SPSO decision report

Case: **201600669, Forth Valley NHS Board**
Sector: health
Subject: nurses / nursing care
Outcome: some upheld, recommendations

Summary

Ms C, who works for an advocacy and support agency, complained on behalf of Mr B regarding the care and treatment provided to Mr B's father (Mr A) during his admission to Forth Valley Royal Hospital. Ms C complained that Mr A's falls risk was not appropriately assessed on two different wards, that the nursing care provided to him was not reasonable, and that staff attitude and communication with Mr A's family was unreasonable.

During our investigation, we obtained independent advice from a nursing adviser. We found that whilst Mr A's assessment and care in relation to falls on the first ward he stayed on was reasonable, on the second ward his levels of confusion were not taken into account when assessing the risk of falls. We considered this to be unreasonable. We also found that whilst the nursing care provided to Mr A was reasonable in terms of personal care and administration of medication, the nursing care plans had not taken into account Mr A's need for emotional support. We also found that the use of bedrails for Mr A had been inconsistent. We did not consider this to be reasonable and upheld this complaint. In terms of staff attitude and communication with Mr A's family, we found that communication had often been unplanned and ineffectively co-ordinated, but that this was often due to short-notice changes to plans for Mr A given his fluctuating physical state. We considered that a planned approach to communication may have been beneficial, but that there was no evidence of unreasonable staff attitude towards the family. We made several recommendations to the board to address the failings identified.

Recommendations

We recommended that the board:

- take steps to ensure that the impact of cognitive impairment on patient safety on the relevant ward is appropriately assessed and that measures to minimise harm are a prominent aspect of care plans;
- apologise to Mr B for the failings identified in relation to the falls assessment and care provided to Mr A;
- take steps to ensure recording and use of bedrails is consistent;
- take steps to ensure that emotional support is identified as a care need and planned for where appropriate;
- apologise to Mr B for the failings identified in relation to the nursing care provided to Mr A; and
- consider whether a planned approach to communication, agreed between patients' families and staff, should be put in place.