SPSO decision report

Case: **202101294, Fife NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) by the board. A had dementia and was experiencing worsening delirium following a urinary tract infection. A was admitted to hospital by an out-of-hours doctor who visited A at home. C's sibling accompanied A in the ambulance but was told that they were unable to stay with A in hospital due to COVID-19 visiting restrictions. A was transferred to a side ward and later that evening, fell from the bed. A had a head laceration and complained of right hip pain. A head CT and hip x-ray were undertaken which confirmed a right hip fracture. A was transferred to an orthopaedic ward (specialists in the treatment of diseases and injuries of the musculoskeletal system) but it was decided A would not survive an operation due to the fall and hip fracture trauma. A died a few days later.

We took independent advice from a consultant geriatrician (a specialist in the care of older adults) and a senior nurse in falls prevention.

We found that a reasonable level of information from A's family was recorded and taken into account by medical staff, that the assessment of A's delirium was reasonable and that it is common practice for a doctor to try and speak directly with a patient with significant dementia or delirium to allow them to assess the individual's capacity. We also found that it was reasonable to transfer A to a side room, that the action taken by medical staff following the fall was reasonable, as was the communication with the family. Furthermore, that the pain relief was reasonable and was a priority of staff who saw A.

However, we found that there were a number of failings in the nursing care and treatment provided to A. We found that it was unreasonable that no family members were allowed to stay with A, that there was a lack of information documented in the nursing records and a lack of completed paperwork in relation to assessments that should have been carried out on A. Whilst nursing staff's immediate attendance and commencement of the post fall assessment and escalation tool was reasonable, we also found that there was a delay in contacting the family and failure to use a straight lift. Therefore, we upheld this part of C's complaint.

C also complained that the board failed to carry out a reasonable investigation into A's fall in hospital. We found that a serious adverse event review (SAER) should have been carried out instead of a local adverse event review (LAER). Therefore, we upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the specific failings identified in respect of the complaint. The apology should meet the standards set out in the SPSO guidelines on apology.

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

- Family members should be communicated with in a timely manner, particularly after a patient has fallen whilst in hospital, and the detail of conversations should be recorded. Relevant staff should be aware of the requirements for the assessment for potential fracture, safe manual handling for possible fracture including using flat lift equipment.
- Patients' nursing care should be clearly and accurately recorded including any conversations with family members. Entries should be legible, signed and dated.
- Adverse events should be reviewed and reported in line with relevant guidance and in a way that fully reflects the patient journey and outcome with appropriate regard to learning and improvement and communication with the family throughout the process.
- Assessments such as mobility; bedrail and TIME assessments should be completed appropriately and consistently and recorded in the nursing records.
- Relevant staff should be aware of changes to guidance.

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.