SPSO decision report

Case: **201204747, Forth Valley NHS Board**
Sector: health
Subject: communication, staff attitude, dignity, confidentiality
Outcome: some upheld, recommendations

Summary

Mr C, who is a MSP, complained on behalf of Mrs A's family. Mrs A, who was 94, was admitted to hospital with shortness of breath, and chest and back pain. Her family were told that she would be examined for a possible chest infection or a clot on her lung. Mrs A was found to have a chest infection and pneumonia. The family were reassured that she would be discharged home within a few days. During her admission, however, Mrs A had a fall and a number of seizures. She also developed confusion. Her breathing difficulties persisted and she died nine days after admission.

Mr C raised a number of concerns about the treatment and nursing care provided during Mrs A's admission. He also complained about the level of communication with the family.

We took independent advice from two of our advisers, one a specialist in the care of older people, and the other an experienced nurse. Our investigation found that, although Mrs A was initially assessed as being at a low risk of falling, she was not reassessed in line with the board's policy after she fell, and so we upheld the complaint about this. That said, we were satisfied with the level and type of investigations that the board carried out to assess whether she had incurred any injuries or whether her condition had changed. We did not uphold the other complaints, as generally we found the nursing care to be adequate, although we highlighted some issues that could have made Mrs A's stay in hospital more comfortable. Mrs A's family had found the communication from staff to be poor and the information contradictory on some occasions. Based on the clinical records, however, we were satisfied that the family were given full details of the nature and severity of Mrs A's condition. We recognised that there may have been additional conversations not documented in the notes, but felt that, overall, the communication was sufficiently frequent and detailed.

Recommendations

We recommended that the board:

- remind staff of the post-fall protocol outlined in the in-patient falls resource pack and the need to properly record all action taken; and
- provide the Ombudsman with evidence of the additional training provided to nursing staff.