SPSO decision report

Case: **202404349, Highland NHS Board**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A). A was admitted to hospital due to a nose bleed that would not stop. During admission, A used a hospital trolley to cross the ward to the toilet. A jug of water spilt from the trolley and A fell, sustaining a fractured shoulder and a fractured knee. C was concerned about A's medical and nursing care and about the communication from the board.

We took independent advice from a nursing adviser and a consultant geriatrician.

We found that the falls screening questions were not completed on A's admission, safe care pauses were not demonstrable from the daily care plan or nursing documentation, A's walking aid was not within reach and a decision was made to mobilise A when the floor was wet, rather than call for help and ensure the environment was safe. We found that the board's investigation into A's fall did not make attempts to identify the second staff member who witnessed the fall and take a statement from them. There was also a failure to activate the Duty of Candour process in this case. We found that A's B12 injection should have been administered in a more timely way and that medical staff did not promptly inform C and their family of the results of the X-rays and the implications of the fractures for A. Finally, we found that the board did not respond to all of the concerns that C raised. We upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family 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:

- Appropriate steps should be taken in the prevention and management of falls.
- Where appropriate, patients and/or their families should be informed of the results of X-rays by medical staff.
- When an incident occurs that falls within the Duty of Candour legislation, the board's Duty of Candour processes should be activated without delay.
- Where a patient has fallen and sustained harm, attempts should be made to identify and take statements from all the staff who witnessed the fall.
- Where clinically appropriate, B12 injections should be administered in a timely way.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded toin accordance with the board's complaint handling procedure and the NHS Model Complaints Handling Procedure. Complaints investigators should fully

investigate and address the key issues raised, identify and action appropriate learning and apologise where issues have been identified. 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.