SPSO decision report

Case: **202301141, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their client (B) about the care provided to B's late parent (A) during their admissions to hospital. A was admitted and discharged from the hospital. A was readmitted a few days later following a fall at their home. A suffered significant injury including spinal and sacral fractures. A remained in hospital for treatment but died a few weeks later. C's concerns related to the clinical and nursing care provided to A during their admissions, particularly in relation to the assessment of A's cognitive function and capacity, their falls risk, and overall assessments carried out with respect to their condition and deterioration.

In response to the complaint, the board acknowledged that protocols on completion of falls and bed rail risk assessments were not followed and that in the day prior to A's death, guidance on the timeliness and extent of observations which should have been carried out were not followed, and that the care fell below the expected standard. The board confirmed that appropriate documentation with respect to the assessment of A's capacity was completed during their admission. C was dissatisfied with the board's response.

We took independent advice from a consultant geriatrician and a registered nurse. With respect to A's clinical care, we found that documentation used to assess A's capacity was not completed to a reasonable standard and we upheld this complaint. We found that the clinical treatment of A during the two days immediately prior to their death was reasonable and we did not uphold this aspect of the complaint.

We considered the nursing care provided to A during the two admissions. We found that the care regarding falls management was unreasonable as appropriate documentation and assessments were not completed correctly or in a timely manner. We also found that there was a lack of evidence of the monitoring of A's condition which would have made clinical assessment of A's condition and deterioration more difficult. We found that the level of care and record keeping was unreasonable and upheld the complaint for each admission.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the failures identified the decision. 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:

- Relevant staff are aware of National Standards with respect to falls prevention; the requirements to complete and update Falls Risks Assessments and that these are carried out accurately and in a timely manner. Assessments, evaluations, and intervention should be completed in line with guidance.
- Relevant staff are familiar with the adult with incapacity process and the importance of delirium screening tools with patients where delirium is observed and evident.