SPSO decision report

Case: **202201215, Fife NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: some upheld, recommendations

Summary

C's spouse (A) was admitted to hospital following a stroke. A remained in hospital for several weeks before transferring to another hospital. A later died. C complained to the board about A's hospital stay and raised concerns about wound management, fall pain management and the identification of hip and shoulder injuries.

The board's response highlighted several areas for improvement. Firstly, there should have been a referral for A's wounds, with more robust documentation. Staff training has been conducted to address these issues. Secondly, A fell twice in the ward, prompting a thorough medical review after each fall. Staff training regarding falls has been provided. Thirdly, although A was on regular pain medication, there should have been a pain recording chart in place. Staff will receive training on this aspect. Lastly, A's hip dislocation likely stemmed from their stroke rather than a fall, with no evidence of shoulder dislocation occurring the ward.

C was dissatisfied with the board's response and brought their complaint to us. We took independent advice from a nurse with a speciality in wound care and a consultant geriatrician (a specialist in medicine of the elderly). We found that staff failed to follow the board's policy on wound management. We also found that whilst the medical care of A's falls was reasonable, the nursing documentation about A's falls was unreasonable, because documentation was incomplete and at times inaccurate. A's care plan was also poor, making it difficult to manage A's pain, and there was a delay in A receiving a medical review over the weekend. Therefore, we upheld these parts of C's complaint. We found that the board's explanation of A's injuries was reasonable. We did not uphold this part of C's complaint.

We also found that the board's complaint response did not provide C with a timely, full and informed response to their complaints about the board's management of A's wounds and falls. Therefore, we made an additional recommendation to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failures in A's care. The apology should meet the standards set out in the SPSO guidelines on apology available at http://www.spso.org.uk/meaningful-apologies.

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

- Nursing staff should be competent in the accurate completion of falls documentation.
- Patients should receive appropriate pain management including regular structured assessment of their pain, e.g. through the use of a structured pain assessment tool or chart. This should be documented. Patients should receive appropriate medical review on escalation, and reviews should be carried out promptly.
- Patients should receive care as required and prescribed in care rounding bundles. Those requiring wound

care should be appropriately managed in line with local and national guidance on wound management. This should be appropriately documented.

In relation to complaints handling, we recommended:

- The board's complaint handling monitoring and governance system should ensure that complaints are properly investigated and responded to; are accurate; timely; and that failings and good practice are identified.

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.