SPSO decision report

Case: **202307773, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C's elderly spouse (A) spent approximately ten weeks in hospital. While in hospital, A fell on two occasions. C complained about the medical, nursing and physiotherapy care and treatment provided by the board.

We took independent advice from a consultant geriatrician (specialist in medicine of the elderly). We found that the medical care after A's falls was reasonable. We found that the board had taken reasonable and proportionate actions to acknowledge, apologise for and support learning and improvement regarding the provision of pain relief and a delay in reviewing an x-ray after A's first fall. We found that the board did not reasonably handle A's prescriptions for haloperidol (a sedating medication) or codeine (a type of painkiller). On balance, we upheld this part of C's complaint.

We took independent advice from a registered nurse. We found that the care and treatment regarding A's falls was unreasonable, as a mechanical aid should have been used to assist A from the floor, and risk assessments and care plans should have been updated. We found that A should have been more closely supervised prior to their second fall. We also found that the board's post-fall protocol was not reasonable in its current form. Finally, we found that A's hygiene needs were not reasonably met in hospital. The board had taken some action to support learning and improvement regarding the management of falls. On balance, we upheld this part of C's complaint.

We took independent advice from a physiotherapist. We found that the care and treatment provided to A was reasonable, and physiotherapy sessions were appropriate, timely and sufficient, considering A's clinical presentation. We did not uphold this part of C's complaint.

Additionally, we found that some points of the board's complaint response were incomplete and made a recommendation to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for the failings identified by this investigation. The apology should meet the standards set out in the SPSO guidelines on apology available at http://www.spso.org.uk/meaningful-apologies.

What we said should change to put things right in future:

- Patients with dementia should receive regular assessments of the benefits of medication, with consideration given to stopping or reducing medication when possible, and patients' families/carers should be informed appropriately.
- Nursing staff should handle falls using safe handling techniques in order to reduce risk to patients and staff. Nursing staff should have access to a reasonable and up-to-date post-falls protocol.

- Nursing staff should ensure patients' physical needs are appropriately assessed and responded to.

In relation to complaints handling, we recommended:

- The quality of the complaint response is very important and should address all the issues raised and demonstrate that each element has been fully and fairly investigated.

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.