SPSO decision report

Case: **201204987, Shetland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: not upheld, recommendations

Summary

Mrs C complained about the care and treatment the board provided to her two-year-old son (Master A). She said that he had a high temperature and had been unwell for three to four days, when she took him to Gilbert Bain Hospital accident and emergency department. Mrs C complained that the board did not keep her son under appropriate observations after initial assessment and that he was inappropriately discharged home. Mrs C and her son returned to the hospital the following day, as his condition had deteriorated. After initial assessment, he was seen by a doctor and was admitted to hospital and later flown by air ambulance to a mainland hospital, where he was diagnosed and treated for a type of flu. Mrs C again complained that staff failed to keep Master A under appropriate observation after initial assessment of his condition. She also said that on both occasions there were delays before a doctor saw her son.

We took independent advice on this case from one of our medical advisers, a consultant in emergency medicine. He explained that the doctor's decision to discharge Master A on the first occasion was reasonable. The documentary evidence suggested that Master A was seen 19 minutes after triage (the process of deciding which patients should be treated first, based on how sick or seriously injured they are). The adviser explained that although a target time for Master A to be seen would have been ten minutes, the wait of 19 minutes was reasonable, given that Master A had none of the symptoms of an exceptionally unwell child. On the following day, Master A was triaged, was observed again just over an hour later, and was seen by a doctor about 20 minutes after that. Although his total waiting time was considerably longer than the target time of ten minutes, the adviser indicated that, in the circumstances, this was not unreasonable if there was greater need elsewhere in the department. We also noted that there was a handover between clinical shifts while Master A was waiting to be seen. The adviser noted that on both occasions Master A had a thorough medical review, and there was a defined care pathway for him. Although we did not uphold the complaints, we did make recommendations about two elements on which the adviser commented.

Recommendations

We recommended that the board:

- feed back to the staff involved our adviser's view that it would have been good practice for a member of staff to have come and seen Master A on the second hospital visit, when Mrs C asked for this; and
- feed back our adviser's comments on record-keeping to the staff involved.