SPSO decision report

Case: **201508175, Lanarkshire NHS Board**
Sector: health
Subject: appointments / admissions (delay / cancellation / waiting lists)
Outcome: some upheld, recommendations

Summary

Mrs C complained about the care that her late husband (Mr A) received at Monklands Hospital after attending the emergency department. Mr A was to be admitted to a private room but none was available. He remained in A&E until a suitable room was found. Mr A was later moved to a different area in the hospital, where he fell while in the toilet.

Mrs C complained that Mr A waited in A&E for too long. She was also concerned that the toilet where he fell was not properly equipped and that staff had not taken reasonable steps to help him afterwards. Mrs C also considered that his risk of falls had not been assessed and that the recording and investigation of the incident had not been carried out properly. Finally, Mrs C complained that Mr A's bed was not adjusted for his height quickly enough.

After taking independent advice from a consultant in emergency care, we upheld the complaint about Mr A's wait in A&E. We found that he had waited longer than was reasonable in the circumstances and that the board had already apologised for this. We recommended a review of their policy for escalating cases like Mr A's.

We took independent advice from a registered nurse in relation to Mrs C's other concerns. We did not uphold the complaint regarding a falls assessment as the advice we received was that this had been carried out in A&E with no risk identified. We also did not uphold Mrs C's concerns about the toilet facilities as we received advice that these were reasonable. We found that there were two different accounts of events around Mr A's fall and we were unable to determine exactly what had happened within the scope of our investigation, therefore we did not uphold this element of the complaint. We did, however, uphold the complaint about the initial investigation of the fall. The advice we received was that although it was appropriately recorded, there were missed opportunities to resolve Mrs C's concerns locally. We made two recommendations to address this.

Finally, we upheld Mrs C's complaint about the failure to adjust Mr A's bed. The advice we received was that this was unreasonable in the circumstances and the adjustment can be made easily. We made two recommendations to the board in light of this.

Recommendations

We recommended that the board:

- review the escalation procedure for individual patients awaiting specific beds, taking into account the adviser's comments;
- review the training they have in place for early resolution of concerns and complaints;
- ensure mechanisms are in place for staff to access support from more senior colleagues in the ongoing resolution of complaints;
- apologise for the failure to take the falls assessment into account and adjust the bed in a timely manner; and

- ensure staff are aware of the appropriate considerations when making adjustments to beds.