 200900395: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Accident & Emergency/Gynaecology

Overview

The complainant (Miss C) attended the Royal Infirmary of Edinburgh, in the area of Lothian NHS Board (the Board), on two separate occasions in early 2009 with a history of abdominal pain and irregular menstrual bleeding. She complained about the management of her pain during these attendances.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Miss C's pain was managed inappropriately (*upheld*); and

(b) the standard of record-keeping was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) review their systems for ensuring that patients' pain is properly assessed in Accident and Emergency and on the gynaecology ward and that patients' needs are met with timely pain management, and provide copies of audits regarding pain assessment and management. The review should consider triage arrangements for patients directly referred by their GP and also initiatives for meeting patients' needs if medical staff are not readily available to prescribe pain relief;	17 November 2010
(ii) ensure that, when handling complaints, all complainants' concerns are addressed and that responses refer to relevant standards and guidelines where appropriate;	17 November 2010

(iii)	apologise to Miss C for their failure to manage her pain appropriately and for not fully addressing this issue when responding to her complaint. The apology should also acknowledge the inappropriate reference to Miss C using her mobile telephone; and	15 September 2010
(iv)	provide evidence that appropriate strategies are in place to ensure that all nursing records meet the standards outlined by the Nursing and Midwifery Council.	17 November 2010

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

Main Investigation Report

Introduction

1. The complainant, Miss C, attended the Accident and Emergency (A&E) department at the Royal Infirmary of Edinburgh (the Hospital) on 27 February 2009 with abdominal pain. Miss C, who was 17 years old, had been referred directly by her General Practitioner (GP) to the on-call surgical team with suspected appendicitis and, following examination by the duty surgeon (Doctor 1), she was transferred to the gynaecology department. Following review by the on-call gynaecologist (Doctor 2), she was diagnosed with suspected pelvic inflammatory disease (PID) and discharged home in the early hours of 28 February 2009 with antibiotics and pain-killing medication.

2. Miss C re-attended A&E with continuing abdominal pain and nausea on 1 March 2009. She was seen by an A&E doctor (Doctor 3), provided with pain relief and, as her blood tests were normal and she was subsequently noted to have been comfortable, she was discharged back into the care of her GP.

3. Miss C complained to Lothian NHS Board (the Board) on 9 March 2009 regarding her care and treatment at the Hospital, specifically her pain management. The Board responded on 3 April 2009. Miss C was unhappy with the Board's response and brought her concerns to the Ombudsman on 22 April 2009.

4. The complaint from Miss C which I have investigated is that:

(a) Miss C's pain was managed inappropriately.

5. In addition, as the investigation progressed, I identified issues concerning the sufficiency of the documentary evidence of Miss C's care and treatment. I, therefore, informed the Board and Miss C that I would also investigate a second head of complaint, namely that:

(b) the standard of record-keeping was inadequate.

Investigation

6. In writing this report, I have had access to Miss C's medical records and the complaints correspondence between Miss C and the Board. In addition, I obtained advice from three of the Ombudsman's professional advisers; a consultant in A&E (Adviser 1); a senior nurse (Adviser 2); and a consultant in obstetrics and gynaecology (Adviser 3).

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

(a) Miss C's pain was managed inappropriately; and (b) The standard of record-keeping was inadequate

8. In Miss C's complaint to the Board, she stated that Doctor 1 reviewed her and ruled out appendicitis when it was established that she had still been eating (as loss of appetite is a characteristic of appendicitis). Upon her subsequent transfer to gynaecology, Miss C advised that she waited for three to four hours to be seen by Doctor 2 and that, during this time, she was in severe pain and was not provided with any pain relief. She said that Doctor 2 suspected PID despite her having advised that her GP had already treated and tested her for this a few weeks previously and tests had come back clear. She said Doctor 2 did not listen to her and prescribed the same medication her GP had given her, which she said had made no difference to her pain or heavy menstrual bleeding.

9. Miss C advised that, when she returned to A&E on 1 March 2009, she was in so much pain she could barely walk and she was 'left crying in pain in the waiting room for over an hour'. She stated that a nurse then came (to obtain a urine sample) and took her out of the wheelchair (which the receptionist had provided for her) and left her standing outside the toilet as it was in use. Miss C said that she was then placed in a bed, provided with pain relief and left for a few hours before being sent home with advice to contact her GP if she experienced further pain. She described the treatment she received as 'shocking' and said she just wanted 'to be made better'. She advised that she had been having problems since she was ten years old, she was in constant pain and it was really getting her down.

10. In their response to Miss C's complaint, the Board confirmed that she was reviewed by Doctor 1 during the evening ward round in A&E on 27 February 2009. They indicated that she had given a history of abdominal pain along with a longer history of heavy and irregular menstrual bleeding but no loss of appetite or stomach upset. They advised that, upon examining Miss C's abdomen, Doctor 1 did not find any evidence of inflammation and had thought it likely that she was suffering from PID or another gynaecological

problem. Doctor 1 also explained to Miss C that it was unlikely that she had appendicitis, particularly as she was continuing to eat normally.

11. The Board said that, upon Miss C's transfer to the gynaecology ward (Ward 210), there were high levels of patient activity and she had had to wait until medical staff were free to review her. They apologised for the distress this delay caused Miss C and said that the reason for the delay should have been explained to her at the time. They confirmed that nursing staff could not give patients unprescribed medication but stated that, if her pain was severe, they should have endeavoured to get a member of the medical staff to attend.

12. With regards to Miss C having received repeat antibiotic treatment for PID, the Board explained that this was appropriate as untreated PID can have a significant and potentially devastating effect on future fertility. The Board said that the reason for repeating this antibiotic therapy should have been made clear to Miss C.

13. In respect of Miss C's irregular menstrual bleeding, the Board noted that this had led to her having her contraceptive implant removed. They observed that she had had a contraceptive injection two weeks prior to her initial A&E attendance and they advised that this could also cause irregular bleeding initially.

14. The Board indicated that, when Miss C next attended A&E on 1 March 2009, she was reviewed by Doctor 3 and a full assessment was carried out. They said that she was noted to have been alert and texting on her mobile telephone and observations of temperature, pulse, blood pressure and respirations were unremarkable. They also noted that her abdomen had been soft with mild tenderness and a urine test had indicated that she had blood in her urine. Routine blood tests were carried out and she was given painkillers and anti-inflammatories. The Board advised that Miss C was then observed within A&E and, upon review at 02:30, she was noted to have been comfortable and her blood tests were normal. In view of this, she was discharged home at that point for GP follow-up.

15. Finally, the Board acknowledged Miss C's ongoing health problems and her need to attend A&E in times of severe pain when her GP was not accessible. However, they confirmed that, although it was possible to provide

her with measures to alleviate her pain, it was not possible to diagnose her problems in an A&E setting.

16. Miss C was unhappy with the Board's response and she felt that her complaint had not been taken seriously. She reiterated her concerns to the Ombudsman and provided more detail regarding her experiences in A&E. On her first attendance, she advised that she was placed in a cubicle upon arrival and told to change into a hospital gown. She said that she was in a lot of pain and that she asked the nurse who was looking after her for pain relief. The nurse provided her with paracetamol which she said 'didn't seem to touch' her pain. She stated that she waited around three hours before Doctor 1 reviewed her. After she was transferred to gynaecology, Miss C advised that both she and her partner had asked nursing staff for pain relief but they were advised that nothing could be done until the doctor got there.

17. When she re-attended A&E on 1 March 2009, Miss C advised that, after providing a urine sample, she was left in the waiting room for over three hours before being provided with a bed. When Doctor 3 reviewed her, she advised him that she had stomach pain most days and had recently suffered heavy menstrual bleeding again. She indicated to him that her pain had become unbearable over the previous few days and he provided her with pain relief, which she said 'just took the edge off'. Miss C expressed concern that Doctor 3 had displayed a lack of empathy and had not listened to her. She stated that she was made to feel that her pain was not as bad as she was making it out to be and as though they had just treated her 'like a wee girl'.

18. Miss C indicated that she was not happy that the apologies in the Board's response were worded sorry 'if' she felt, seemed, or appeared not to have been treated appropriately. She also expressed unhappiness with the Board's reference to her texting on her mobile telephone, saying that this also made her feel that they were treating her 'like a wee girl'. She stated that she was 'upset, in pain, angry' and 'frustrated' and that she was texting her mum and her sister asking what she could do.

19. Miss C said she just wanted to be listened to and have her pain fully investigated. She reiterated that she was in pain nearly every day and had to take lots of pain relief. She advised that her menstrual bleeding was also very heavy and she felt so run down.

Adviser 1's view

20. My complaints reviewer asked Adviser 1 to review the records and comment on Miss C's treatment in A&E.

21. Adviser 1 noted that Miss C was referred to A&E by her GP on 27 February 2009, with lower abdominal pain which had become worse that day. The GP's diagnosis was possible 'appendix' and a 'surgical review' was requested. The referral letter included Miss C's previous history of gynaecological complaints and noted that her GP had been treating her as having possible PID, despite 'all tests [being] negative'. The actual treatment given by her GP was later documented by the gynaecologist as two types of antibiotic.

22. Adviser 1 indicated that, when Miss C attended A&E at 16:55 on 27 February 2009, initial observations were made by A&E staff but pain score and pain assessment were not documented. Painkillers were given at 18:00 and Miss C was seen by Doctor 1 on a ward round, however, no time was recorded in respect of this review. A brief history was documented, an abdominal examination was noted and a diagnosis of PID was made. An emergency referral was then made to Doctor 2 at 19:30. Adviser 1 indicated that Doctor 2 had documented Miss C's history and examination findings. He noted that blood test results were unremarkable. Further painkillers were given at 21:30 and Doctor 2 discussed Miss C's case with a more senior doctor, although the time of this discussion was not recorded. Urinalysis revealed only blood, and the urine pregnancy test was noted as negative. The discharge letter stated that appendicitis was unlikely and Miss C was discharged back into the care of her GP with painkillers and a two week course of antibiotics for PID.

23. Adviser 1 observed that Miss C re-attended A&E with abdominal pain on 1 March 2009 at 23:19. He advised that initial observations were made by the A&E team but pain score and pain assessment were not documented. Miss C was seen by Doctor 3 (untimed) and brief notes of her history and examination findings were made. Initial painkillers were given at 00:50 and then again at 01:25 (now 2 March 2009). Urinalysis was documented as having blood present but the urine pregnancy test was again negative. Blood tests were requested. Further vital signs were noted at 01:25 and the nursing notes commented that Miss C was in pain at 01:30 but no further nursing comments were made after this time. Adviser 1 noted that Miss C was observed in A&E prior to being discharged and Doctor 3's discharge letter stated that she had

been comfortable, was now well and that blood tests were all normal, except for a mild anaemia. The letter stated that Miss C was given only painkillers as treatment and discharged around 02:30. The complete blood tests were not noted in the documentation.

24. With regards to the Board's investigation of Miss C's complaint, Adviser 1 noted that they obtained a statement from the gynaecology department on 19 March 2009. He advised that this contained reasonable explanations regarding the waiting time on Ward 210 ('labour ward was busy and the medical staff were tied up there' and thus 'competing priorities') along with an apology for not having explained this at the time. The statement also contained an explanation regarding the repeat treatment with antibiotics and an explanation regarding causes for irregular vaginal bleeding, as well as an apology for not having explained these issues. A statement was also provided on this date by an A&E nurse and this provided explanations about the referral process on 27 February 2009 and commented on the waiting time as 'the department on this day was extremely busy' and the surgical team were also 'extremely busy with referrals'. An apology was also provided for not having explained this aspect. With respect to the A&E attendance on 1 March 2009, Adviser 1 stated that the issue of pain relief was not fully addressed.

25. Adviser 1 said that a statement from an A&E consultant, provided on 23 March 2009, gave a reasonable explanation for the A&E attendance on 1 March 2009. However, he stated that issues regarding pain relief on 27 February 2009 were not fully addressed. He noted that an undated and unsigned statement was in the case file which he assumed was from a member of the surgical team who saw Miss C on 27 February 2009. He advised that this provided a reasonable explanation of events from the surgical perspective, including the briefly documented clinical assessment, although it did not address the issue of pain relief. Adviser 1 observed that the Board's response to Miss C utilised comments from the relevant staff and he stated that, apart from the issue of initial pain relief in A&E, explanations and apologies were provided on the issues raised.

26. With regards to Doctor 1 having ruled out appendicitis, Adviser 1 noted that Miss C appeared to have been seen directly by the duty surgical team in A&E on their evening ward round, rather than a more junior surgeon via the normal mechanisms. He said that this meant that Miss C was seen earlier by a more senior surgeon who was able to make an experienced and individualised

judgement decision about her management. He stated that these, sometimes difficult, judgement decisions were based on knowledge, experience and training and were fundamental to the clinical practice of medicine. Adviser 1 advised that diagnosing appendicitis can, therefore, sometimes be a challenge (although a commonly used rule of thumb is asking about eating, as patients with appendicitis do not usually feel like eating). On the other hand, Adviser 1 said that there appeared to have been sufficient evidence from Miss C's history and examination findings to have warranted a gynaecological opinion at that time and so Doctor 1's referral was reasonable. Adviser 1, therefore, concluded that the Board's explanation was appropriate although, in his view, it could have been more detailed.

27. In respect of the delay in reviewing Miss C, Adviser 1 stated that, due to a lack of documentation, the exact timings of her surgical assessment on 27 February 2009 were not clear (arrival at A&E around 16:55 and seen by Doctor 2 around 19:30). He noted that the Board had explained this apparently unavoidable delay and apologised for it and he said that this explanation was reasonable and the total waiting time that occurred did not seem unreasonable. He, therefore, concluded that the explanation and apology provided appeared reasonable, taking into account the realities of a busy day in a hospital and the available resources.

28. Adviser 1 observed that Miss C then re-attended at 23:19 on 1 March 2009 and initial painkillers were given at 00:50, which he said was not timely. Further painkillers were provided at 01:25. He also noted that pain score and pain assessment were not documented (as also on 27 February 2009). He stated that this issue of timely analgesia in A&E was not addressed in appropriate detail by the A&E nursing or medical staff statements, or by the Board's response. On the other hand, he said that the remaining clinical management undertaken by A&E staff did not appear unreasonable. Thus, apart from the issue of initial A&E pain relief, Adviser 1 viewed the Board's explanation as appropriate although he again noted that it could have been more detailed.

29. Finally, with regards to Miss C's plea for help to resolve her problems, Adviser 1 acknowledged that the management of ongoing conditions in A&E was sometimes a challenge. He concurred with the rationale provided by the Board that making a diagnosis in A&E was sometimes not possible due to the resources and expertise available. He also agreed with the Board that

arranging pain relief was an important part of patient care in A&E even if precise diagnosis was not possible. However, he was not convinced that timely initial pain relief actually occurred in A&E, as per national guidance (see Annex 4), although further pain relief and follow-up arrangements (for further pain management) did occur. He, therefore, said that, again, the Board's explanation was reasonable apart from the access to timely initial pain relief in A&E. He noted that their response did not refer to recognised appropriate national standards and guidelines (Annex 4) and he recommended the use of relevant guidelines in the future.

Adviser 2's view

30. My complaints reviewer also asked Adviser 2 to review the records and comment on the nursing aspects of Miss C's care.

31. With regards to Miss C's first A&E attendance, Adviser 2 stated that the nursing records for both A&E and Ward 210 did not meet the required professional standards (Nursing and Midwifery Council: The Code standards of conduct, performance and ethics for nurses and midwives, 2008). She said that the standards stated that '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'. She noted that there was no triage record other than a baseline set of observations and the wording 'see letter'. She said that she would have expected to see an assessment relating to the condition of Miss C on arrival, how she appeared, whether she was in pain, and a pain score using an appropriate pain measurement tool. She advised that there was provision on the A&E record for both an initial pain assessment score and a further pain score review but that neither had been completed. Adviser 2 said that she would also have expected to see a triage prioritisation category based on the initial assessment (ie the minimum time the patient should wait to see a doctor). She said that the fact that Miss C was an 'expected' patient (directly referred by a GP) did not excuse a lack of triage as her need for clinical prioritisation was no different to that of 'normal emergency' patients. Adviser 2 indicated that 'expected' patients were just as likely to deteriorate and can be forgotten due to them awaiting review by specialist teams. She was concerned by a comment in the A&E Charge Nurse's statement which said A&E receptionists contact the duty teams for 'expected' patients. She advised that this suggested that 'expected' patients may not be assessed by the triage nurse and that this was worrying for the reasons noted above. The A&E Charge Nurse also said that the department was 'extremely

busy' and, therefore, there was a wait for initial assessment, however, Adviser 2 stated that this did not excuse absent nurse triage.

32. Adviser 2 observed that the gynaecology statement provided to the Board said that they were looking at ways to reduce waiting times for emergency attendees, however, she said that it was a shame that this was not transferred to the Board's response to Miss C. She stated that Miss C only received a token explanation about the high workload of the unit, which was not helpful to her in understanding what may change in the future. She also noted that the gynaecology statement said that staff would be asked to reflect on Miss C's experience but, again, this was not communicated in the Board's formal response.

33. Adviser 2 noted that Miss C received mild oral pain relief (Co-codamol) at 18:10 and then Paracetamol and Dihydrocodeine at 21:30, which was a stronger combination. She said that, whilst these may have relieved Miss C's pain, they were administered a long while after she arrived, during which time she described experiencing severe pain. Adviser 2 stated that there was no way of knowing how effective the pain relief was as there was an absence of any kind of pain assessment and review. Timings of events were unclear as none of the records were timed and she could locate only one set of physiological observations for a nine-hour period.

34. Adviser 2 noted the Board's explanation that nurses would not be able to give unprescribed medication but should have sought medical assistance if it was felt that Miss C was in severe pain. However, she noted that the Board had not explained whether any nursing staff had received advanced training to be able to administer pain relief, as was the case in many A&E departments, or whether any other similar initiatives had been implemented to meet patients' needs. She observed that the Board had not referred to the absence of nursing triage or any further records and she said that it was not acceptable that there were no A&E or ward nursing records for a patient who was in the Hospital for over nine hours. In commenting on the proposed report, the Board advised that a second set of observations were performed at approximately 19:30 when Miss C arrived in Ward 210. They noted that these included factors such as blood pressure, respiratory rate and oxygen saturation, however, they acknowledged that they did not include a pain score.

35. With regards to Miss C's second A&E attendance, Adviser 2 stated that, again, there was no triage record or pain assessment. She noted that the A&E Charge Nurse wrote in his statement that triage assessment was undertaken by a registered nurse and he gave details of the assessment, however, there were no records to support his statement. Adviser 2 said that this was unacceptable. She noted, however, that there were two later nursing entries, the first of which referred to preparation of Miss C prior to examination by Doctor 3, and the other noted that she was in pain at 01:30 and pain relief was given. Adviser 2 agreed with Adviser 1 that pain relief was delayed. She noted that Miss C was in A&E for 90 minutes before she received any pain relief and that this was mild (paracetamol) and clearly not effective judging by the nursing entry at 01:30. She stated that further pain relief would have been more appropriate for Miss C's needs.

36. With regards to the Board's reference to Miss C texting on her mobile telephone as a means of demonstrating that she was pain-free and well, Adviser 2 noted that this had upset Miss C. She said that this was understandable as, in her view, it was not appropriate and should not have formed part of a Board response. She said she would expect clinical evidence to support a conclusion that a patient was stable. The fact that she was using her mobile did not, in Adviser 2's view, reflect whether Miss C was in pain and she noted that Miss C had explained that she had been contacting her family to ask them what she should do. Adviser 2 suggested that the Board should apologise for this inappropriate judgement of a patient. She noted that Miss C has been left with the impression that she was not believed by the Board and she agreed that some of the wording in the Board's response letter did imply that Miss C had the impression of poor care, rather than a tacit acceptance of her poor experience. Adviser 2 summarised that the Board's response should have been more accepting of Miss C's negative experience of compassionate care. She suggested that the Board should be asked to provide evidence that appropriate strategies are in place to ensure that all nursing records meet the standards outlined by the Nursing and Midwifery Council. In addition, she indicated that the Board should make sure systems are in place to ensure patients' pain is properly assessed in A&E and on Ward 210 and that their needs are met with timely pain management.

Adviser 3's view

37. Finally, my complaints reviewer asked Adviser 3 to review the records and provide a gynaecological opinion on Miss C's care and treatment.

38. Adviser 3 observed that the GP referral to A&E described an episode of low abdominal pain with initial treatment for PID and also noted Miss C to have had problems with prolonged and heavy vaginal bleeding. This had led to a removal of a contraceptive implant on 11 February 2009 and Miss C had been commenced on contraceptive injections. Adviser 3 noted that, following his ward round, Doctor 1 had described a history of low abdominal pain 'for years' and that, in Miss C's letter of complaint to the Board, she described 'tummy pains' from the age of 10. Doctor 1 also recorded that Miss C's pain had increased on the day of admission but that, although an abdominal examination had revealed some tenderness to the lower left and right abdomen, there were no signs of an acute abdomen and she was referred for a gynaecological opinion.

39. Adviser 3 noted that Doctor 2 recorded a long-standing history of pelvic pain that had increased up to the week prior to admission predominantly to the right iliac fossa (right lower abdomen). Blood was noted to have been present within a urine test, however, Adviser 3 stated that this was not unsurprising in a woman who was bleeding vaginally and he noted that all blood results were within the normal range. He advised that appropriate swabs were taken and that a speculum examination had not revealed any abnormalities apart from generalised pelvic tenderness. A differential diagnosis was that of either a subtreated PID or possible appendicitis and Doctor 2 sought advice from an acting registrar. The decision was to treat PID and Miss C was prescribed antibiotics (ofloxacin and metronidazole).

40. Adviser 3 summarised that Miss C had presented to A&E with an acute exacerbation of what appeared to have been a long-standing chronic condition going back over a number of years. He noted that she was 17 at the time of presentation but her complaint read as if she had been experiencing abdominal pains from the age of 10 onwards. He said that the team looking after Miss C must have been reassured by the normality of the blood results taken and ultimately the negative findings on swabs. The diagnosis, however, was unclear although Miss C was treated as if she had PID. Adviser 3 said that this diagnosis was not unreasonable given some of the presenting symptoms.

41. Adviser 3 advised that Miss C had presented with four of the seven symptoms suggestive of a diagnosis of PID, as outlined in the Royal College of Obstetricians & Gynaecologists (the College)'s Green-top Guideline No. 32 (see

Annex 3). He stated that, in mild or moderate PID ie where there is no tubo-ovarian abscess, there was no difference in outcome whether patients were treated as out-patients or admitted to hospital, but he advised that delayed treatment increased the severity of the condition. He said that treatment with ofloxacin and metronidazole, as in Miss C's case, was appropriate. He noted that the College document highlighted the helpfulness of vaginal ultrasound, particularly where there was diagnostic difficulty, and it also highlighted that a raised white blood count and C-reactive CRP (a marker for inflammation/infection) were useful to support the diagnosis. He indicated that no ultrasound scan was undertaken here but both CRP and white blood count were within the normal range. Adviser 3 said that the situation here was also complicated by the longstanding nature of Miss C's symptoms and also the bleeding pattern which was very likely to be secondary to methods of contraception (implant and injection), both of which can cause menstrual disturbances (Dewhurst's Textbook of Obstetrics & Gynaecology) (see Annex 3).

42. Adviser 3 indicated that there was often more than one component to chronic pelvic pain, which included conditions related to the gastrointestinal system and bladder, and there were also recognised psychological causes of chronic pelvic pain (Dewhurst's Textbook of Obstetrics & Gynaecology and the College's Guideline No. 41 - see Annex 3). He noted that there did not appear to have been an investigation of other possible causes of the chronic pelvic pain other than possible gynaecological causes. He stated that this did not seem unreasonable given Miss C's gynaecological history.

43. Adviser 3, therefore, concluded that the referral by the surgeons for a gynaecological opinion was reasonable. He indicated that the diagnosis here was difficult as chronic pelvic pain can have many underlying causes. He said that the Board did treat the most likely cause, that is, of acute or chronic PID, although the blood tests were all within the normal ranges. He observed that they had not arranged an ultrasound scan during this admission nor had they taken steps for such a scan to be undertaken as an out-patient procedure or arranged for a follow-up. However, he noted that both of these actions were undertaken by Miss C's GP. He summarised that, with the exception of the omission to arrange a pelvic ultrasound scan, in his view, Miss C's overall gynaecological management was reasonable.

(a) Conclusion

44. The advice I received indicates that the time Miss C waited to be seen by doctors was not unreasonable in the circumstances and the referral to gynaecology, and subsequent PID diagnosis, were both appropriate. The Board have apologised for not offering fuller explanations at the time.

45. However, the advice, which I fully accept, has identified that Miss C was not provided with timely pain relief and the Board have not acknowledged this or offered an appropriate apology. There is no record of Miss C's pain having been assessed and scored and the timescales for the provision of pain relief did not follow the guidelines issued by the British Association for Accident and Emergency Medicine. In addition, there is no record of Miss C having received a triage assessment and Adviser 2 has raised concerns regarding the triage process for patients referred to A&E by their GP.

46. In responding to Miss C's complaint, the Board stated that nursing staff cannot prescribe pain relief but acknowledged that they should have endeavoured to get medical staff to attend if Miss C's pain was severe. However, the Board did not clarify whether they have implemented any other pain management initiatives to meet patients' needs, such as advanced training for nursing staff to be able to prescribe pain relief.

47. The Board's response to Miss C could also have better acknowledged her negative experience rather than merely implying that she had an impression of poor care. Miss C was clearly upset by the wording of the response and I agree with Adviser 2 that it was inappropriate for the Board to have used the fact that she was using her mobile telephone as a benchmark for her medical condition. The Board's response could also have been in more detail, as the issues surrounding the absence of triage assessment and timely pain relief, were not appropriately addressed. It would have been good practice for the Board to have considered and referred to the relevant national guidance when addressing the latter issue. In the circumstances, I uphold this complaint.

(a) Recommendations

48. I recommend that the Board: *Completion date*

(i)	review their systems for ensuring that patients' pain is properly assessed in Accident and Emergency and on Ward 210 and that patients' needs are met with timely pain management, and provide copies of audits regarding pain assessment and management. The review should consider triage arrangements for patients directly referred by their GP and also initiatives for meeting patients' needs if medical staff are not readily available to prescribe pain relief;	17 November 2010
(ii)	ensure that, when handling complaints, all complainants' concerns are addressed and that responses refer to relevant standards and guidelines where appropriate; and	17 November 2010
(iii)	apologise to Miss C for their failure to manage her pain appropriately and for not fully addressing this issue when responding to her complaint. The apology should also acknowledge the inappropriate reference to Miss C using her mobile telephone.	15 September 2010

(b) Conclusion

49. Throughout the course of the advice I have received, concerns have been raised regarding the standard of record-keeping in respect of Miss C's two attendances at the Hospital. In particular, Adviser 2 has highlighted serious concerns regarding the adequacy of the nursing records from both A&E and Ward 210. Many of the records are untimed and there are no records to indicate that appropriate triage or pain assessments were carried out. This is unacceptable and I, therefore, uphold this complaint.

(b) Recommendation

50.	I recommend that the Board:	*Completion date*
(i)	provide evidence that appropriate strategies are in place to ensure that all nursing records meet the standards outlined by the Nursing and Midwifery Council.	17 November 2010

51. 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

Miss C	The complainant
A&E	The Accident & Emergency department within the Hospital
The Hospital	Edinburgh Royal Infirmary
GP	General Practitioner
Doctor 1	The on-call surgeon who reviewed Miss C on 27 February 2009
Doctor 2	The on-call gynaecologist who reviewed Miss C on 27 February 2009
PID	Pelvic inflammatory disease
Doctor 3	The A&E doctor who reviewed Miss C on 1 March 2009
The Board	Lothian NHS Board
Adviser 1	The Ombudsman's A&E adviser
Adviser 2	The Ombudsman's nursing adviser
Adviser 3	The Ombudsman's obstetrics & gynaecology adviser
Ward 210	The gynaecology ward within the Hospital

Annex 2

Glossary of terms

Acute abdomen	The sudden onset of severe abdominal pain that requires medical or surgical management
Anaemia	A lack of red blood cells or low haemoglobin in the blood
Appendicitis	Inflammation of the appendix
Co-codamol	A painkiller used to treat mild to moderate pain
C-reactive CRP	A protein in the blood which indicates inflammation and is a marker for some diseases
Differential diagnosis	The process of diagnosing a patient's illness by weighing the probability of one disease versus that of other diseases
Dihydrocodeine	A painkiller used to treat moderate to severe pain
Iliac fossa	The lower abdomen
Metronidazole	An anti-biotic medication used to fight bacteria in the body
Ofloxacin	An anti-biotic medication used to fight bacteria in the body
Paracetamol	A painkiller used to treat mild to moderate pain
Pelvic inflammatory disease (PID)	A bacterial infection of the female reproductive organs
Speculum	An instrument used to widen an opening to look within a passage or a cavity

Triage	The process of initial assessment, which prioritises patients based on their clinical need
Tubo-ovarian abscess	A severe form of pelvic inflammatory disease
Urinalysis	A test that determines the content of the urine

Annex 3

List of legislation and policies considered

The Nursing and Midwifery Council – The Code: Standards of conduct, performance and ethics for nurses and midwives, 2008

The British Association for Accident and Emergency Medicine, Clinical Effectiveness Committee, Standards for Accident and Emergency Departments, January 2006 (see Annex 4)

The Royal College of Obstetricians and Gynaecologists, Green-top Guideline No. 32, Management of Acute Pelvic Inflammatory Disease, November 2008

The Royal College of Obstetricians and Gynaecologists, Guideline No. 41, The Initial Management of Chronic Pelvic Pain, April 2005

Dewhurst's Textbook of Obstetrics and Gynaecology for Postgraduates, Sixth Edition, D. Keith Edmonds, 1999

Annex 4

British Association for Accident and Emergency Medicine
Clinical Effectiveness Committee
Standards for Accident and Emergency Departments
January 2006

Section 3: Pain Standards

These standards require initial pain assessment (e.g. pain score) and early provision of pain relief such that:

Patients in severe pain (pain score 7 to 10) should receive appropriate analgesia, according to local guidelines,

50% within 20 mins of arrival or triage whichever is the earliest.
75% within 30 mins of arrival or triage whichever is the earliest.
90% within 60 mins of arrival or triage whichever is the earliest.

Patients with moderate pain (pain score 4 to 6) should be offered or receive analgesia, according to local guidelines,

75% within 30 mins of arrival or triage whichever is the earliest.
90% within 60 mins of arrival or triage whichever is the earliest.

90% of patients with severe pain should have documented evidence of re-evaluation and action within 30 minutes of receiving the first dose of analgesic.

75% of patients with moderate pain should have documented evidence of re-evaluation and action within 60 minutes of receiving the first dose of analgesic.