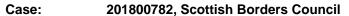
SPSO decision report



Sector: local government

Subject: sheltered housing issues / residential homes

Decision: some upheld, recommendations

Summary

Mr C complained that his late mother (Miss A), who stayed in a council owned care home, was not provided with appropriate care in relation to monitoring her prior to and after a fall in which she broke her arm. He also complained that the council failed to appropriately communicate with him regarding Miss A's condition.

In response to Mr C's complaints, the council identified that there had been some failings in recording. They provided us with an action plan for improvements to be made, and a new policy in relation to falls. On reviewing the council's policies and guidance alongside Miss A's notes, we found that when she fell and complained of pain in her arm, there was a failure to immediately seek urgent medical opinion as per the council's policy. We also found that the falls risk assessment had not been reviewed as often as was specified by guidance. We upheld this aspect of Mr C's complaint, however, considered that the council's new falls guidance would, if followed, prevent a recurrence of these events.

In relation to communication with Mr C about Miss A's condition, we found that Mr C was not Miss A's recorded next of kin and that there was no policy that required Mr C to be contacted by the council. We did not uphold this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

Apologise to Mr C for failing to follow their policies on care after a fall and falls risk assessment. The
apology should meet the standards set out in the SPSO guidelines on apology available at
www.spso.org.uk/leaflets-and- guidance.

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

The council should follow their policies on care after a fall and falls risk assessment.

