SPSO decision report

Case: **202407708, Ayrshire and Arran NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C was Power of Attorney (POA) for the patient (A). C complained about the care and treatment that A received in hospital. A suffered two falls, resulting in five fractured ribs. A also acquired pressure sores, contracted pneumonia and died shortly after discharge. C that they were not timeously informed of the falls or A's deteriorating health. C also complained about the board's handling of their complaint.

The board advised that A was assessed by a doctor after both falls and pain medication was increased. Due to ongoing pain, x-rays and a CT scan were taken weeks later which showed the injury. The board advised that treatment would have been the same if they had known of the injury earlier. The board also noted that they had increased care rounding following the falls and provided a pressure relieving mattress.

They acknowledged that on some occasions care rounding had been delayed due to clinical pressures. The board apologised that A had developed pressure sores and that they had not communicated effectively with C. They advised that staff had been reminded of falls guidance, pressure ulcer guidance and to contact POAs and next of kin.

We took independent advice from a nurse. We found that the board had not regularly evaluated the risk of falls before A fell and did not appropriately review A after their falls. We found that they had not sufficiently managed the risk of pressure ulcers and did not appropriately manage the pressure ulcers once they had developed. We also considered that POA documentation was not correctly filled in on admission and that C had not been appropriately updated regarding important health matters or A's falls.

We found that the complaint response had taken too long, that C had not been regularly updated and that the complaint investigation could have been more thorough. We upheld all aspects of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise that C was not appropriately recorded as POA and was not kept informed of A's pneumonia and pressure sores. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- 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/information-leaflets.

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

- Documentation should meet the required NMC "The Code" standards, in regards to assessment, planning, implementation and evaluation of nursing care (APIE process), including for falls. Care and comfort rounding should be carried out timeously. Wound assessment should be carried out and recorded,

to guide treatment. Datix incidents should be escalated to Adverse Events for review when there has been avoidable harm.

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.