SPSO decision report

Case: **201902642, Lanarkshire NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) at University Hospital Monklands. During their admission, there was an incident involving A in the early hours of the morning. The board said that A was mobilised to a commode and, at A's request, given privacy to use it. The board said that A fell during this time and sustained injuries. C was sceptical of the account given by the board of how A sustained their injuries. A remained in hospital until their death a little over a week later.

C complained to the board that A was injured, about medical treatment and nursing care after A was injured, and about the attitude of a specific doctor. In response, the board advised C of their view of what had happened, apologised that A had fallen and assured C that work was ongoing in relation to reducing the number of patient falls at the hospital. C was dissatisfied with the board's response and raised their complaints with this office.

We found that the board had not reasonably assessed A's falls risk, had not reasonably undertaken staff handovers in respect of A, unreasonably mobilised A to the commode without their hip brace and unreasonably allowed A to use the commode alone and unsupervised. We upheld C's complaint about the care provided to A in respect of their falls risk.

There was disagreement between C and the board about the circumstances of particular parts of A's care and treatment following their injury but, notwithstanding this, we found A's care and treatment following their injury was reasonable. We did not uphold C's complaints about the care and treatment of A following their injury.

In relation to C's complaint about the attitude of a specific doctor, the recollections of C and the doctor about a specific discussion are contradictory but the evidence available of board staff's communication with C shows these were reasonable. We did not uphold C's complaint about the attitude of the doctor.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's family for providing A with unreasonable care in relation to their falls risk. The apology should make clear mention of each of the failings identified and 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:

- Relevant staff should be properly trained regarding the completion of neuro observations in line with SIGN 110, the need for accurate record-keeping in line with the Nursing and Midwifery Council code, specifically around recording all conversations with families and adding times to all records and risk assessments, and the appropriate action to take, and record, regarding the administration of pain relief following injuries.
- Relevant staff should be properly trained regarding the safe positioning of commodes, and the

management of delirium and the appropriate completion of the '4AT' bundle in line with the delirium toolkit.

- Relevant staff should be properly trained in the completion of care plans to reflect need in relation to cognition, mobility and maintaining a safe environment.
- Relevant staff, including allied health professionals, should be properly trained regarding assessment of mobility and risk assessment of moving and handling (including following a fall).
- Situation, background, assessment, recommendation (SBAR) transfer handovers are recorded for relevant staff regarding falls risk and safety interventions in place.
- The board should ensure their falls risk assessment procedures are compliant with the Scottish Patient Safety Programmes (SPSP) guidelines 'Prevention of falls driver diagram and change package' (2013) and include a prompt for staff regarding bathroom safety.

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.