SPSO decision report

Case: **202102718, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained that the board failed to provide appropriate care for their parent (A).

C said that the lack of care resulted in A falling from their bed, while the bedrails were in place. As a result, A fractured their hip. C said that staff had been made aware that A was confused a very disorientated at the time.

We asked the board to provide an explanation as to how A was able to fall from the bed if bedrails were in place. The information provided by the board showed that A had been found trying to get out of bed on two previous occasions. This led us to question what interventions were put in place to try and prevent a fall from happening and why this appears not to have been successful.

We took independent advice from a nursing adviser. We found that the lack of a proper assessment of A's mental capacity and their previous attempts to climb out of bed contributed to the fall incident and that this was a significant oversight. Additionally, we found that the board failed to maintain accurate and appropriate records, particularly in relation to the 4AT (Rapid Clinical Test for Delirium Detection), on the two occasions that A was found trying to get out of bed, and the fall itself. We therefore upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. 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:

- Patient records should be accurately completed, signed and dated with the appropriate level of information included, in accordance with the relevant nursing and midwifery standards.
- Patients should be appropriately reassessed when there is a change in their behaviour and, if bedrails are in use, consideration given to carrying out a reassessment of their use.
- Patients over 65 should be assessed in line with the board's admission procedures including a 4AT so that a full assessment of the patient risk is achieved.

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.