

The importance of care plans and falls policies 20HDC02247

The Deputy Health and Disability Commissioner has found Bay of Plenty District Health Board (now Te Whatu Ora Hauora a Toi Bay of Plenty) breached the Code of Health and Disability Service Consumers' Rights (the Code) in its care of an older man.

Ms Deborah James found Te Whatu Ora Hauora a Toi Bay of Plenty in breach of Right 4(1) which states that every consumer has the right to services provided with reasonable care and skill.

"Te Whatu Ora breached Right 4(1) 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," Ms James said.

The man had a complex medical history and was a high falls risk. His falls plan identified that he should not be left alone whilst in the hospital bathroom. The man had four unwitnessed falls in the bathroom and following the fourth fall, he complained of neck pain. A subsequent CT scan showed a fracture of the second cervical vertebra, which put him at high risk for life threatening complications. He passed away shortly afterwards.

"In my view, Te Whatu Ora Hauora a Toi Bay of Plenty had a responsibility to ensure the patient received care of an appropriate standard that complied with the Code. However, there were several issues with the care he received," said Ms James.

These issues included the lack of critical thinking applied to the patient's falls risk assessment in relation to his bathroom needs. There was also a consistent failure to adhere to his care plan and the falls policy was not followed by several nurses and doctors. In three cases the patient's wife was not informed of her husband's falls and after one fall an incident report was not completed.

"These inactions and/or failures by multiple staff members, and their failure to adhere to policies and procedures, demonstrate a pattern of poor care and a culture of non-compliance with policies," said Ms James. "At a systemic level these failures had a negative impact on the care provided to the patient."

In response to the breach, Ms James 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 Te Whatu Ora Hauora a
 Toi Bay of Plenty's 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.
- Consider providing falls prevention mats for at-risk patients.

Since the complaint, Te Whatu Ora Hauora a Toi Bay of Plenty has made the following changes to its practice:

- Developed an online module for all staff, which includes delirium care and management of patients with a high risk of falls.
- Created a plan to develop an onsite care companion teaching package that will include delirium management, cognitive pathophysiology, falls minimisation, and frailty assessment.
- Set the call bell system 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.
- 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.

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Editor's notes

The full report of this case will be available on HDC's <u>website</u>. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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