SPSO decision report

Case: **202301731, Forth Valley NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: some upheld, recommendations

Summary

C complained about the nursing care and treatment provided to their parent (A) who was admitted to hospital after a fall.

We took independent advice from a registered nurse. We found that there were unreasonable time gaps between care and comfort checks, making it impossible for the board to provide assurance that appropriate checks were completed. We found that the necessary risk assessments and care documentation were not completed to the required standards, with no person-centred care plan in place for A. We also found that the standard of record-keeping was unreasonable. Therefore, we upheld this part of C's complaint.

C complained that the board had failed to provide them with timely updates on A's care and treatment. The board accepted that C was not provided with appropriate updates regarding changes to A's health. We upheld this part of C's complaint.

C also complained about the board's communication in response to their complaint. C said that the board had not investigated their concerns about A's dementia diagnosis and reduced capacity, and had referred in the complaint response to allegations by nursing staff about C's behaviour which detracted from the complaint. We found that the board had shared the issues for investigation with C, inviting correction. We also found that it was reasonable for the board to take into account the experiences of the relevant nursing staff when responding to concerns C had raised. Therefore, we did not uphold this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific communication and process 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:

- Patients should be appropriately assessed by nursing staff, in particular in relation to continence and cognition issues, and nursing care provided in line with the assessments carried out and in a timely manner. Records about a patient's care and treatment and decisions made should be clearly and accurately documented, in accord with the relevant professional standards and guidelines, and reflect a person-centred approach. Patient records should include clear details explaining why a decision about care and treatment has been made.
- Family members should be communicated with in a timely and appropriate manner.

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.