SPSO decision report

Case: **202208467, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the nursing care and treatment provided to their late parent (A). A had a fall during an admission to hospital. Their condition deteriorated and a large intracranial (brain) bleed was identified. A died shortly after. C complained that the nursing staff provided unreasonable care and treatment as they did not put the correct safety measures in place, given A's frailty and instability on their feet.

The board said that A was reviewed by physiotherapy who assessed A as being safe and able to mobilise independently with a walking stick. The board said that nursing staff carried out care rounding and that A was checked 30 minutes prior to their fall. Following the fall, it was noted that A was able to get up with assistance and an assessment was completed by nursing staff. When checked later, it was found A had become unconscious. The board carried out a scan of A's head and found a large intracranial bleed.

We took independent advice from a registered nurse. We found that there was a lack of documentation and documented evidence of action taken by staff in response to cognition and mobility. Care rounding documentation was not completed to a reasonable standard or carried out to the prescribed frequency. When A's needs changed, the care rounding was not increased. We found that the nursing staff failed to complete the mobility risk assessment, consider the use of bedrails and identify A required more help when their condition changed. We noted that the care provided by nursing staff when the fall happened and after the fall was reasonable.

We also found that the Significant Adverse Event Review that was carried out after the fall was not carried out in line with national guidance. The Duty of Candour process should have been followed in this case and it was unclear from the documentation whether this had been activated or not. We upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failures identified by the investigation. 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:

- SAERs should be completed in line with the national framework and the board's own protocols.
- Assessments, evaluations, and intervention bundles should be completed in line with guidance. Nursing documentation should include evidence of action taken due to changes observed, such as, change in cognition, change in mobility, use of oxygen, and factors that may impact safety such as the ability to use a call bell.
- The frequency of care rounding required for a patient should be prescribed and recorded accurately in the care rounding documentation. Once prescribed, the care rounding should be completed within the frequency identified. This should be recorded in the documentation to demonstrate care rounding has

happened. Frequency of care rounding should be reflective of need. When there are changes in need, the frequency prescribed should change to meet the patients needs.

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.