SPSO decision report

Case: **202208872, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their late parent (A) received while in hospital. A suffered a fall and broke their hip. C complained that A was never provided with a falls monitor despite being assessed as a falls risk. C also said that there was a delay in reporting the fall and having A assessed.

The board apologised to C for the fact that, due to a lack of falls alarms, A had not received one. They explained that additional alarms had been obtained to ensure a sufficient supply on the ward. They also accepted that a 'top to toe' examination should have been carried out following A's fall and that there was a delay in identifying that A had a broken hip. They explained that a full review of A's fall was underway, and if any learning points were identified, they would be acted upon. In addition, a teaching session had been carried out to ensure best practice was followed at all times. The board provided us with details of the learning points that had been identified as a result of the complaint.

We took independent advice from a registered nurse. We found that there was no evidence that A received timely risk assessments or person-centred care. Although a fall with harm was apparent from A's misaligned leg, this went unnoticed. Basic assessments, including pain assessment, were not conducted, resulting in a delay in recognising A's pain. Additionally, wound charts were not completed, and there was a failure to follow policy regarding pressure ulcer prevention, malnutrition, and wound assessment and management. While the board had taken action in response to the complaint, we considered that there were still areas for learning and improvement. Therefore, we upheld C's complaint.

We also found that the board's complaint response had not been open, transparent, and accurate. The board had failed to identify a number of failings in A's care and treatment. Additionally, the board had not provided this office with all relevant information in response to our initial enquiry. A significant number of relevant documents were only made available to us after a follow-up enquiry. We made recommendations to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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 should ensure that nursing staff are aware of their responsibilities for completing relevant documentation in relation to person centred care planning, risk assessment and wound assessment and that the documentation is to the standard required. The board should ensure that there is a consistency of approach from nursing staff when a patient places themselves on the floor and the board's guidance on what nursing staff should be doing is followed.

- The standard and content of patient documentation in relation to person centred care planning, risk assessment and wound assessment should comply with all relevant guidance and policies and with best practice.

In relation to complaints handling, we recommended:

- Complaint investigations should be carried out in line with the NHS Model Complaints Handling Procedure. They should be accurate in their findings and conclusions, clear, and supported by relevant evidence, such as medical records.

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.