SPSO decision report

Case: **201405493, Ayrshire and Arran NHS Board**
Sector: health
Subject: appliances / equipment / premises
Outcome: some upheld, recommendations

Summary

Mrs C complained to the board about how her elderly aunt (Miss A) had been cared for in University Hospital Ayr. Mrs C complained to us that Miss A was not given a bed with rails, that hospital staff did not monitor Miss A's movements, and that they did not respond in a reasonable time to Miss A falling in her ward. Miss A died shortly after the fall. Mrs C also complained about the delay in the board investigating and responding to her complaint.

We looked at the board's file on Mrs C's complaint and at Miss A's medical records. We also took independent advice from two of our advisers, one specialising in nursing, the other in general medicine. We found that when Miss A was admitted to hospital, an assessment was made that she needed bedrails. However, on the night Miss A fell, the bedrails on one side of her bed were not in use, apparently at her request. This change was not recorded by hospital staff, and is significant because they should, when making decisions like lowering the bedrails, have borne in mind that Miss A had delirium.

We found that staff failed to follow a procedure, called the bedrails algorithm, for dealing with the lowering of bedrails, which meant that Miss A was not supervised at the time she fell. Without bedrails, an alternative should have been put in place, such as close monitoring, to compensate for the lowering of the bedrails on one side. We concluded that staff did not take sufficient account of Miss A's delirium and risk of falls in providing care to her. We upheld these aspects of Mrs C's complaint. However, we did not find evidence that staff failed to respond immediately when Miss A fell.

We found, and the board acknowledged, that there was a significant delay in responding to Mrs C's complaint. We also found that updates to Mrs C were not in line with the national NHS complaints guidance. We upheld this aspect of Mrs C's complaint.

Recommendations

We recommended that the board:

- remind relevant nursing staff of the bedrails algorithm;
- provide us with details of the actions taken to ensure there has been learning from this complaint; and
- remind all staff involved in dealing with Mrs C's complaint of the national NHS complaints guidance, and of the importance of updating complainants in reasonable time.