SPSO decision report

Case: **201600065, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

Mr C raised a number of concerns about the care provided to his mother (Mrs A) at Queen Elizabeth University Hospital. During Mrs A's admission, she was found to have fallen whilst in the bathroom. The nurse who found Mrs A did not identify any immediate signs of injury and noted that Mrs A had not reported loss of consciousness. Nursing staff subsequently carried out observations, and a doctor carried out an examination, noting no injuries. Following the examination, Mr C noticed that the bed sheets by Mrs A's elbow were spotted with blood and he reported this to nursing staff, who arranged for a small wound on Mrs A's arm to be dressed. The following day, Mr C noticed bruising around his mother's hairline and reported this to nursing staff, who had not previously noted this. A scan was then arranged, the results of which indicated that Mrs A had an acute subdural haematoma (bleeding in the space between the brain and the skull). Mrs A was subsequently transferred to a neurosurgical ward, and a procedure to evacuate the subdural haematoma was carried out.

A number of weeks following the fall, the board decided to undertake a significant clinical incident investigation. This took a number of months to be finalised, and it concluded that the assessment of Mrs A's risk of falling was not carried out appropriately and made a number of recommendations. To assess whether the board had taken appropriate steps in response to the failings identified, we took independent advice from a nursing adviser and a medical adviser.

Based on the nursing advice we received we could not conclude that Mrs A would not have fallen had the falls risk assessment been carried out appropriately, and had the appropriate interventions been in place. However, we considered that it was unreasonable that the board did not take the steps that they could reasonably have been expected to take to reduce the risk of Mrs A falling. We upheld this complaint, and we made a recommendation in relation to falls risk assessment.

Mr C was unhappy that nursing and medical staff failed to identify and treat his mother's injuries. In response to Mr C's complaint, the board acknowledged that nursing staff should have observed the bruising to Mrs A's head when delivering personal care and apologised that medical staff also missed this injury. The medical adviser was critical that a top-to-toe examination was not carried out by medical staff following the fall, and was also critical of how the medical examination was documented. We were satisfied that a dressing was appropriately applied to the cut to Mrs A's arm, and that a scan was arranged within a reasonable time after the bruising on her head was noticed. However, we found that the examination following the fall was not reasonable, and we upheld this aspect of the complaint. We made a number of recommendations for improvement.

We were also critical of the way the board handled Mr C's complaint. We found that staff had potentially missed an opportunity to recognise Mr C's complaint at an earlier stage, and we considered that this may have delayed the start of the complaint investigation. We noted a number of other shortcomings in the way the board handled and responded to Mr C's complaint. We upheld this aspect of the complaint and made a recommendation.

Recommendations

What we asked the organisation to do in this case:

- Send Mr C a written apology for failing to carry out a reasonable assessment of Mrs A following her fall.

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

- Junior medical staff should be trained on how to carry out appropriate assessments for patients who have fallen.
- The member of medical staff who assessed Mrs A should reflect and learn from the adviser's comments on record-keeping.

In relation to complaints handling, we recommended:

- Complaints should be handled in accordance with the proper procedure.

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.