SPSO decision report

Case: **201303029, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained about the nursing care that her late daughter (Ms A) received while in Monklands Hospital, where she had been admitted with severe stomach problems. While in hospital Ms A was transferred to a second ward, and Mrs C's complaint was about the nursing care her daughter received in that ward. Ms A suffered two falls there and Mrs C complained that nurses had referred to her daughter as a 'boarder' and that she had not been treated with dignity or respect. After the second fall, and some two and a half weeks after being admitted, Ms A was transferred to intensive care after she had a seizure. Her condition deteriorated further and she died the next day.

We took independent advice on this complaint from our nursing adviser, who considered Ms A's relevant clinical records and the complaints correspondence.

Our investigation found that, while the key areas of nursing care were reasonable, a falls assessment and care plan was not implemented after Ms A's first fall, although our adviser said that this might not have prevented the second fall. We also found that the level of communication with Mrs C and her family in the ward before Ms A was transferred to intensive care was not of an acceptable standard. We upheld the complaint, and noted the action already taken by the board in response to it. This included explaining the learning that had come from the complaint, and apologising that an SBAR report (a situation-background-assessment-recommendation report, used as a communication tool) was not completed on transfer between wards; that Mrs C had felt that the nursing staff had not provided the standard of care or communication expected; and that there had been a lack of communication.

Recommendations

We recommended that the board:

- remind nursing staff on the ward of the need to complete appropriate falls assessment and care planning in line with their falls assessment procedure; and
- ensure that staff on the ward are reminded about the importance of communication with relatives and carers.