SPSO decision report

Case: **202001129, Forth Valley NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained to the board about the circumstances whereby their late parent (A) was a patient at Forth Valley Royal Hospital. A had been admitted after suffering a stroke (a serious medical condition that happens when the blood supply to part of the brain is cut off). A also had delirium and a background of dementia. Whilst an in-patient, A suffered a fall. Staff were aware that A had to be supervised and to be accompanied at all times when they were out of bed. However, despite being under close observation, a contracted nurse allowed A to remain in the toilet unsupervised and they sustained a fall which resulted in a severe head injury and subsequently A's death. C believes that A should not have been left unattended and that, had that been the case, the fall may have been prevented.

We took independent advice from an appropriately qualified adviser. We found that staff at the hospital had carried out a comprehensive falls risk assessment in regards to A and that A was not to be left unsupervised. It was felt that A had no awareness regarding the use of the call bell system (a button or cord found in hospitals that patients can use to alert hospital staff of their need for help). However, a nurse had stepped out of the toilet to afford A some privacy and A attempted to rise from the toilet unaided and suffered a fall. Although the record-keeping regarding the falls risk was completed to a good standard, there was a breakdown in communication between permanent staff and the contracted nurse about the specific level of observation required for A. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure in communication. 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:

- Staff should ensure that when passing information to others that full details of the levels of observation required are understood.

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.