SPSO decision report

Case: **201902465, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care their parent (A) received during an admission to Queen Elizabeth University Hospital. A was admitted following a fall at home and had a further fall in hospital, resulting in a fracture to their right shoulder. C complained that A's fall in hospital could have been prevented, if ward staff had followed the board's falls prevention protocols, had correctly assessed A's risk of falls and had taken appropriate measures to ensure their safety on the ward.

We took independent advice from a nurse. We found the record-keeping was unreasonable and not of the required standard in relation to the assessment and prevention of A's fall and also the incident reporting of the fall. The falls risk assessment was completed within the stipulated policy timescale of 24 hours from admission. However, the decision not to undertake this during the immediate admission appeared to have been taken by a student nurse without oversight from a registered nurse. We found no evidence to confirm what interventions, besides bed rails, had been put in place to prevent A from falling.

The incident report of the fall lacked clarity and consistency. The incident was initially miscategorised as minor and was not updated to serious when the fracture was diagnosed, so the relevant escalation and review was not triggered. The board indicated that a review had subsequently taken place, but we saw no evidence of this or of the learning and improvement derived from it. The adverse event review findings were not discussed or shared with C, as they should have been in keeping with national Being Open in NHS Scotland guidance. We upheld this complaint. We also found that the board did not respond to C's complaints in a timely and robust manner.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the identified inadequacies in record-keeping surrounding A's fall; for the lack of supervision of the student nurse who assessed A; for failing to share with C a copy of their adverse event review; and failing to investigate C's complaint in a timely and robust manner. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- The board should review their performance with regard to the Being Open principles to ensure that appropriate systems are in place to share the outcome of incident reviews with patients and family members.
- The board should review their procedures to ensure accurate reporting, and appropriate review and investigation, of adverse events.
- The board should review their record-keeping in this case to ensure that nursing staff are meeting the standards required of them in this respect.

- The board should take steps to ensure that appropriate supervision of student nurses is in place.

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.