SPSO decision report

Case: **202403956, Lothian NHS Board - Acute Services Division**
Sector: Health
Subject: Nurses / nursing care
Decision: upheld, recommendations

Summary

C's parent (A) suffered a number of falls during an admission to hospital where A sustained a head injury and subsequently died. C complained to the board that A's falls risk was not effectively managed.

The board identified some failings in relation to A's falls care, including a lack of personalised falls prevention plan and a lack of falls risk signage over A's bed. However, they noted that staff were fully aware of A's falls risk and took measures to reduce this, and they did not find that A fell due to a lack of reasonable care.

We took independent advice from an experienced mental health nurse. We found that there was a failure to effectively assess A's significant falls risk and tailor interventions to their individual needs. We noted that the board did not consider it appropriate for A to have received one-to-one nursing or be moved to a more observable area, however, no evidence was provided of consideration having been given to the risks and benefits of such interventions. We upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and their family for failing to reasonably manage A's falls risk. 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:

- Falls prevention assessment and planning should be personalised and carried out in line with up-to-date board policies and procedures.

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.