Te Whatu Ora Hauora a Toi Bay of Plenty (formerly Bay of Plenty District Health Board)

A Report by the Deputy Health and Disability Commissioner

(Case 20HDC02247)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man by Te Whatu Ora Hauora a Toi Bay of Plenty. In particular, it concerns the care provided when he suffered four falls whilst in hospital.

Findings

2. The Deputy Commissioner found Te Whatu Ora Hauora a Toi Bay of Plenty in breach of Right 4(1) of the Code for the lack of critical thinking applied to risk assessments, the failure to adhere to care plans, and failure by nurses and doctors to follow the falls policy.

3. The Deputy Commissioner reminded Te Whatu Ora Hauora a Toi Bay of Plenty about the importance of adverse event reports reflecting the entirety of events.

Recommendations

4. The Deputy Commissioner recommended that Te Whatu Ora Hauora a Toi Bay of Plenty provide a written apology to the man's wife; provide training to all house officers and nurses on falls management policy; provide ongoing training for registered nurses and healthcare assistants on the assessment and monitoring of falls risk and, six months after this training, conduct an audit to assess whether the training has reduced the number of falls; update the falls policy and clinical notes template; and consider providing falls prevention mats for at-risk patients.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to Mr A by Bay of Plenty District Health Board (Bay of Plenty DHB).[1] The following issue was identified for investigation:

- *Whether Bay of Plenty District Health Board provided Mr A with an appropriate standard of care in 2019.*

6. This report is the opinion of Deputy Commissioner Deborah James, and is made in accordance with the power delegated to her by the Commissioner.

7. The parties directly involved in the investigation were:

Mrs A	Complainant, consumer's wife
Bay of Plenty DHB	Provider

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references to Bay of Plenty DHB in this report now refer to Te Whatu Ora Hauora a Toi Bay of Plenty.

8. Also mentioned in this report:

Dr B	House officer
Dr C	House officer
Registered Nurse (RN) D	Registered nurse
RN E	Registered nurse
Dr F	House officer

9. Independent advice was obtained from a registered nurse, Karole Hogarth (Appendix A) and a general surgeon, Dr Mark Sanders (Appendix B).

Information gathered during investigation

Introduction

10. This report relates to the management of four falls experienced by Mr A, aged in his eighties at the time of events, during his admission to hospital in 2019. Mr A sustained a neck fracture from the fourth fall and, sadly, passed away shortly afterwards.

11. Mr A had a complex medical history, including prostate cancer, and had in place an ileostomy,[2] a catheter,[3] and a nephrostomy tube.[4] Mr A was frail and experienced chronic pelvic pain, and was dependent on his wife for his care. His wife assisted him to use a walker to walk a few steps. He was a high falls risk. In Month1[5] it was decided that his treatment would be managed conservatively with analgesia.

12. On 5 Month1 Mr A presented to the Emergency Department (ED) at Hospital 1 with acute and chronic abdominal pain. A falls risk assessment was completed and Mr A's high falls risk was identified.[6] Mr A's medical records included a summary report for care plan support services following an interRAI assessment[7] a few months previously. The report stated that Mr A had experienced numerous falls in the past 90 days and had a very high falls risk.

13. Mr A remained in hospital until 7 Month1, when, upon his request, he was discharged.

[2] Diversion of the small bowel (small intestine) through an opening in the abdomen. The opening is known as a stoma. A special bag is placed over the stoma to collect waste products that usually pass through the colon (large intestine).
[3] A device inserted into the bladder to drain urine.
[4] A tube placed into the kidney to drain urine directly from the kidney.
[5] The relevant month is referred to as Month1 to protect privacy.
[6] Four out of five falls risks were identified, which included a fall within the last three months; five or more medications; and the need for another person to help with activities of daily living.
[7] Nurses and registered healthcare workers use interRAI to assess an older person's care needs in the community and in aged residential care.

Hospital 2 — falls risk assessment and prevention plan

14. Mr A's chronic pain persisted, and he presented to the ED at Hospital 2 on 14 Month1. He was admitted to the surgical ward [8] under a consultant general surgeon for pain management. It is documented in the admission note that Mr A took methadone and morphine[9] (at home) for his pain.

15. A falls risk assessment was completed, and three positive falls risks were identified.[10] The falls prevention plan put in place included Mr A wearing non-slip socks and having the call bell within his reach.

Mr A's toileting needs

16. While in the ED it was documented that Mr A used a wheelchair to get to the toilet, and that he would ring the call bell when he was finished. Notwithstanding that Mr A had an ileostomy, catheter and nephrostomy tube, he found relief from his chronic pelvic pain by relaxing his muscles when he sat on the toilet, and he spent up to 20 minutes on the toilet.

17. The hospital's falls prevention plan in the continued plan of care stated: "[D]o not leave alone on commode [and] do not leave patient if out of bed." The plan did not make reference to Mr A's preference to sit on the toilet for a long duration.

18. Bay of Plenty DHB stated that it was made clear to Mr A that he was to ask for assistance when getting up from his bed, and that if he went to the toilet he was to ring the call bell to be assisted back to bed. It was not documented in the admission and plan of care form or the continued plan of care that this had been communicated to Mr A.

19. Bay of Plenty DHB stated that it was not possible to assign someone to wait for Mr A to finish his toileting for lengthy periods of time, and the toilet door had to be shut for privacy and hygiene reasons. Bay of Plenty DHB said that Mr A was reluctant to interrupt staff members to attend the toilet with him, but he was watched as closely as possible[11] given other priorities in the ward at the time.

20. Mrs A stated that some hospital staff had asked why Mr A needed to go to the toilet when he had a stoma bag and a nephrotic and suprapubic catheter, and that staff members had told Mr A that he did not need to go to the toilet and had "walked away". Bay of Plenty DHB apologised for staff members having questioned Mr A's need to use the toilet, and stated that it was most regrettable that he was made to feel unsupported.

[8] Hospital 2 does not have a urology service, and any acute urology patients are admitted under the on-call general surgeon. Bay of Plenty DHB stated that it is common for general surgery in Hospital 2 to admit sub-speciality patients with input from Hospital 1.
[9] An opioid pain killer.
[10] These included a fall within the last three months, the patient's use of a mobility aid, and the patient's need for assistance.
[11] Mr A had hourly nursing checks.

First fall — 16 Month1

21. On 16 Month1 a nurse documented[12] that Mr A had had an unwitnessed fall (fall one) and had been found on the floor of the en suite and had refused to be returned to bed. She documented that he had multiple skin tears on his left leg and a graze on his left hip. The nurse recorded that she completed observations and noted that Mr A's heart rate was increased. She documented that she dressed and cleaned Mr A's wounds, informed the on-call house officer (Dr B) that Mr A needed to be reviewed, and advised Mr A to use the call bell at all times. The nurse also documented that she had notified Mrs A.

22. The nurse completed an incident report immediately after Mr A's fall, and classified his fall as SAC 4 (minor). Mrs A confirmed that she was notified of the fall.

23. There is no record that Mr A was reviewed by Dr B.

24. Mrs A told HDC that she noticed bruising on Mr A's chin and face. No record of bruising was documented by nursing staff.

25. Mr A's falls assessment was reviewed by nursing staff and further precautions were put in place, including that he should be assisted to the toilet, have hourly checking, and have a clutter-free environment.

17–19 Month1

26. There were no documented falls during this period, and it was documented that Mr A was assisted to the toilet.

27. Dr B examined Mr A about his catheter concerns on 17 Month1 but there is no reference in the clinical notes to his fall the previous day.

28. A CT scan on 17 Month1 showed that the tip of Mr A's catheter was located in his rectum. Associate Professor Karole Hogarth[13] noted that this could have meant that there was more urine than expected in Mr A's bladder giving him more of an urge to pass urine via the normal route. Mr A also seemed to gain some pain relief by the act of sitting on the toilet. The catheter was re-sited back into Mr A's bladder.

Second and third falls — 20 Month1

29. On 20 Month1 Dr B reviewed Mr A and documented that he did not feel sedated and that he had to wait "too long" for nurses to give him his medication and to be assisted to the bathroom. Dr B documented that he did not examine Mr A formally. Dr B increased Mr A's morphine dose to 40mg and the midazolam[14] dose to 10mg. At 2.20pm it is documented by a nurse that Mr A seemed to be confused at times. The medical record documents that Mr A was reviewed by the house officer and his medication was changed back to 20mg of

[12] The nurse did not document what time this fall took place.
[13] The full report can be found at Appendix A.
[14] A benzodiazepine medication commonly used in palliative care.

morphine and 10mg of midazolam. It is also documented that Mr A was mobilising to the toilet with his frame and two assistants.

30. Mrs A visited Mr A that day. She recalls that he was very frustrated when he had to wait a long time for a response to the call bell when he was on the toilet.

31. At 7.45pm Mr A had an unwitnessed fall (fall two). RN E completed an incident report, and the ward clinical manager received an automatic notification of the incident for review. However, RN E did not document this fall in Mr A's medical record.

32. At 8.20pm RN E documented that Mr A had been found on the toilet floor for the second time that shift (fall three). RN E recorded: "Nil obvious injury noted. O[n] C[all] H[ouse] S[urgeon] informed." RN E did not complete an incident report in relation to the second fall on 20 Month1, and Mrs A was not informed. RN E stated that he should have completed an incident report before the end of his shift, but did not because of the busyness and acuity of the ward.

33. At 10.50pm Dr C, a house officer, documented that Mr A had fallen twice in the last shift. Dr C noted: "[F]ound on the floor. Was able to stand up and walk to the bed, with no obvious injuries as per R[egistered] N[urses] currently comfortable and asleep." Dr C did not document whether a physical examination or neurological assessment was completed at this time.

21 Month1

34. Mr A's falls assessment was reviewed by a nurse who documented that Mr A had a high falls risk and should be assisted as required.

Fourth fall — 23 Month1

35. On 23 Month1 RN D took Mr A to the toilet, where he remained for 30 minutes. RN D documented[15] that during the 30 minutes Mr A was on the toilet he experienced severe pain and was given analgesia, and on three occasions had been advised to return to bed. It is unknown what time Mr A was taken to the toilet, but it was before 12.30pm.

36. Mr A called for assistance, but RN D was unable to answer the call bell in a timely manner. In response to the provisional opinion, Mrs A told HDC that a patient in the same room told her they had heard Mr A fall and "call out" and so they had pushed the call button repeatedly, but it had taken staff at least 20 minutes to attend. Bay of Plenty DHB said that the call bell shows on the communicator panels in the corridor, and the nurse has to step away from the patient being attended to check where the call has come from.

37. When RN D attended Mr A he was on the bathroom floor (fall four). Mr A told RN D that he had attempted to stand. In response to the provisional opinion, Mrs A told HDC that Mr A

[15] In the incident form at 2.25pm.

told her that he was not trying to stand and he reached across his body to press the buzzer and the chair had twisted and toppled over causing him to fall.

38. At 12.30pm RN D documented that Mr A had an injury on his head (a small skin tear on the left-hand side under his scalp) and a skin tear on his left knee, and that he was fully conscious and in pain. RN D recorded that the house officer reviewed Mr A and advised that neurological observations should be completed and a computerised tomography (CT)[16] head scan undertaken if Mr A deteriorated. RN D documented in the incident form[17] that Mr A's observations, including neurological observations, were within the normal range.

39. Three members of staff lifted Mr A to his feet, and he was transferred to bed and given analgesia.

40. At 2pm RN D documented that Mr A had "full power all limbs" but had developed pain around his neck. RN D recorded that his investigation showed little cause for concern and that analgesia was re-administered.

41. RN D completed an incident form at 2.25pm and documented that "in retrospect Mr A needed either full supervision in the bathroom or to be returned to bed in the first instance". RN D did not inform Mrs A of the fall, and the incident form stated that this was not applicable. Mrs A told HDC that she was not notified of the fall officially, and found out only when she asked.

42. Bay of Plenty DHB acknowledged that Mr A should have been checked every few minutes, and should not have been left unattended on the toilet for 20 minutes.

43. At 2.30pm Dr F, a house officer, assessed Mr A and documented[18] that he was complaining of generalised pain in the back of his head and neck, and resisted doing neck movements on instruction. Dr F reviewed Mr A's head and noted that there were no lacerations and no boggy swelling,[19] and that he had no cervical spine tenderness. She documented that Mr A had been observed moving his neck without much pain, and had "5/5 power upper limbs" and normal sensation. Dr F's impression was that there was no acute injury, and she documented her plan to continue neurological observations for eight hours and to consider a cervical spine X-ray if Mr A had ongoing pain. She noted that she considered that an X-ray was not indicated at that time.

44. At 9.30pm it is documented that Mr A was complaining of pain in his head and neck, and the nurse informed an on-call house officer.

[16] A CT scan combines a series of X-ray images taken from different angles of the body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues.
[17] At 2.25pm.
[18] At 7.20pm.
[19] Abnormal texture of tissues characterised by sponginess, usually because of high fluid content.

45. Mrs A's recollection is that Mr A had severe bruising and swelling on his face. Mrs A stated that Mr A told the nurse that he had broken his neck.

24 Month1

46. At 2pm nursing notes document that Mr A was in pain and tearful. At 4.50pm the house officer documented that Mr A was asleep at the time of review, and that the surgical team would review Mr A in the morning.

47. Mrs A stated that when she visited on 24 Month1[20] Mr A was in extreme pain and his face was swollen, bruised and grazed, and he told hospital staff on numerous occasions that he had broken his neck, and the staff took no action. In response to the provisional opinion, Mrs A provided a photograph of Mr A that shows a bruise on the left side of his face. Mrs A told HDC that she told a nurse that Mr A's morphine was not assisting with his pain, and she had to wait until 2pm before she could see a doctor and ask that Mr A have an X-ray to assess whether he had damaged his neck.

25 Month1

48. A CT scan undertaken on 25 Month1 showed a fracture of Mr A's second cervical vertebra, which placed him at high risk of life-threatening complications.

Subsequent events

49. Mr A was transferred to palliative care and, sadly, he passed away.

Bay of Plenty DHB Adverse Event Report

50. The key findings of Bay of Plenty DHB's Adverse Event Report included the following:

- The importance of ensuring that all falls prevention strategies are available and clearly explained to the patient and to the patient's nominated support person.
- The early utilisation of care companion beds and, if necessary, an increase in care companion rooms.
- The call bell system required improvements as it did not easily alert staff to the location of the call.
- The importance of early identification of patients who would benefit from palliative care support not just at the end of life.

51. The report contained comment from two orthopaedic surgeons. One noted that ideally, X-rays should have been requested on 23 Month1 after Mr A's fall. The other surgeon stated that if Mr A was suffering pain in the neck on movement with restriction of range of movement, one could argue that this was grounds for an X-ray, but on the other hand, it would be reasonable to wait for a couple of days and obtain an orthopaedic opinion at that point.

[20] Mrs A told HDC that this occurred on 25 Month1.

52. Bay of Plenty DHB told HDC that Mr A's second fall (fall three) on 20 Month1 was not included in the Adverse Event Report as an incident report was not completed.

Meeting between Bay of Plenty DHB and Mrs A — 12 November 2020

53. At a meeting with Mrs A on 12 November, Bay of Plenty DHB acknowledged that it had failed Mr A. When staff found that they were not able to stay with Mr A for the long periods he needed to sit on the toilet, an alternative plan should have been put in place, such as asking a healthcare assistant to stay with Mr A or advising a family member how to call for assistance if it was required.

Responses to provisional opinion

Te Whatu Ora Hauora a Toi Bay of Plenty

54. Te Whatu Ora Hauora a Toi Bay of Plenty was given the opportunity to respond to the provisional opinion and stated that it appreciated the opportunity to provide further comments but did not have any.

Mrs A

55. Mrs A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, her comments have been incorporated into the report.

Opinion: Bay of Plenty DHB (now Te Whatu Ora Hauora a Toi Bay of Plenty) — breach

Introduction

56. Te Whatu Ora Hauora a Toi Bay of Plenty is responsible for the operation of the clinical services it provides. Bay of Plenty DHB had an organisational duty to provide an appropriate standard of care to consumers of its services.

57. At the time of events, Bay of Plenty DHB had a policy entitled Falls — Risk & Management of inpatient falls (relevant sections are outlined in Appendix C). Mr A fell four times during his admission to Hospital 2. The deficiencies in the implementation and compliance of the falls policy by multiple medical and nursing staff members are outlined below. I consider that Te Whatu Ora Hauora a Toi Bay of Plenty holds responsibility for these deficiencies at an organisational level, for the reasons outlined below.

58. To assist my assessment of this matter, I obtained independent clinical advice from a general surgeon, Dr Mark Sanders, and a registered nurse, Associate Professor Karole Hogarth, which I refer to below.

Falls risk assessment and management plan

59. Mr A's falls risk was assessed on admission, and his care plan on 14 Month1 stated that he should not be left unattended if he was out of bed, and should not be left alone on the commode. After the first fall on 16 Month1, Mr A's falls risk assessment was reviewed and further precautions were put in place, including that he should be assisted to the toilet, have hourly checking, and have a clutter-free environment. On 21 Month1, the day after his second and third fall, Mr A's falls risk assessment was reviewed and it was documented that he was a high falls risk and should be assisted as required.

60. My independent advisor, RN Hogarth, acknowledged that planning and documentation were undertaken, falls assessments were completed, Mr A's risk was noted, and strategies were put in place. However, she advised that Mr A's toileting requirements needed a more holistic view, and this was a mild departure from accepted practice. RN Hogarth explained that care plans are an opportunity to think critically and use clinical reasoning to establish best practice pathways of care for an individual, and that care plans should be flexible and should be used to anticipate needs rather than being reactive. RN Hogarth stated that the charge nurse or duty nurse could have considered whether Mr A required a "patient watcher" and whether his whānau could have been engaged to assist.

61. I accept this advice. I acknowledge that Te Whatu Ora Hauora a Toi Bay of Plenty has accepted the clinical findings in relation to the risk management plan for Mr A. A falls assessment was completed and a care plan was put in place, but it lacked critical thinking about Mr A's toileting needs. It was known that Mr A's risk of falling was increased because he was left alone in the toilet for long periods of time, and that nurses would not always be able to attend call requests straight away if they were assisting other patients. Notwithstanding this, there was insufficient exploration of other possible options to ensure Mr A's safety whilst he was on the toilet. A falls management plan is not a tick-box exercise, and critical thinking is required to ensure that all risks are considered and strategies are put in place to reduce the risk of falls.

Implementation of care plan

62. Mr A was often left alone on the commode for up to 20 minutes. His care plan on 14 Month1 stated that he should not be left unattended if he was out of bed, and should not be left alone on the commode. However, in reality Mr A was instructed to press the call button when he was finished, and to wait for nursing staff to attend to assist him off the commode. When the call button was pressed, the call bell showed on the communicator panels in the corridor. This required nursing staff to step away from the patient they were attending in order to check where the call had come from.

63. Te Whatu Ora Hauora a Toi Bay of Plenty's response to Mr A's care plan not being implemented has varied somewhat. Te Whatu Ora Hauora a Toi Bay of Plenty told Mrs A that a healthcare assistant should have been provided to assist Mr A, but told HDC that it was not possible to assign someone to stand and wait for Mr A to finish for lengthy periods of time, and that for privacy and hygiene reasons the door had to be shut.

64. RN Hogarth advised that the failure to adhere to Mr A's care plan was a moderate departure from accepted practice. RN Hogarth stated that while not meeting the care plan requirements, regular checking over periods no longer than five minutes, and reminding Mr A not to move without assistance and to use the call bell, would have been the minimum level of care expected. RN Hogarth said that it was the responsibility of the registered nurse who assisted Mr A to the commode to ensure that he remained safe.

65. I accept this advice. Whilst I consider that on 23 Month1 RN D should have followed Mr A's care plan and not left him on the toilet without checking him, I acknowledge that this had been the practice on the ward for the past nine days. There were many occasions on which Mr A was left unattended on the toilet. Therefore, my criticism is not directed towards one individual, but at the system that enabled this to occur. In addition, nursing staff, including RN D, were not provided with adequate alternatives in the care plan so that necessary nursing care on the ward could be provided while also ensuring that Mr A was not left alone on the toilet.

Falls management

66. Bay of Plenty DHB's falls policy stated that an incident management form should be completed as soon as possible after the event and before the end of a shift. It is also stated that the registered nurse responsible for the care of the patient would ensure that the family was notified. The doctor notified of the fall was to examine the patient within two hours of notification, or sooner if acute care was required as advised by the registered nurse who reported the event. The examination was to include assessment of neurological status and any possible injuries. The assessment was to be documented in the patient's health record, and the doctor was to be available to discuss the injury, including an explanation of the risks, with the patient/family.

16 Month1

67. During his admission to Hospital 2, Mr A had four falls. After the first fall on 16 Month1, RN B notified Dr B and informed Mrs A, but did not complete an incident form. Dr B did not review Mr A as per the falls policy. Mr A's falls assessment was updated and further precautions were put in place.

68. My clinical advisor, Dr Sanders, stated that Dr B was asked to review Mr A on 16 Month1, but there is no written documentation that she did. Dr Sanders advised that this was a moderate departure from the standard of care he would expect, and also a deviation from the hospital's falls policy. Dr Sanders stated that the nurse may have given some details to Dr B at the time, but that did not take away from the fact that Mr A should have been reviewed as per the falls policy, and that review should have been documented.

20 Month1

69. Mr A had two unwitnessed falls on 20 Month1. The first fall took place at 7.45pm. RN E completed an incident report but did not document the fall in Mr A's records. The second fall took place at around 8.20pm, and RN E documented the fall in Mr A's notes but did not

complete an incident form. Mrs A was not informed about the falls. It is unclear from the documentation whether Dr C examined or spoke to Mr A.

70. Dr Sanders stated that Dr C reviewed Mr A promptly on 20 Month1, but there is no indication from Dr C's notes that Mr A was actually examined or spoken to. Dr Sanders said it appears that Mr A may have sustained some bruising to the chin and face, indicating a head injury, and this review should have been more complete. Dr Sanders advised that the post-fall assessment was a moderate departure from the standard of care, and a deviation from the hospital's falls policy, which required assessment of neurological status in such situations.

71. I agree with Dr Sanders' comments. I am critical that there is no evidence that Dr C conducted a physical examination and/or a neurological assessment. In addition, the notes do not record the facial injuries that Mrs A reported having seen. In the absence of this evidence, I consider that the medical assessment was inadequate.

23 Month1

72. Mr A's fourth fall took place on 23 Month1 after he was left unattended on the toilet for between 20 to 30 minutes. RN D informed Dr F and completed an incident form, but did not inform Mrs A. Dr F assessed Mr A at 2.30pm.

73. Dr Sanders advised that Dr F's assessment of Mr A on 23 Month1 appears reasonable, as Dr F considered Mr A's neck pain and whether an X-ray was required. However, Dr Sanders considers that there should be a low threshold to initiate an investigation such as a scan or X-ray for patients who have fallen in hospital, particularly recurrently, and especially given Mr A's symptoms. Dr Sanders stated that given the persistence of Mr A's pain, an X-ray or a scan should have been instigated. Dr Sanders noted that the falls policy indicates that a CT scan should be considered in the presence of facial bruising or if the patient has hit their head when falling. Dr Sanders advised that the lack of an X-ray and/or a scan was a moderate departure from the accepted standard of care. He also advised that falls happen in hospital and, as with any adverse events that occur while a patient is under hospital care, falls should be investigated promptly and appropriately, with a low threshold for investigations.

74. RN Hogarth advised that the hospital's falls policy was not followed, assessments were not undertaken as required, and communication with Mr A's family was not always followed.

75. I accept this advice. Staff were inconsistent in following the falls policy, and the multiple failures relating to this outlined above point to a problem at a systemic level.

Conclusion

76. In my view, Bay of Plenty DHB had a responsibility to ensure that Mr A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). Overall, as outlined above, there were several issues with the care Mr A received at Hospital 2. In particular:

- There was a lack of critical thinking applied to Mr A's falls risk assessment in relation to his toileting needs.

- There was a consistent failure to adhere to Mr A's care plan.
- The falls policy was not followed by several nurses. Mrs A was not informed of Mr A's second, third or fourth fall, and an incident report was not completed after fall three.
- The falls policy was not followed by several doctors:
  - Mr A did not receive post-fall assessments by a doctor within two hours following fall one and fall two.
  - Mr A's medical review following fall three was inadequate.
  - Imaging should have been requested earlier after fall four.

77. The above inactions and/or failures by multiple staff members, and their failure to adhere to policies and procedures, demonstrates a pattern of poor care and a culture of non-compliance with policies. These failures at a systemic level had a negative impact on the care provided to Mr A. Accordingly, I find that Bay of Plenty DHB failed to provide Mr A with services with reasonable care and skill, in breach of Right 4(1) of the Code.[21]

Adverse Event Report — adverse comment

78. Mr A's third fall was not included in Bay of Plenty DHB's Adverse Event Report because an incident form had not been completed. I remind Te Whatu Ora Hauora a Toi Bay of Plenty of the importance of adverse event reports reflecting the entirety of the events and not limiting such reviews to what is reported in incident reports.

Changes to practice

79. Te Whatu Ora Hauora a Toi Bay of Plenty has made the following changes to its practice:

- The development of an online module for all staff, which includes delirium care and management of patients with a high risk of falls.
- A plan to develop an onsite care companion teaching package that will include delirium management, cognitive pathophysiology, falls minimisation, and frailty assessment.
- A new pager system was trialled but was found to be less effective than the call bell system. The call bell system has been set to be audible to all staff (including other disciplines such as doctors and allied health staff members), and all staff members are encouraged to respond to call bells.

80. In addition, the hospital's falls risk committee is working to understand and mitigate the risk of falls with an improved investigation method and reporting of details of falls.

[21] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Recommendations

81. I recommend that Te Whatu Ora Hauora a Toi Bay of Plenty:

a) Provide a written apology to Mrs A for the deficiencies in care identified in this report. The apology should be sent to HDC within three weeks of the date of this report.

b) Provide training to all house officers and nurses on Te Whatu Ora Hauora a Toi Bay of Plenty's falls management policy. Te Whatu Ora Hauora a Toi Bay of Plenty is to provide HDC with evidence that this has been done, within six months of the date of this report.

c) Provide ongoing training for registered nurses and healthcare assistants on the assessment and monitoring of falls risk. Te Whatu Ora Hauora a Toi Bay of Plenty is to provide HDC with evidence that this has been done, within six months of the date of this report.

d) Conduct an audit (six months after the implementation of the training recommended at c) to assess whether the training has reduced the number of falls. Te Whatu Ora Hauora a Toi Bay of Plenty is to provide HDC with evidence of the number of falls prior to the training and six months after the training, within six months of the date of this report.

e) Update the falls policy and clinical notes template to include:

- a section in the clinical notes to indicate that a follow-up assessment for any adverse impact of the fall has occurred within 48 hours of a fall; and/or
- a post-falls assessment checklist in the patient's notes;
- a separate section for a medical review with a specific prompt as to whether X-rays or scans are required;
- a list of practical mechanisms that could be instigated for the patient.

Te Whatu Ora Hauora a Toi Bay of Plenty is to provide HDC with evidence that this has been done, within six months of the date of this report.

e) Consider providing falls prevention mats in Hospital 2 for at-risk patients. Te Whatu Ora Hauora a Toi Bay of Plenty is to provide HDC with evidence of the rationale for providing, or not providing, such mats, within six months of the date of this report.

Follow-up action

82. A copy of this report with details identifying the parties removed, except Bay of Plenty DHB/Te Whatu Ora Hauora a Toi Bay of Plenty and the advisors on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Associate Professor Karole Hogarth:

"REFERENCE: 20HDC02247 COMPLAINT: BAY OF PLENTY DISTRICT HEALTH BOARD

Thank you for the request to provide clinical advice regarding the complaint from the family of [Mr A] (dec) on the care provided during his admission to [Hospital 2] in [2019].

In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I registered as a nurse in 1989. Upon registration I was appointed to a new graduate position at Waikato Hospital and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Waikato Hospital. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract, I moved to England and worked as an RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as an RN and as an RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enrol in a PhD which I did following a further year of travel where I worked as an RN for the Australia Blood Service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role two days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Nursing and Midwifery students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full-time position in the School of Nursing at Otago Polytechnic teaching sciences. My current role is Associate Professor and Head of Nursing. I am a Justice of the Peace for New Zealand having completed the requirements for this role in 2016 and reaccreditation in 2021 and am on the Otago Polytechnic Ethics committees for Auckland and Dunedin campuses.

The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr A] by Bay of Plenty District Health Board (BOPDHB) was reasonable in the circumstances and why.

With particular comment on:

1. The adequacy of the risk management plan in place to manage [Mr A's] falls risk.

2. The adequacy of his subsequent management following the falls. In particular, comment on the timeliness of seeking medical review and performing further assessments.
3. The adequacy of [Mr A's] pain management.
4. The adequacy of the BOPDHB Falls Policy 'Falls — Risk reduction and management of inpatient falls.'

Any other matters in this case that warrant comment.

For each question I am asked to advise:

1. What is the standard of care/accepted practice?
2. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) is this considered to be?
3. How would it be viewed by my peers?
4. Recommendations for improvement that may help prevent a similar occurrence in the future.

In preparing this report I have reviewed the following documentation:

Letter of complaint dated 3 December 2020

BOPDHB's response dated 8 March 2021.

Clinical records from BOPDHB covering the period [up to and including his admission].

Background

[Mr A] was admitted to [Hospital 2] with chronic kidney pain in [Month1]. [Mr A] had a complex medical history and was admitted for pain management and palliative care. He was heavily medicated with morphine and listed as a high falls risk. On the second day of his admission to hospital, he fell in the bathroom and had a subsequent fall which resulted in swelling and bruising to his face. [Mr A] reportedly told staff that he had broken his neck, however it was not until several days later that an x-ray was arranged. The x-ray revealed a fracture of the second cervical vertebra, at which point [Mr A] was immobilised and placed in a neck brace. [Mr A] sadly died two weeks later. The death certificate lists the fracture as contributing to his death.

[Mrs A] is concerned about the length of time it took for [Mr A] to be attended by a nurse (20 minutes) following his fall. [Mrs A] is also concerned that despite [Mr A] being labelled as a high falls risk, the risk management plan stating he should not be left unattended while out of bed or on the commode was not followed.

My comments are confined to the care provided by the Bay of Plenty District Health Board.

The adequacy of the risk management plan in place to manage [Mr A's] falls risk.

a. What is the standard of care/accepted practice?

Falls risk assessment is part of a primary assessment when a patient is admitted ensuring a baseline and to put strategies in place as necessary to ensure safety. Reassessment of falls risk should occur if there is any change in the patient's condition and after any falls.

[Mr A] had a complex history, and it was noted on admissions that he had had numerous falls in the preceding 90 days. Falls risk assessment would have included his complex medical history and his current health state.

Known considerations specifically related to his falls risk as indicated in his notes should have included:

- Falls history
- Walking frame used for mobility
- Chronic pain
- Opioid pain relief with increasing doses
- Polypharmacy and potential drug side effects
- Pain relief that was provided by sitting on the toilet for extended periods
- Previous CVA
- Hearing and vision difficulties
- [Mr A's] desire for independence (rightfully)
- Advanced age

Most of the above were noted by the staff at admission (6 [Month1] and 14 [Month1]), with an increase in falls risk documented between these two admissions. Falls risk assessment was completed with strategies put in place to minimise risk such as:

- Non-slip socks
- Supervision
- Bell in reach
- Declutter
- Enablers — cot sides (with consent)
- Intentional rounding

In [Mr A's] care plan (14 [Month1] admission) it was stated:

Falls — 'do not leave patient if out of bed'

Mobility — 'do not leave alone on commode'

One area that appears to be unappreciated was [Mr A's] need to sit on the toilet as it provided a degree of pain relief (one staff member described this in his notes as 'doing his thing'). This could have been explored further given that falls risk was greatest when he was needing to get to or using the bathroom. The above statements recognise this risk but it is not documented whether the issue of the toilet was discussed with [Mr A] or his family or if strategies were considered. [Mr A] wished to retain a degree of independence though it was not clear from the notes whether [Mr A] had insight into his own safety and ability to mobilise independently.

[Mr A's] plan was reviewed and documented as his condition changed. The gap in the plan was the follow through by the staff.

If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information given I would consider that there is a **mild** departure from accepted practice in the relation to the **risk management plan** for [Mr A]. Planning and documentation were undertaken, falls assessment was completed, his risk was noted, strategies were put in place. The area that needed a more holistic view as stated above was toileting. I can see that staff would consider a person with SPC, nephrostomy and colostomy not needing toileting in a traditional sense. However due to [Mr A's] intractable pain providing assistance in any way that reduced this pain would be accepted standard of care and should have been discussed and a plan made to facilitate this safely.

How would it be viewed by my peers?

I believe that my peers in practice and education would agree that the planning that was undertaken was adequate and if [Mr A's] specific toileting needs had been considered and followed through that the plan would have met the accepted standard of care.

Recommendations for improvement that may help to prevent a similar occurrence in the future.

BOPDHB have acknowledged the gaps in [Mr A's] care and made a number of suggestions for changes to ensure safety such as assigning an HCA, asking family to participate with RN oversight.

The adequacy of his subsequent management following the falls. In particular, comment on the timeliness of seeking medical review and performing further assessments.

a. What is the standard of care/accepted practice?

A fall is of concern for any patient and their family and should be followed up by staff if it was witnessed or unwitnessed. Witnessed falls are generally easier to assess as the

force and mechanism of fall can be judged by staff as to the potential for injury. Many falls are unwitnessed as was the case with [Mr A] on several occasions. These can be the most difficult to evaluate especially assessing the potential for injury. This relies on the information from the patient and should be considered carefully and followed up as soon as notified. The role of staff in any fall is to support, assess and provide treatment as needed. In the event of an incident staff need to respond according to policy and procedure to ensure that the safety and wellbeing of the patient is maintained, this includes a call for reviewing by a physician and communication with the family.

[Mr A] was reviewed by a House Officer in the morning of 20 [Month1] where it was documented that [Mr A]:

- Did not feel sedated
- Stated he was waiting too long to be assisted to the bathroom
- Had used 25mg prn morphine the previous day.

Following review by the HO and palliative care team on 20 [Month1], [Mr A] was commenced on subcutaneous infusion of morphine 40mg and midazolam 10mg at 1130hrs, morphine was later reduced to 20mg following review by the HO. Due to the changes in his medication earlier that day it would be expected that there would be further checking of [Mr A's] status, level of pain relief achieved, and review of his sedation levels if any over the following 24 hours.

[Mr A] was noted to have had two falls on the afternoon of 20 [Month1], it is not clear if Adverse Event Reports were completed for these two falls, [Mrs A] was not aware of these falls until notified later even though she talked to pm staff on that day re blood test. No injuries were noted. (Refer to Policy 6.3.5 Appendix 2 Management and Reporting of Inpatient Falls Algorithm.)

On 22 [Month1] following review by the HO [Mr A's] morphine via syringe driver was increased and clonazepam was added to his regime. [Mr A] had the fall which resulted in significant injury at lunchtime of 23 [Month1] (documentation at 1230hrs), he had been left unattended and did not get a response to ringing the bell until 20mins after first ringing (the waiting time for response was not documented in the clinical notes).

The fall was described as unwitnessed from commode to floor with two new skin tears noted on L) head and L) knee, neuro observations commenced, new neck pain, reviewed by HO at 1430hrs. On assessment resisted neck movements, no C-spine tenderness generalised pain in back of head and neck, normal sensation and power in limbs. C-spine x-ray was 'not indicated' at that point following this assessment. [Mr A] had a history of neck issues — rhizotomy C2/3, discectomy? (mentioned in notes). His high level of pain relief may have masked some of the new pain from the fall and injury and it would have been prudent to at least x-ray C-spine on the Saturday (this is a medical decision though the RN could have given context given that the HO was the on

call and not the regular physician). It is unclear if the HO discussed this with a registrar or consultant as per BOPDHB policy 6.1.2.

The questions from this are:

- Was an incident form completed for the falls on 20 [Month1], if not why not?
- Why were family not notified of the falls on 20 [Month1]?
- Why was [Mr A] in the bathroom unattended on the 23 [Month1] when it was clearly stated in his care plan he should not be unsupervised when out of bed?
- Why did it take 20 minutes for staff to return to him if they knew he was in the bathroom?
- Was a full post falls assessment completed at the time to identify cause and corrective actions? (Policy 6.3.5 Appendix 2 Management and Reporting of Inpatient Falls Algorithm.)
- Was the decision to not x-ray/CT on the 23 [Month1] discussed with a senior physician?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information given I would consider that there is a **severe** departure from accepted practice and care of [Mr A] in regard to the **management following his falls**. The policy for an unwitnessed fall was not fully followed, assessments were not undertaken as required, communication with the family did not meet expectations and documentation is incomplete.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that the documented actions do not meet the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

BOPDHB have made suggested improvements to their processes around falls prevention. The RN involved in the incident of the 23rd [Month1] has apologised. Further staff in-service may be useful to look at incidents with a view for restoration.

It would be useful (as part of the falls policy) when there has been an incident to include a section in the clinical notes to indicate that follow up within the post fall 48 hours occurred. This will show continuity of care as issues may arise over time e.g., bruising, immobility, increased pain and also ensure that incident documentation has been completed as per the policy. The importance of accurate documentation in regard to falls management cannot be overstated. Other suggestions include auditing of safety processes, falls prevention mat if available and appropriate.

Ongoing regular in-service for RN, ENs and HCAs on the assessment of falls risk, monitoring, maintaining mobility in those with comorbidities and the importance of exercise for balance and strength.

It would also be useful to update all team members on the policies guiding care and that the principles of direction and delegation are fully understood to ensure continuity of care at the expected level.

The adequacy of [Mr A's] pain management.

a. What is the standard of care/accepted practice?

Adequate pain relief is a right for all persons in care. The accepted standard of care related to pain management includes assessment of pain, regular pain medication as prescribed, minimal breakthrough pain, and that the patient would state that they have minimal, or no pain and that pain does not impact on their ability to undertake normal activities as defined by the patient. The assessment of this in conjunction with the health care team and family is essential to ensuring the appropriate medication, at the appropriate level is administered regularly as needed. Documentation should be thorough and pain charts used to determine the patient's stated levels of pain. This should be recorded along with the drug given and the resident's response following administration. Referral to other services may be indicated such as the pain team, palliative care team to explore options.

[Mr A] was a very challenging case with multiple issues and complex needs. His intractable pain was well documented following multiple procedures with acknowledgment of an emotional component to his pain.

[Mr A's] pain was regularly assessed, and pain relief was administered frequently as requested. Pain scores were documented in the nursing notes by some staff, there was no pain chart provided for this review. It is documented in the notes that [Mr A] appeared settled initially following administration of his medication though he did have a high degree of break through pain. Treatment options were explored following review by the palliative care team which visited regularly or as needed. Other options such as nerve block were explored by the medical team though the pain consultant did not consider this an option for [Mr A] (this was reconsidered [later in his admission]).

[Mr A's] pain relief was increased and methods of delivery added (subcutaneous) to accommodate his increasing needs. [Mr A] was prescribed and given a range of pain-relieving medication and it is obvious that the MDT were trying to find a regime that worked for him by including drugs that targeted pain in different ways.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information given I would consider that there is no departure from accepted practice in the management of [Mr A's] pain. Due to the complexity of [Mr A's] needs

the MDT had difficulty finding a protocol that gave him the level of pain relief he needed to remain comfortable. This would have been very distressing for the patient and his family.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that the assessment, management and regular review of [Mr A's] pain met the accepted standard.

d. Recommendations for improvement to prevent a similar occurrence in the future.

As [Mr A] and his family did acknowledge that there may be an emotional component to his pain exploring some alternative methods of pain relief may have been useful. This may not have been an option while an inpatient but could have been recommended for looking into after discharge.

The adequacy of the BOPDHB Falls Policy 'Falls — Risk reduction and management of inpatient falls.'

a. What is the standard of care/accepted practice?

All health care providers should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (e.g., falls management, health and safety) and it should provide a broad outline of the provider's requirements and leave scope for some decision making by staff dependent on the scenario. Guidelines can be included, and it should be clear who has responsibility for the care, treatment and follow up including documentation. Procedures can also be included as appendices to be used on a day-to-day basis in patient care. A flow chart can be very useful for staff to follow and to have consistency of responses.

BOPDHB's Falls — Risk Reduction Policy provides an excellent amount of information for staff with guidelines and links to important resources that are a useful adjunct to the policy document. It links well with the other policies such as Incident Management and Care Delivery.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information given I would consider that there is no departure from accepted practice in the Falls — Risk Reduction policy.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree with my assessment that the policy meets the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

I would suggest checking all of the external links in the policy documents, many are broken or inactive.

Review completed by: 12 April 2022"

"HDC REPORT — ADDENDUM

REFERENCE: 20HDC02247 [MR A]

I have been asked to provide further comment on the above case following responses from Te Whatu Ora — Hauora a Toi Bay of Plenty regarding the mild departure identified in relation to the risk management plan for [Mr A].

With particular comment on

1. The appropriateness of the staff's failure to adhere to [Mr A's] care plan and in particular that he should not have been left on the toilet alone.

Please also comment on:

a. If there has been a departure from the standard of care or accepted practice, how significant the departure is considered to be.

b. How it would be viewed by your peers.

c. Any recommendations for improvement that may help.

2. Whether the responses provided changes the opinion in your report that there was a severe departure from accepted practice and care for [Mr A] in regard to the management following his falls.

1. The appropriateness of the staff's failure to adhere to [Mr A's] care plan and in particular that he should not have been left on the toilet alone.

Care plans are put in place to ensure consistency of care, that all of the patient's needs are met (in collaboration including physical, psychological, spiritual), and to allow team members to organise care around a timeline. It is also an opportunity to think critically and use clinical reasoning to establish best practice pathways of care for an individual. Care plans are flexible and should be used to anticipate needs rather than being reactive. It was clearly identified on assessment that [Mr A] was a falls risk and in his care plan stated 'do not leave patient if out of bed'; 'do not leave alone on commode'.

[Mr A] was left alone when out of bed as evidenced by the falls from the time of his admission with his last fall resulting in significant injury following 20 minutes unattended in the toilet. There may have been some mitigating factors:

- [Mr A] needing to remain on the toilet for prolonged periods of time

- Ward staffing levels and acuity — limited resource
- Staff needing to attend to other patients' needs

a. If there has been a departure from the standard of care or accepted practice, how significant the departure is considered to be.

From the information given I would consider that there is a **moderate** departure from accepted practice in the relation to the staff's failure to adhere to [Mr A] care plan. It is a fact that he was left alone in the toilet against the requirements of the nursing care plan, and this resulted in a fall and injury.

There are several factors to be considered.

- [Mr A] wanting to keep some degree of independence though there is no indication of his insight of his risk. He did at times get up unassisted.
- The need for [Mr A] to sit on the toilet for pain relief which was documented and he was seen by the Palliative Care Team (19 [Month1]) re this.
- Increasing levels of pain relief and the impact on sedation levels.
- Ward staffing — did [Mr A] need a 'patient watcher', could family be engaged for this? This a consideration for the Charge Nurse/Duty Nurse.

It would be the responsibility of the staff member who helped [Mr A] into the toilet to ensure that he remained safe, however if [Mr A] did not call for assistance to the toilet this is difficult to manage. He did have strategies in place (non-slip socks/call bell in reach/hourly rounding/clutter free environment) was there the possibility of a falls mat and lowered bed?

I am sure that there would have been no intent to leave him for a prolonged period without other factors being involved in the decision making. There is also the question of practicality of having a staff member waiting while [Mr A] was in the toilet in a busy ward environment multiple times a day as was needed. Regular checking no longer than five minutes with reiteration of not moving without assistance and using the call bell, while not meeting the care plan requirements would have been the minimum expected.

A review of his care plan and further assessment may have shown a need for further support for example a watch for example when most needed by [Mr A] to ensure his safety (family or staff). [Mr A] was very vulnerable and as described by [a nurse] he was 'anxious, stressed tearful and becoming more frail daily', daily review of needs was indicated.

Documentation of falls was noted in the nursing though Adverse Event Reports were not completed at the time though were investigated as per the reporting document. There was also the failure to notify family in a timely manner regarding the falls that occurred.

How it would be viewed by your peers.

I believe that my peers in practice and education would agree that the documented actions do not meet the accepted standard of care but that there are often mitigating factors which may have compromised [Mr A's] safety in this case.

Any recommendations for improvement that may help.

As above

- Clear planning for review due to deterioration, increasing frailty, pain relief needs, mobility etc.
- Options for enablers such as falls mat alarm and a lowered bed.
- Input from leadership around the need for increasing support.

Changes have been implemented by Te Whatu Ora — Hauora a Toi with staff development, teaching packages, and further work by their Falls Committee. Staffing would be another area to look at.

2. **Whether the responses provided change the opinion in your report that there was a severe departure from accepted practice and care for [Mr A] in regard to the management following his falls.**

Following review of the response which addressed the questions that I had in my original response I would amend the departure from normal practice from severe to **moderate.** The information clarified points raised. This includes the adverse event reporting with the follow up and changes noted in the falls post assessment, acknowledgement of the communication with family and clarification re [Mr A] mobilising without assistance.

The main concern that remains is that [Mr A] waited 20 minutes for assistance in the bathroom and the query around follow up and further assessment with the physician following this.

Associate Professor KJ Hogarth

19 October 2022"

Appendix B: Independent clinical advice to Commissioner

The following expert advice was obtained from Dr Mark Sanders, general surgeon, dated 13 October 2022:

"I have been requested by the commissioner to provide an opinion on case number 20HDC02247.

I have read and agreed to follow the commissioner's guidelines for independent advisors.

Professional Credentials of 'expert advisor' relevant to this report:

My name is Mark Nathan Sanders and I am a vocationally registered consultant general surgeon employed by Te Whatu Ora, Te Tai Tokerau/Northern Region.

I hold an MBBS from the University of Newcastle upon Tyne, U.K., awarded in 1988. I hold a fellowship of the Royal College of Surgeons of London, England, and a fellowship of the Royal College of Surgeons of Edinburgh both gained by examination in 1993. I also hold a fellowship of the Royal Australasian College of Surgeons gained by examination in 2001. Following fellowship training I was appointed a consultant senior lecturer at the University of Bristol and the Bristol Royal Infirmary in the U.K. Since 2002 I have worked as a consultant general surgeon based at Whangarei Area Hospital. Since 2007 I have also worked in private practice at Kensington Hospital, Whangarei. My practice in Whangarei encompasses a wide range of general surgical conditions in this provincial hospital setting. I have been Head of the Dept of Surgery. I have held various training and committee positions for the Royal Australasian College of Surgeons and I am currently an Examiner for the final fellowship in General Surgery.

I declare no conflict of interest in this case.

EXPERT ADVICE REQUIRED

[Mr A], hereafter known as the patient, was a gentleman with a complex and extensive urological history, with chronic pelvic pain, and nephrostomy in situ, a suprapubic catheter in place and an ileostomy. He previously had numerous interventions on his prostate and rectal regions. He was on significant oral doses of pain relief including methadone and morphine. He was admitted to [Hospital 2] with an acute exacerbation of his chronic pelvic pain on 14 [Month1] after having been discharged approximately 7 days previously after a 2 day stay with the same set of symptoms. While in [Hospital 2] the patient sustained 3 falls, this is the focus of my report as per the HDC Commissioner's request, during the last one of which the patient sustained a fractured neck vertebrae. This was picked up on the CT scan 2 days after the event. The neck fracture was managed with a cervical collar. The patient's overall condition continued to deteriorate, palliative care was instituted, but the patient died [a short time later].

The neck fracture is mentioned as a significant condition contributing to the death in part 2 of the medical certificate of cause of death.

Specifically I've been asked to provide an opinion on the patient's management by [Hospital 2] during this time with particular request to comment on:

1. You would have expected any further actions or investigations following the patient's fall on:

16 [Month1] from [Dr B], House Officer.

20 [Month1] from [Dr C]

23 [Month1] from [Dr F]

2. The adequacy of Bay of Plenty DHB's falls policy, 'falls-risk reduction and management of inpatient falls'

3. Any other matter in this case that you consider warrants comment.

EVIDENCE TO SUPPORT CONCLUSION

I've been furnished with information from the Commissioner's Offices electronically which includes:

- A letter of complaint from the patient's wife.
- A response by BoP DHB dated 21 September 2020.
- Various additional documents in relation to a response to the complaint from 9 October 2020 and a meeting on 12 November 2020 and further email traffic following that.
- A response from the BoP DHB to HDC dated 8 March 2021 and a further response dated 13 September 2022.
- A copy of the BoP DHB's falls policy, 'risk reduction and management of inpatient falls policy'.

TIMELINE OF EVENTS

This timeline provides an overview which is more specifically orientated towards the questions I've been asked, that of the events around the falls.

14 [Month1] the patient was admitted to [Hospital 2] with a further acute on chronic exacerbation of pelvic pain. This has been documented in the admission notes as abdominal, rectal and penile. The patient has a complex past urological history, including prostate disease, and nephrostomy in situ, an ileostomy in place, with a previous repair of a recto-urethral fistula and the patient also had a suprapubic catheter in situ.

A falls assessment had been undertaken on the patient at this admission with 3 positive risk factors for falls documented and a falls prevention plan was completed. Written notes state; 'do not leave the patient if out of bed', cot sides for safety, non-slip socks and to ensure the call bell is within reach.

I note at this point that this falls assessment was reviewed on 16 and 21 [Month1], with a comment on the former date that the patient should be assisted to the toilet and on the latter date to be assisted PRN (as required). On the day of admission it was documented that the patient had attempted to walk assisted to the toilet but required a wheelchair.

At this point I make note of the fact that the patient still wanted to go to the toilet despite having a suprapubic catheter, nephrostomy and ileostomy. Some comment has been made in the notes that it was felt he should not actually need to go to the toilet because of these. At this point I also note that the suprapubic catheter, on CT scan on 17 [Month1], was noted to have its tip in the rectum and required some manipulation to bring it back into the bladder. This could have meant that there was more urine than expected in the patient's bladder giving the patient more of an urge to void the normal route. The patient did also seem to gain some pain relief by the act of sitting on the toilet as well. Various analgesic and other medical treatment was started for his more chronic condition.

16 [Month1], the patient is documented as being up to the toilet with a frame and supervision. There is then an additional note, untimed, that the patient had an un-witnessed fall and that the patient was found on the fall (sic) in the ensuite (presumably floor). Multiple skin tears on the left leg and a graze on the left hip were documented. The nurses made the on call house officer (OCHO) aware and asked them to review the patient. The patient was advised to use the call bell at times. 21.00hrs the patient was documented as alert and orientated and was assisted to toilet. I can see no written evidence of any house officer review after this fall. There is a note made by the house officer the next day, 17 [Month1], and no mention of a fall made here.

17–20 [Month1] ongoing cares and development of an overall management plan. No documented falls. During this time it should be noted the patient was assisted to the toilet.

20 [Month1] there is a note saying the patient was complaining about waiting too long for meals or to be taken to the bathroom. This would imply that he's waiting some time for help. 14.20hrs the patient is documented as being confused at times. It was noted that he was on significant analgesics including morphine and methadone in addition the patient was also on midazolam. It was documented that he was assisted with 2 people and the frame to go to the toilet. 20:00hrs a nursing note to say 'still wants to go to the toilet and do his thing' and then in the same note that the patient was found on the floor (toilet) 'the second time'. No obvious injuries were noted and the on call house surgeon was informed. 20.50hrs the house officer, [Dr C], documents that the patient

fell twice last night, being found on the floor but was able to stand up and walk to the bed, with no obvious injuries as per the RN's (Registered Nurse) notes. The patient is documented as being currently comfortable and asleep.

From that I could not say whether the patient had been formally examined or spoken to but have to assume that probably neither occurred as documentation is insufficient and that the notes were made based on the nurse's comments.

I note in the complaint letter that there is bruising to the chin and face mentioned by the patient's wife. This would imply that the patient hit their head if that were the case but is not documented elsewhere.

21–23 [Month1] on going in hospital based care with arrangements made for palliative care input.

23 [Month1] there is documentation at 12.30hrs, there's been a fall, un-witnessed from the commode to the floor. Reports head injured, nursing comments: 'left head under scalp small skin tear' and new left knee skin tear. Fully conscious, in pain and the same note mentions the patient was reviewed by the house officer, with advice for neurological observations and, if he deteriorates, then a CT head. This is a nursing note. At 14.00hrs further nursing note, saying the patient now had pain around neck 'little cause for concern and analgesia was administered'.

I note that the complaint letter corroborates the overt evidence of a head injury mentioning bruising and swelling around the face. The later CT requested actually mentions periorbital haematoma. 19.20hrs there's a report from the house officer, [Dr F], written in retrospect having seen the patient at 14.30hrs. The note there says that the patient was complaining of head and neck pain and on review there were no lacerations or boggy swellings and no cervical spine tenderness implying this was checked. The patient was however complaining of generalised pain in the back of the head and neck and was resisting doing neck movements on instruction. Apparently however the patient was subsequently observed to move their neck 'without much pain'. The patient had no neurological weakness or altered sensation. The impression from the House officer was that there was no acute injury and advice given to continue with neuro observation and if on going pain could consider a cervical spine x-ray, but this was not considered indicated at present. This would imply that the possibility of a cervical spine injury was considered at least. 21.30hrs that night the patient was noted still complaining of head and neck pain.

24 [Month1] the patient is noted as being asymptomatic the whole afternoon but at other times complaining of pain.

25 [Month1] patient complaining of increasing pain and concerns were raised by the patient's wife with requests for a scan. At 12.30hrs a registrar ward round, [the doctor] agreed to this and the patient underwent a CT head and neck. At 16.00hrs a CT was reported and it showed a fracture of the odontoid peg of the second cervical vertebrae

that was broken at the base of the peg and displaced 5mm. This is an unstable fracture. The patient had a Philadelphia collar fitted and spinal cares instituted after Orthopaedic advice and details of this were passed to the wife as the nursing notes say.

I do note an amendment to the report on 26 [Month1] which said there might be a slight wedging of T3 and T4 (Thoracic vertebrae) although they don't say whether these are acute.

26 [Month1] was seen by the Orthopaedic Team, who had advised the previous day, plans were to continue with the collar and not for surgery.

28 [Month1] it appears a full palliative care assessment was undertaken with planned placement. The patient had a soft collar applied instead of the hard collar, apparently for patient comfort. From then until the time [of discharge] it appears the patient was having on going palliative care optimisation.

SPECIFIC ISSUES

1. Whether you would have expected any further actions or investigations following the patient's falls:

On looking at the BoP DHB's — Risk Reduction and Management of Inpatient Falls document, I note in section 3.2 that the doctor should be notified of all falls and examine the patient within 2 hours of notification, and that examination must include assessment of the neurological status and any possible injuries. This assessment must be documented.

16 [Month1] from [Dr B], house officer. It appears the nurse did ask the on call house surgeon to review as per the policy, however I can see no written evidence that this has occurred. It would appear that [Dr B] was the house officer for this patient having seen them on the ward round that morning and remained the house surgeon the following day, and this was during daylight hours. This therefore has been a moderate departure from the standard of care that I would expect but also a deviation from the DHB's own policy. Details may have been passed to the house officer by the nurse at the time that they contacted them which may have filled the house officer in with some of the details but that does not take away from the fact that the patient should have been reviewed as per the policy and that documented.

20 [Month1] the house officer, [Dr C], did review the patient promptly, within 30 minutes it would appear, however the wording of their report implies to me that they were writing based on the Registered Nurse's notes that the patient had been able to walk back to the bed. There is no indication from their notes that the patient was actually examined or spoken to. Given the fact that it appears from the complaint letter that the patient may have sustained some bruising to the chin and face, indicating a head injury, this review should have been more complete and is therefore a moderate departure from the standard of care. Again a deviation from the DHB's own policy, which requires assessment of the neurological status with the possible injuries as

mentioned above. c) 23 [Month1] it appears the house officer, [Dr F], did review the patient at the time and within the 2 hours indicated in the policy, according to her retrospective written report (the report was not completed at the time but obviously there are a lot of potential reasons for this) however it did occur. The assessment that was undertaken and the report written does appear reasonable and in particular the neck pain issue was contemplated and thoughts given for an x-ray of the neck. This is, I feel, a reasonable assessment and comment. However I feel there should be a low threshold to actually initiate an investigation such as a scan or x-ray for patients that have fallen in hospital, particularly recurrently, especially given symptoms. I feel that as the patient was still complaining of head and neck pain later that night that then at least an x-ray, if not a scan, as they tend to give more detailed information, should have been instigated, maybe not at the time of the initial assessment but later on in the day given the persistence of the pain. BoP DHB's own falls document does mention that the presence of facial bruising or if the patient hit their head when they fell then a CT scan should be considered. This I feel therefore is a moderate departure from the accepted standard of care.

The adequacy of Bay of Plenty falls policy 'falls risk reduction and management of inpatient falls':

This document is probably better assessed by someone in a nursing management role who would deal with these in greater depth than I do in my field, however I have reviewed the policy and compared it with my local DHB's policy, which is not necessarily a gold standard, but I feel is useful. BoP DHB's document is, to my reading, a very standard policy covering assessment and management after a fall. It also prompts the completion of additional forms after a fall.

I do think it should be noted that this is quite a complex case and the patient still had some degree of mobility and independence initially although was documented as being at high risk for falls at the time of admission. They were left unattended in the bathroom despite this high falls risk. I do however appreciate the practicalities that the patient may have spent some considerable time in the bathroom as part of not only voiding but also the muscle relaxation and pain relief effect this may well have had. The practicalities sometimes dictate that there is not always going to be someone available to be with them all the time. However the patient was not managed as per the DHB's own policy on falls.

I've concentrated my comments particularly as requested on the falls and the medical response to the falls in this case. I can see no other particular concerns regarding the overall management of the patient's other acute or chronic issues.

RECOMMENDATIONS

Falls happen in hospital and, as with any adverse event that occurs while the patient is under a DHB's care, should be promptly and appropriately investigated with a low

threshold for investigations. Ensuring the importance of falls is passed to the ward Doctors and Nurses by adherence to the DHB policy should be encouraged.

Looking at my local DHB's policy by comparison and just to offer some advice that may be helpful, it does include a couple of features which I think may be useful and worth considering in any future revision by BoP DHB. One of these is a post falls assessment check list as a separate sheet to go in the patient's notes after a fall. This prompts actions as guided by the location of any injuries. It also has a separate section for a medical review again with a specific prompt as to whether x-rays or scans are required. This may serve as an aide memoire.

In addition there is a post falls assessment checklist which is more from the nursing side and includes an analysis of the fall and has space at the end for a senior nurse review to see whether any action is required. I note that BoP DHB, in the notes, do have a quite appropriate initial falls assessment but could maybe benefit from a list of practical mechanisms that could be instigated for the patients as part of that document again as an aide memoire for the nurses admitting the patient.

Submitted for your review and consideration

Yours sincerely

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Appendix C: Bay of Plenty DHB Policy: Falls Risk reduction and management of inpatient falls

Issued date: December 2018

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3. Post fall assessment and management

3.1 The registered nurse (RN)/registered midwife (RM) responsible for the care of the patient will ensure the Post Fall Assessment and Management algorithm (refer Appendix 2) will be followed for all falls (witnessed/unwitnessed or near miss).

3.2 Doctor notified of fall should examine patient within two (2) hours of notification or sooner if acute care required as advised by RN/RM reporting event. Examination must include assessment of neurological status and any possible injuries. Assessment must be documented in patient's health record. Doctor should be available to discuss the injury, including an explanation of the risks, with the patient/family.

3.3 The incident, the outcome, initial and ongoing assessment, observations and actions taken will be documented in the health record.

3.4 Reassess and update the Multidisciplinary Care Plan and flipchart.

3.5 The RN/RM responsible for the care of the patient will ensure the family is notified in accordance with Incident Management Open Disclosure principles and practice.