SPSO decision report

Case: **201301394, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C's son (Mr A) had been suffering from headaches and vomiting for several days. When Mr A's condition got worse, Mr C took him to the emergency department at Perth Royal Infirmary. They arrived at 01:17, and at 01:29, a triage nurse assessed Mr A and gave him paracetamol (triage is the process of deciding which patients should be treated first based on how sick or seriously injured they are). She arranged for Mr A to see an out-of-hours GP in the department at 03:15, and, without having taken any observations (temperature, blood pressure, pulse and oxygen levels) sent him home to wait for that appointment. After arriving home, Mr A's condition deteriorated further, and he could not move his neck or lift his knees. Mr C returned with him to the hospital at around 03:00, where Mr A saw a GP and was admitted to a medical ward at 03:36 with suspected meningitis, which was confirmed by tests. He was treated with antibiotics and discharged a week later.

Mr C complained that the board failed to provide Mr A with a reasonable standard of care and treatment, in that the triage nurse failed to take any observations and recognise the seriousness of Mr A's condition. He also said that the delay of two hours between Mr A being seen by the nurse and by the GP was not reasonable in light of the serious and potentially life-threatening disease Mr A was suffering from. He complained that the board failed to respond appropriately to the complaint, including that they failed to adequately explain why the nurse did not undertake observations when she examined Mr A.

We took independent advice on this case from our nursing adviser, who said that the care and treatment Mr A received from the triage nurse fell below a reasonable standard. She did not carry out a set of observations, which meant that her decision to refer Mr A to the out-of-hours service was based on minimal information that might have resulted in his further deterioration. The adviser was also critical that Mr A was not allowed to remain in the emergency department and instead was sent home. These failings made a stressful situation more difficult for the family, given Mr A's serious condition. In relation to complaints handling, we were satisfied that the board provided as full an explanation as they could in the circumstances, but in light of the delays, inaccuracies and use of technical terms in the complaint response, we upheld the complaint.

Recommendations

We recommended that the board:

- review the triage process and provide evidence that appropriate protocols and/or guidance are in place;
- take steps to ensure nursing staff in the emergency department at the hospital carry out observations and document patients' vital signs during triage, and report back to the Ombudsman the actions taken;
- provide evidence that their processes ensure staff involved in triage have the appropriate education, training, skills, competencies and adequate supervision in place to provide a reasonable standard of care;
- consider the failings identified to ensure that future responses are appropriate; and
- apologise to Mr C for the failures identified.