SPSO decision report



| Case: | 201205072, Lanarkshire NHS Board |
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| Sector: | health |
| Subject: | communication / staff attitude / dignity / confidentiality |
| Outcome: | upheld, recommendations |

Summary

Mr C complained that his wife (Mrs C) sustained injuries while she was a patient in Wishaw General Hospital. Mrs C suffered from dementia and normally lived at home. She was in hospital for some seven months, during which she fell several times, sustaining minor injuries, and was involved in a series of incidents with other patients or visitors to the ward. Towards the end of her stay in hospital, Mr C was helping his wife to change when he noticed bruising on her back, which he considered could only have come from punches. When he reported this to a staff nurse, it became apparent that no staff member had reported these injuries. One nurse had seen - but had not reported - them, assuming someone else would already have done so.

Our investigation found that there were failings in the assessment and monitoring of Mrs C's falls risk; vulnerable adult safeguarding; record-keeping and communication with the family. Although staff took appropriate action after Mrs C fell, there was no evidence that they told her family on these occasions, and it was entirely inappropriate that no-one reported the bruising on Mrs C's back. Mrs C was a vulnerable adult and staff should have taken appropriate action to report and record this, as reflected in the board's own guidance. It was not, however, possible during our investigation to establish how Mrs C had sustained these injuries.

Our investigation found that the board had investigated Mr C's concerns and had acknowledged the failings that our investigation confirmed. They had already taken some reasonable remedial action so we made recommendations aimed at confirming that this had been effective.

Recommendations

We recommended that the board:

- provide the Ombudsman with evidence that all aspects of the remedial action plan formulated after the internal investigation have been implemented or are progressing within reasonable timeframes; and
- provide the Ombudsman with reassurance that all staff involved with caring for vulnerable adults have the knowledge, skills and training to recognise, raise and respond appropriately to safeguarding issues.