SPSO decision report

Case: **202301037, Tayside NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C submitted a complaint on behalf of their relative (A) who received treatment at hospital. A had previously suffered a stroke (causing left sided weakness) and was admitted after being unwell for a few days. C complained about the nursing care provided to A while they were in hospital.

We took independent advice from a nursing adviser. We found that there were failings in relation to nursing documentation, moving and handling practices, a lack of equipment, and a lack of assessments as to A's needs. In particular, there was no falls assessment and appropriate action and recording did not take place after A's fall. In relation to moving and handling, we found that glide sheets should have been utilised and that appropriate equipment should have been available in the ward. The board failed to reasonably record the care that they provided, or carried out appropriate assessments to ensure person-centred care to confirm that A's needs were met. As such, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings as identified. 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:

- All patients must have a falls risk assessment completed on admission and after a fall a post falls assessment should be completed.
- Every patient should have a person-centred plan of care.
- All patients must have a moving and handling risk assessment undertaken within 24 hours of admission.
- Nursing documentation should be complete and reflect a person's care needs, plan of care, care delivered and evaluation of the care delivered.
- Basic moving and handling equipment should be readily accessible for all patients and staff.
- All patients should have their care needs identified and risk assessments undertaken in order to develop a person-centred plan of care.

In relation to complaints handling, we recommended:

- Complaint investigations should respond to all of the main points raised and identify failings and take learning from what happened.

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.