SPSO decision report

Case: **202007694, Perth and Kinross Council**
Sector: Local Government
Subject: Standard of care
Decision: not upheld, recommendations

Summary

C complained about an incident in which their late parent (A) fell from their wheelchair prior to being assisted into bed by two home carers employed by the council. Following the fall, the carers assisted A from the floor and proceeded with the transfer into bed. However, A was later taken to hospital where it was discovered they had sustained a fractured femur as a result of the fall. C considered that the fall had been caused by the carers' failure to check A was safely secured in the wheelchair by failing to ensure A's lap belt was fastened, the footrests were in the correct position and a glide and lock sheet was in place. C also complained that the carers had failed to obtain medical assistance following the fall despite A being in pain.

The council's position was that A had been safely secured in their wheelchair and the fall had occurred when the carers were preparing to move A with the use of a hoist, at which point it was discovered that a lock and glide sheet had not been inserted into A's wheelchair. The council also stated that the carers had proceeded to move A into bed after checking whether A had suffered any injury and required medical assistance, which A had declined.

We took independent advice from an occupational therapy adviser. We found that it was not possible to say how A's fall had occurred given the differing versions of events. We noted that, based on A's risk assessments, A had not required the use of a lock and glide sheet and that the carers would not have been responsible for ensuring it had been placed into A's wheelchair. In any case, this may not have prevented the fall from occurring. Additionally, we noted that lap belts were not considered a measure of restraint and it was normal practice for this to be removed by carers when attending to a service user, unless otherwise specified. We also considered that it had been appropriate for the carers to have moved A after the fall given the evidence suggested that they had checked whether any injury had been sustained and assistance was required.

Therefore, we did not uphold the complaint. However, we identified that the council had failed to adequately investigate the incident involving A and accordingly made recommendations under section 16G of the SPSO Act 2002, which requires the Ombudsman to monitor and promote best practice in relation to complaints handling.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to carry out a fact finding investigation in relation to the incident involving A despite advising this had been commissioned in the complaint response and the lack of certainty as to the correct date on which A had been admitted to hospital in the council's complaint response. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/information-leaflets.

In relation to complaints handling, we recommended:

- Incidents like this should be reviewed and/or overseen by senior management to identify the root causes of the incident and whether any learning can be taken forward.
- The council should ensure that information provided in response to complaints is factually accurate.

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.