SPSO decision report

Case: **201603071, Forth Valley NHS Board**
Sector: health
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

Mr C complained about the care his late wife (Mrs A) received from nursing staff during two admissions to Forth Valley Royal Hospital. On the first occasion she was admitted with sepsis (a blood infection) and on the second occasion she was admitted with a hip fracture. In particular, Mr C complained that the board failed to carry out appropriate falls risk assessments, failed to appropriately manage Mrs A's medication and delayed in obtaining a review for Mrs A following a fall. Mr C also complained that it took an unreasonable amount of time for him to be able to speak to a senior staff member about his concerns.

During our investigation we took independent advice from a nursing adviser. The adviser considered that the overall care in relation to falls assessments, monitoring, care and falls prevention was unreasonable. They also found significant failings in how Mrs A's medication was managed.

The board accepted that it took an unreasonable amount of time for Mr C to speak to a senior staff member about his concerns. They also accepted that there was a delay in having Mrs A reviewed following her fall. The board also accepted that there were significant failings in how Mrs A's medication was managed. The board identified learning as a result of the complaint.

In light of the independent medical advice we received, we upheld all of Mr C's complaints. Although the board had taken steps to address the complaint, we made recommendations in light of our findings.

Recommendations

What we asked the organisation to do in this case:

- The board should issue a formal apology to Mr C for the unreasonable level of care provided to Mrs A in relation to falls assessments, monitoring and care.

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

- The board should ensure that patients at very high risk of falls should be considered for referral to a falls co-ordinator or falls specialist.
- The board should ensure that in future situations similar to Mrs A's a medical review is requested sooner.

In relation to complaints handling, we recommended:

- The board should ensure that senior charge nurses, and other frontline staff, have the skills and confidence to undertake early resolution of complaints.

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.