Maidstone and Tunbridge Wells NHS
NHS Trust

Complaint case study for publication on Trust website June 2015:

Mr A contacted the Patient Advice and Liaison Service (PALS) to raise concerns about his wife's experience in A&E.

Mrs A has a lung tumour and is under the care of the cardiothoracic team at Guy's Hospital. Early one morning, Mrs A experienced severe pain. Her husband contacted NHS 111 and an ambulance was called, which brought her to the Accident and Emergency Department at Tunbridge Wells Hospital. They brought all the information they had from Guy's with them.

The first doctor they saw in A&E was not interested in reading any of the information they had brought with them and told them that he did not have time to read the notes. Blood samples were taken for testing and Mr & Mrs A had wait for the results.

At 8am, there was a shift change. A second doctor attended who they described as arrogant and rough. He took another blood sample from Mrs A's wrist/thumb, but left the tourniquet on. This doctor kept referring to Mrs A's heart, which they already knew was not the cause of her pain as she had had an ECG done on the ambulance and another at triage, both of which were normal. They were told that the cause of the pain was unknown.

Mrs A was transferred to CDU, were there were no beds and no drip stands. Staff managed to find one drip stand, which Mrs A had to share with another patient.

Other patients had been taken to a private area when the doctor wanted to speak with them, but the doctor just approached Mrs A where she was and told her that he did not know what was wrong, she should continue taking her own supply of pain medication and go home. He wrote up a prescription for oramorph. When the nurse came to administer it, it was noted that Mrs A is allergic to morphine. This has been determined early on in her attendance and she was wearing a red wristband to indicate her allergy. They are concerned at the prescribing error.

When Mrs A got home, she began vomiting. Mr A was able to arrange a GP appointment the next day, where Mrs A was diagnosed with a stomach ulcer.

Our findings

This complaint was investigated by a Consultant in Emergency Medicine and an A&E Matron and the complaint was partly upheld.

Review of the medical records and interviews with staff involved revealed that due to Mrs A's severe pain on arrival, Dr G was asked to see her as a priority. Dr G prescribed intravenous painkillers and intravenous omeprazole to treat a possible stomach ulcer. Apologies were offered that the doctor appeared disinterested in the information Mr & Mrs A had brought with them; the doctor did read this following his initial assessment.

Dr G was concerned that the pain could have been related to Mrs A's lungs or heart, and to exclude this he organised an x-ray and blood tests specifically to rule out these possible causes of her pain. Mrs A's care was then handed over to his colleague, Dr B. Dr B

ordered further tests to rule out a blood clot. On review, the consultant felt that these tests were a reasonable precaution, even with a normal ECG.

Apologies were offered for the poor behaviour described and for the tourniquet being left on. Apologies were also offered for the drug prescribing error, although reassurance was given that the medication was not administered to the patient.

The following action was taken as a result of this complaint:

Dr B was reminded of his duty to treat patients with kindness and respect and the concerns about his conduct were shared with the medical director.

A written reminder was issued to staff about the need to remove tourniquets.

Staff were reminded of the need to check prescribed medications against a patient's allergies.

Nursing staff reminded that it is not acceptable for patients to share a drip stand and additional stands are being purchased. An equipment audit was also undertaken to identify any other shortages.