SPSO decision report

Case: **202302720, Forth Valley NHS Board**
Sector: Health
Subject: Admission / discharge / transfer procedures
Decision: upheld, recommendations

Summary

C complained about their attendance at the A&E after their child (A) had a seizure. C said that A's observations (to measure vital signs like heart rate, blood pressure, and temperature) had not been taken, but that the nurse had told C that they were. C also raised concerns about attitude and behaviour.

The board's complaint response said that the nurse had intended to reflect to C that observations had been taken by the ambulance crew, and that the nurse had triaged A and determined that A was able to wait for a doctor. C was dissatisfied with the explanations provided. The board told us that a further review of the records showed that the nurse had taken observations, but staff present concluded that there was no physical evidence of the nurse taking observations at any point at triage.

We took independent advice from a qualified nurse. The evidence suggested that observations were not carried out, and that there were failings during the triage of A to act on their abnormal heart and pulse rate promptly. Appropriate repeat observations and a Glasgow Coma Scale score were not taken. There was also a lack of clarity as to whether A was assessed as an adult or paediatric patient. We upheld this complaint.

We found that there had been record keeping failings, including records which did not match the accounts provided by the nurse, paediatric assessment tools not being completed, incorrect oxygen saturation levels having been recorded, and nursing and medical entries not being time stamped. There was also a lack of explanation for the discrepancies in the board's accounts of observations being taken. We upheld this complaint.

We found that C and SPSO have, at times, been provided with inaccurate and inconsistent information in relation to whether A's observations were taken. We therefore upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and C for failings in care and treatment, record keeping, communication, and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- All documentation should be in line with GMC and NMC guidance (all records accurate, dated and signed and attributable to the person who entered the data).
- If a child is admitted then the documentation should reflect that paediatric tools and assessments have been used.
- Patients should be appropriately triaged on arrival to A&E, observations carried out promptly and accurately, findings acted upon, and GCS scoring carried out where appropriate. Observations should be

appropriately recorded in the patient record.
- Reflection by staff, whether for complaint processes or revalidation, should be accurate and take into account what is reflected in the medical records. If it differs from what is in the medical records there should be an explanation provided for this.

In relation to complaints handling, we recommended:

- Complaint investigations should be thorough and identify any inaccuracies in record keeping to ensure a full and accurate complaint response is provided. Information provided to SPSO should be accurate, complete and on time. All relevant records in relation to an SPSO investigation should be provided from the outset of our enquiries. The failure to do so in this case led to delays in the investigation.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.