SPSO decision report

Case: **202308943, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained that nursing staff had failed to properly supervise their parent (A) resulting in a fall and that there was a lack of documented information about A's plan of care in the medical records. A was admitted to hospital for hip surgery following a fall at their home. A few weeks later, A fell and hit their head. This led to A sustaining a subdural haematoma (SDH, a brain injury) and A died as a result.

C complained that following A's fall there was a failure to treat A as a priority, and raised concerns that A was transferred from a trauma ward to an orthopaedic ward. C believed that A should have been transferred to another hospital, outwith the board, for surgery.

In response, the board said that A's care pre-fall had been in line with the relevant supervisory assessment. They apologised for a delay in A receiving a medical review following the fall, however, they said that nursing staff had carried out appropriate neurological observations. The board added that A was not considered suitable for surgery by surgeons and that the case had been considered at a local management team review (LMTR).

We took independent advice from a consultant specialising in the care of the elderly, and an experienced nurse. We found that the documentation in A's nursing records did not evidence that the care and interventions A received to keep them safe from harm and to support their mobility were to the standard required to prevent A falling. Additionally, we found that there were failings in relation to A's neurological observations with a lack of proper assessment, implementation and evaluation and gaps in recording. We considered that while these measures may not have ultimately prevented A's fall, there was unreasonable care and as such we upheld C's complaint.

We found that A's post-fall care fell well below a reasonable level and did not meet the standards described in the board's head injury protocol and the relevant NICE guidance for the management of head injuries. Issues identified included a lack of consultant oversight and a failure to carry out timely neurological interventions and tests when A's condition deteriorated. Additionally, as A had suffered harm and death as a result of a fall, the board should have completed a significant adverse event review (SAER). We upheld C's complaint on that the care and treatment provided to A was unreasonable.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies

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

- Care and treatment should be provided in line with the relevant guidance on head injuries.

- Patients presenting with a decline in their cognitive and/or neurological functions should have their symptoms fully assessed, evaluated and monitored in a timely manner in line with relevant guidance. All nursing documentation should comply with the standards set out in the board’s guidance and the NMC The Code.
- Patients presenting with a decline in their cognitive and/or neurological functions should have their symptoms fully assessed, evaluated and monitored in a timely manner in line with relevant guidance. Where a GCS assessment has shown deteriorations in a patient who has sustained a head trauma, prompt action should be taken in respect of carrying out scanning and seeking specialist advice.
- Where adverse event(s) occur a significant adverse event review should be held in line with the board's protocols and national guidance.

In relation to complaints handling, we recommended:

- Complaint investigations and responses should be accurate in their findings and conclusions, clear, and supported by relevant evidence, such as medical records and where possible include responses from staff involved in the events complained about. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.