SPSO decision report

Case: **201808068, Lanarkshire NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained that the board failed to take reasonable steps to prevent her father (Mr A) from falling in hospital. We took independent advice from a nursing adviser. We found that staff had completed the required risk assessments prior to Mr A's fall and that the fall would have been hard to predict. However, updates to the care plan in place for Mr A lacked detail and the plan itself was not updated to address the changes in Mr A's functional ability. Although there was an indication on the falls risk assessment that Mr A was attempting to walk alone, there was nothing recorded in the nursing records or care plan to support or address this.

Staff also failed to follow the board's policy in relation to the assessment and use of the bedrails. In addition, there was no evidence of nursing staff updating Mr A's falls risk assessment or his care plan immediately after the fall, nor was there a record of a delirium screening at that time. In view of these failings, we upheld this aspect of the complaint.

Ms C also complained that staff failed to contact the family to inform them of the fall until the following morning. We found that, as Mr A had sustained a significant injury, staff should have called the family at the time of the fall, when the harm was confirmed, or earlier in the morning before the shift changed. Given this, on balance, we also upheld this aspect of the complaint.

Finally, Ms C complained that staff had attempted to use inappropriate equipment on Mr A after his second operation. Staff had to use a commode to transfer Mr A to the toilet because the stand aid had been condemned and the hoist had no battery. We found that when the decision was taken to use a commode in this way, a risk assessment should have been completed and recorded and an agreed approach noted in Mr A's care plan. Given the failure to do this, we upheld this aspect of the complaint.

We noted that the board had apologised for these failings and have made further recommendations for learning and improvement.

Recommendations

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

- All staff should follow the board's bedrail policy.
- Patient care plans and risk assessments should be completed and updated appropriately.

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.