SPSO decision report

Case: **201808786, Forth Valley NHS Board**
Sector: Health
Subject: policy / administration
Decision: upheld, recommendations

Summary

C complained about the care of their late parent (A) at Falkirk Community Hospital (FCH). A had a cognitive impairment and gained access to washing-up detergent that had been mistakenly left out in the staff kitchen area. A subsequently became unwell and advice was sought from the out-of-hours (OOH) GP service prior to eventual transfer to Forth Valley Royal Hospital (FVRH), where their condition deteriorated and they died the following week. C raised a complaint with the board, seeking answers as to what happened, and the board commissioned a Significant Adverse Event Review (SAER). The board were unable to conclude with any certainty whether detergent was ingested and contributed to A's death.

C complained to us about inaccuracies and inconsistencies in the SAER and clinical records, and also about timescales surrounding the SAER and complaint processes.

We took independent clinical advice from a nursing adviser and a GP adviser. It was not possible from the evidence available and advice obtained for us to confirm whether A ingested detergent. We found that the SAER was open, transparent and evidence-based. The report acknowledged that there were inconsistencies and inadequacies in the records. However, we considered that the SAER did not adequately probe into the contact with, and actions of, the OOH GP. The initial advice given by the GP was to monitor A, when the observations should have prompted medical review. The GP assumed these observations were incorrect. When the GP later advised transfer to hospital, this was left to nursing staff to arrange and clear advice was not provided surrounding the urgency of the ambulance request. We found that the GP deviated from standard practice and failed to provide appropriate care to A.

While the SAER acknowledged that record-keeping standards were not adhered to, we highlighted a further shortcoming in that the transfer from FCH to FVRH was not formally documented. We found that there was delay in staff completing an incident report following the detergent incident, and a delay in completing the SAER. We also found that there were delays in responding to C's complaint, and some confusion between the SAER and complaint processes. The board acknowledged these delays and apologised that the complaint process was very protracted at such a distressing time for the family.

We upheld all of C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for the unreasonable delay in completing an incident report, the unreasonable delays in concluding the SAER and responding to the complaint, and the confusion between the two processes, the failure of the SAER to probe sufficiently into the contact with, and actions of, the OOH GP, and the OOH GP's deviation from standard practice and failure to provide appropriate care to A. 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:

- The board should ensure there are clear mechanisms in place for investigating both significant adverse events and complaints, and clarity between the two processes, with adherence to the board's SAER policy and Complaints Handling Procedure. The board's SAER policy should align with Healthcare Improvement Scotland guidance.
- Documentation needs to improve to support safe, effective quality and person-centred care delivery. The board should ensure protocols exist for documentation of handovers and clinical contacts.
- The board should ensure that SAER investigations comprehensively examine contributory factors, and that where possible these are reviewed by someone with knowledge of the relevant speciality, as per Healthcare Improvement Scotland guidance.
- The board should ensure the OOH service has clear protocols in place for escalations to hospital for medical review, including roles and responsibilities in this regard. GPs should act with due care when receiving second hand clinical information.

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.