INWO decision report

Case: **202310767, Orkney NHS Board**
Subject: **HSCP – Health/ Record keeping**

Summary

The complainants raised concerns about a service provided through a partnership between the Board and the local authority. The Board investigated and upheld some of the concerns. After some time, the complainants complained to the Independent National Whistleblowing Officer (INWO) that;

- The Board and partnership had not taken reasonable action to address the concerns upheld by the Board's investigation (upheld)
- The Board and partnership had not managed the concerns in accordance with the National Whistleblowing Standards (the Standards) (upheld)

One of the concerns upheld by the Board was that an electronic patient record (EPR) system did not meet the record keeping requirements of the service, and this meant that patient records were often incomplete. After some delay, a new and more suitable EPR system has been procured and is being tested by other teams. In the short to medium term the service will continue to use the old EPR. Our investigation focused on the risks arising from this and we took advice from an independent professional adviser.

We found that staff could not easily get a complete picture of a patient's health and wellbeing, because relevant information was stored across the EPR system, paper records and local computer systems. This also prevented staff from working effectively with other agencies regarding patient safeguarding.

We reviewed the management of an action plan developed by the Board and partnership. We found that the complainants were not informed of the investigation's recommendations, and the action plan did not adequately address the investigation's findings and recommendations.

We reviewed how the Board addressed the concerns in line with the Standards and made findings about the clarity of the stage 2 response, sharing lessons from the upheld concerns more widely, delays in starting the whistleblowing process, support for the whistleblowers during the early stages of the process, communication, and responsibility for handling whistleblowing concerns within the partnership and Board.

Our decision in this case was to uphold the complaints and we have made recommendations to address the issues we identified.

Recommendations

What we asked the organisation to do in this case:

- Apologise to the team for the findings in this decision notice. 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 and OHAC communicate effectively with NHS whistleblowers working in the partnership.
- The Board and the OHAC manage and mitigate ongoing risks relating to EPR issues.

In relation to complaints handling, we recommended:

- Compliance with the National Whistleblowing Standards