Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

# A Decision by the Aged Care Commissioner

# (Case 21HDC00401)


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## Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mrs A by Calvary Hospital Southland Limited (Calvary).

3. On 19 Month3 Mrs A experienced a fall at Calvary after being walked contrary to physiotherapist advice.

4. The following day, Mrs A was admitted to a public hospital (Te Whatu Ora (formerly a District Health Board[1])). She was diagnosed with fractures to her right distal femur (knee area) and left proximal femur (hip area).

5. Sadly, Mrs A passed away.

6. On 19 February 2021 the Coroner referred the matter to HDC with concerns about the care provided to Mrs A by Calvary. Mrs A's family agreed to the referral.

7. The following issue was identified for investigation:

[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 in this report to Southern District Health Board now refer to Te Whatu Ora Southern.




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- *Whether Calvary Hospital Southland Limited provided Mrs A with an appropriate standard of care in Month3[2] 2018.*

8. In-house clinical advice was obtained from Nurse Advisor (Aged Care) RN Hilda Johnson-Bogaerts (Appendix A).

## Background

9. Mrs A was in her nineties and had resided at Calvary since 2015. When the incident occurred, Mrs A was receiving hospital-level care.[3]

10. Mrs A had multiple comorbidities, including osteoarthritis of the knees,[4] atrial fibrillation,[5] congestive heart failure,[6] venous insufficiency,[7] hypertension,[8] and a pacemaker[9] for bradycardia.[10] Her medical history included a middle cerebral artery stroke,[11] a possible myocardial infarction[12] approximately 20 years previously, diverticulosis,[13] and a hiatus hernia.[14] In addition, Mrs A had undergone a left total knee joint replacement, surgical repair of a left femoral shaft fracture with internal fixation in 2015, and a further surgical repair of a fractured neck of femur in 2016.

11. Calvary's records document that Mrs A's mobility continued to decline in 2018, and she required full assistance of two staff using a high gutter frame (HGF) for short distances. She would usually use a wheelchair to mobilise around the facility.

12. Mrs A's mobility plan recorded the following under 'Problems and Needs':

- Falls risk if mobilization not supervised.
- Unable to stand unaided.
- Increased fatigue/↓ed (reduced) mobility in evenings.

13. On 5 Month3, a physiotherapist, Ms B,[15] assessed Mrs A and documented in her progress notes that her condition had improved. Walking was trialled but this was found to be too fatiguing for Mrs A. The physiotherapist's plan, as documented in the progress notes, was to continue using a sling hoist with the aim to 'progress to 90° TIF with frame'[16] once Mrs

[2] Relevant months are referred to as Months 1-3 to protect privacy.
[3] Hospital-level care offers a higher level of nursing and clinical care than rest-home care.
[4] Wear and tear of the protective cartilage that cushions the joints.
[5] An irregular and often rapid heartbeat.
[6] A condition in which the heart cannot pump blood around the body as well as it should.
[7] A condition in which the flow of blood through the veins is blocked, causing blood to pool in the legs.
[8] High blood pressure.
[9] A device used to control an irregular heart rhythm.
[10] A slower than normal heart rate.
[11] A blockage or rupture of the large artery that supplies the brain.
[12] A heart attack.
[13] Abnormal pouches in the bowel wall formed by weak spots pushing outwards.
[14] Part of the stomach squeezes up into the chest through an opening ('hiatus') in the diaphragm.
[15] Ms B advised that he had been involved in Mrs A's care for many years and had assessed Mrs A regularly.
[16] To increase her mobility gradually, from full dependence using the hoist, to being able to stand and use a walking frame.



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A had improved. Contrary to these instructions, a support worker recorded in Mrs A's progress notes on 11 Month3 that Mrs A was mobilised a short distance using a low walking frame (LWF).

14. Mrs A's progress notes of 15 Month3 record under a sub-heading of 'walking': '[M]obilising short distances only with HGF x 2 A (2 assistants). Struggles further than toilet to bed + very slow + shaky.'

15. Ms B assessed Mrs A again on 18 Month3 and recorded in her mobility plan: 'Pivot transfer with x 2 assistants and handling belt; Full sling hoist if unwell; Do not mobilise/transfer only. Ms B explained the following in Mrs A's progress notes:

> 'Transfer via pivot x 2 assist and handling belt, chair to chair/90° only. *DO NOT WALK/MOBILISE* i.e. move shower chair beside bed/wheelchair beside armchair to limit any distance. [Mrs A] is unable to tolerate walking. If [Mrs A] becomes unwell or weight bearing ability declines please use sling hoist (RoMedic) with care ++.'

16. Ms B said that she gave verbal and written instruction that Mrs A was not to be walked/mobilised, as she could not tolerate it. Ms B advised that although the Patient/ Resident Handling policy did not cover specifics on how physiotherapists are to report changes in mobility and manual handling, she did complete a full assessment and document this in Mrs A's progress notes and handling requirements form.

17. The physiotherapy transfer chart above the bed was not amended to specify that Mrs A was not to be walked, and it did not define the parameters of the pivot transfer.

18. In response to the provisional opinion, registered nurse (RN) RN C said that the physiotherapist's advice in relation to Mrs A's mobility changes was verbally handed over to the appropriate clinical staff at the 'Morning to Afternoon' handover meeting but there is no documentation showing that this information was handed over.

19. On 19 Month3 Mrs A was being assisted to the toilet by two staff members using a mobility belt and an HGF. The incident report states that Mrs A's legs collapsed, and she fell forward onto her knees. Mrs A was lowered gently to the floor and the emergency call bell was activated.

20. Mrs A was hoisted on to her bed, and RN C completed a physical examination. Mrs A's progress notes document the presence of a skin tear but no pain or evidence of limb shortening, rotation, or other deformity.

21. The progress notes document Mrs A's fall only briefly, with no details of the assessments taken following the fall. In its response to the complaint, Calvary provided statements from the staff who assisted Mrs A when she fell and the staff who undertook the assessments after her fall. The statements do not dispute that Mrs A was mobilised (unintentionally) contrary to the physiotherapist's advice, and that this resulted in her fall.



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22. RN C and RN D, who assessed Mrs A after her fall, provided further information about their assessments of Mrs A.

23. RN C said that she checked Mrs A's range of movement in both legs, ankles, and hips. RN C stated that Mrs A's legs were the same length with her knees pointed to the ceiling, and her arms and back were observed and checked. RN C said that throughout the assessment, Mrs A advised that she had no pain. No follow-up assessment was undertaken that day.

24. Later that night, Mrs A complained of left-sided abdominal pain and was administered codeine phosphate for the pain.

25. At 1.40pm on 20 Month3 a healthcare assistant reported to a registered nurse (whose name was not stated in the progress notes) that Mrs A was complaining of 'strong pain in [her] legs'. The progress notes contain no documentation of the actions taken to assess Mrs A's pain.

26. Mrs A's progress notes at 3pm note that she had 'sore knees, back and abdo' and that pain relief was required. Morphine was administered twice but is recorded as having had no effect, with Mrs A describing her pain score as 10/10. It is also documented at this time that Mrs A's breathing was shallow and slow.

27. Calvary's clinical coordinator advised staff to contact the ambulance service to transfer Mrs A to the public hospital. The ambulance summary records that no rotation or shortening of Mrs A's limbs were noted, which is consistent with the post-fall assessment carried out by the nursing staff at Calvary.

28. Mrs A was admitted to the public hospital. X-rays indicated that Mrs A had a right distal femur fracture (consistent with her knee pain) and a left proximal femur (consistent with her left-sided abdominal and back pain).

29. An orthopaedic review deemed Mrs A unfit for surgery. Incremental morphine was given as required, and she was referred to palliative care.

30. On 20 Month3, Mrs A was transferred to a ward for pain management. A nerve block was given, and a syringe driver initiated. Mrs A's clinical records document that she was comfortable following the procedure.

31. Sadly, Mrs A passed away on the evening of 21 Month3. Her death was referred immediately to both the Police and the Coroner.

32. The Coronial Autopsy Report summarised Mrs A's cause of death as bronchopneumonia[17] subsequent to a fall.

[17] Inflammation and fluid in the lungs caused by an infection.



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### Further information

*Te Whatu Ora*

33. Te Whatu Ora provided HDC with a copy of Calvary's final certification audit report dated 6 June 2017, which detailed three areas for improvement, including a high-risk finding regarding medication management. A progress monitoring report dated Month1 showed that all corrective actions were met in June 2017.

### Responses to provisional opinion

34. Mrs A's family were given an opportunity to respond to the 'introduction', 'background', and 'further information' sections of my provisional opinion. Mrs A's family made no comment.

35. Calvary was given an opportunity to respond to my provisional opinion. Calvary's response has been incorporated into this report where relevant.

## Opinion: Calvary — breach

36. First, I express my sincere condolences to Mrs A's family for their loss. I acknowledge Mrs A's and her family's distress in the days prior to her passing. In addition, I appreciate the patience of Mrs A's family throughout the coronial and HDC investigations.

37. The New Zealand Health and Disability Services Standards (NZHDSS)[18] require that aged-care facilities ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.

38. I consider that Calvary had overall responsibility to ensure that Mrs A received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Services Consumers' Rights (the Code), and this included responsibility for the actions of its staff.

### Coordination of care

39. On 5, 11, and 15 Month3, Mrs A was not mobilised in accordance with the physiotherapist's plan.

40. On 18 Month3, the physiotherapist recorded in Mrs A's mobility plan and the progress notes her assessment and advice that Mrs A was not to be walked/mobilised. The physiotherapy transfer chart above Mrs A's bed was not amended to specify that Mrs A was not to be mobilised/walked and did not define the parameters of the pivot transfer.

41. Calvary said that the changes to Mrs A's mobility plan were handed over to the appropriate clinical staff verbally, but this is not documented and there is no evidence that clinical staff reviewed this information prior to commencing their shift on 19 Month3.

[18] https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/services-standard.



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42. On 19 Month3, contrary to the physiotherapist's instructions, Mrs A was helped to the toilet by two staff members, who mobilised her using a mobility belt and an HGF. However, Mrs A's legs collapsed, and she fell to the floor, assisted by the staff members.

43. My in-house aged-care advisor, RN Johnson-Bogaerts, advised that Mrs A's progress notes and care plan were updated correctly and in a timely manner. However, RN Johnson-Bogaerts said that the instructions above Mrs A's bed were 'somewhat ambiguous' because they included the use of a gutter frame, intending it to be used as a support when pivoting from the bed to the chair, and not for walking. RN Johnson-Bogaerts advised that the care staff appear to have acted on the chart above Mrs A's bed and not the updated mobility plan and progress notes, which contained the instructions that Mrs A was not to walk.

44. In addition, RN Johnson-Bogaerts is concerned that the nursing staff did not identify the entries made by the care staff in relation to the difficulty Mrs A was experiencing when walking. RN Johnson-Bogaerts advised:

> 'It would appear that the care home at the time had issues with hand-over of changes of care instructions to oncoming staff and with staff not always reading progress notes of previous shifts. Together this would be viewed by my peers as a moderate to significant deviation from accepted practice.'

45. I accept RN Johnson-Bogaert's advice. While I consider that the physiotherapist had documented Mrs A's mobility requirements appropriately and in a timely manner in the clinical records, I am critical that the oncoming staff did not review the clinical records (Mrs A's mobility plan and progress notes) at the beginning of their shift to identify any changes in Mrs A's care plan.

46. This lack of review of the clinical records resulted in Mrs A being mobilised contrary to the physiotherapist's instructions on several occasions (11 Month3, 15 Month3, and 19 Month3), and in Mrs A sustaining a fall on 19 Month3.

47. As noted by RN Johnson-Bogaerts, I am also concerned about the lack of follow-up by clinical staff regarding the concerns noted by support staff about Mrs A's difficulties when walking. In my view, the overall coordination of Mrs A's care between staff members at Calvary in relation to her mobility was inadequate.

**Post-fall assessment**

48. On 19 Month3, following her fall, Mrs A was assessed by RN C, who did not document details of the assessment undertaken. On 19 Month3 (no time included), RN D briefly documented that Mrs A had sustained a skin tear on her inner left leg from her walking frame, but no details were recorded of any assessment undertaken.

49. RN Johnson-Bogaerts advised that as it is not unusual for there to be a delay in the appearance of post-fall pain, swelling, bruises, and other symptoms, she would expect a follow-up assessment to be made at least one to two hours post-fall, and for the assessment to be documented in Mrs A's records.



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50. RN Johnson-Bogaerts advised that the lack of follow-up assessment of Mrs A post-fall was a minor deviation from accepted practice. I accept this advice and consider that Mrs A should have been assessed regularly following her fall.

**Documentation**

51. Mrs A's fall was documented in her progress notes, but there is no documentation of the post-fall assessment undertaken by RN C.

52. RN Johnson-Bogaerts advised that documentation of the incident, nursing assessments, and outcomes was lacking and not in line with the organisation's procedures and accepted practice within the Nursing Council's standards, thus making the lack of documentation a moderate deviation from the accepted standard.

53. RN Johnson-Bogaerts noted that although there is evidence that communication occurred, the minimal documentation made it difficult to comment on the adequacy and sensitivity of the communication.

54. I accept RN Johnson-Bogaerts' advice on the lack of documentation and am critical that several staff members failed to document the care they provided to Mrs A appropriately.

55. A full and accurate clinical record is vitally important. In previous reports, this Office has stressed the importance of good record-keeping and the accuracy of clinical records.[19] Calvary has a responsibility to provide oversight of its staff in relation to the standard of documentation.

56. In my view, these deficiencies indicate a pattern of poor documentation at Calvary, which I find concerning.

**Conclusion**

57. I find that Calvary failed to provide services to Mrs A with reasonable care and skill, in breach of Right 4(1) of the Code, for the following reasons:

- The inadequate coordination of care between staff in relation to Mrs A's mobility;
- The failure to follow the physiotherapist's instructions when mobilising Mrs A;
- The lack of post-fall assessment; and
- The poor standard of documentation.

## Changes made since events

58. Calvary undertook an internal investigation into these events and identified areas for improvement to prevent the likelihood of reoccurrence.

59. As a result of this incident, Calvary implemented a traffic light system, with input from the physiotherapist, to ensure that patient mobilisation and handling requirements are

[19] For example, opinions 19HDC01764, 19HDC01547, 12HDC00437, and 11HDC01103.



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explained clearly on the boards above patients' beds. Calvary said in the response to the provisional opinion that the physiotherapist aides are responsible for keeping the boards above patients' beds updated with the multidisciplinary team.

60. Calvary said that it has implemented a separate whiteboard in the Nurses Office for the physiotherapist aides to record any changes to mobility.

61. Calvary stated that it continues to use its handover form, which is given to each of the staff members during each handover meeting. Calvary said that previously the handover form included a section for 'mobility', but this has been replaced by a section for 'diet'. Calvary said that if any changes are required, the form is updated by the Clinical Coordinator.

62. Calvary said that it has purchased and implemented the Healthcare Compliance Solutions Limited (HCSL) computerised clinical programme. Calvary stated: 'This gives any staff member the ability, when they have written their progress notes, to tick a box to notify RN, which in turn shows up as Handover notes for the Nurses.'

63. Calvary has provided HDC with its process for updating the bedside charts. Calvary said that the charts are updated following an assessment and discussion between the physiotherapist aides and the registered nurse or Clinical Coordinator. It said that this usually occurs when concerns or changes in mobility or transfers are noted by the hospital aids. Calvary said that the physiotherapist aides are responsible for updating the bedside charts.

64. Calvary introduced a group strength and balance class for residents, which is accredited by ACC. Calvary said that in its last certification audit it attained a CI[20] rating for these classes. Calvary also said that it has employed a further physiotherapist and two physiotherapist aides, which has decreased falls in the hospital wing of Calvary Hospital.

65. Calvary stated that its physiotherapist aides provide staff with 'Manual Handling Education' on patient transfers and the use of 'Slippery Sams' and hoists. Calvary said that this education is available to the staff monthly, to give them the opportunity to attend at least one session per year, and the education is also given one-on-one at staff orientation.

66. Calvary also said that it has purchased an education programme called 'Altura', which enables its Educator to sort compulsory annual or bi-annual topics and to send monthly emails to staff notifying them of the education due in that month. Calvary stated that the first compulsory topic was 'Falls: Balancing Risk', and that all staff completed this training, as well as 'Documentation' training. Calvary said that as at December 2023, 43% of its staff had completed training on 'H&S: Supporting People to Move', and that 13% of staff are in the process of completing this training.

67. Calvary said that training on 'Effective Handovers' will be available to staff in February 2024.

[20] Continuous Improvement.



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68. All staff who were involved in Mrs A's care following her fall advised that they have reflected on the circumstances and have reviewed their patient records, handover, post-fall assessments, and documentation standards.

69. Calvary said that while only a few of the staff members involved in the incident are currently still employed by Calvary, it continues to use Mrs A's case 'as an example of how things can go very wrong when people don't take notice of instructions'.

## Recommendations

70. As recommended in the provisional opinion, Calvary provided a formal written apology to Mrs A's family, which will be provided to the family with a copy of this report.

71. Considering the changes made by Calvary since the events, I recommend that Calvary provide education/training to its staff on handover/coordination of care. Evidence showing the content of the education/training delivered and the attendees is to be provided to HDC within six months of the date of this decision.

## Follow-up actions

72. A copy of this report will be sent to the Coroner.

73. A copy of this report with details identifying the parties removed, except Calvary Hospital Southland Limited and the advisor on this case, will be sent to HealthCERT and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



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## Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from aged-care advisor RN Hilda Johnson-Bogaerts:

'**CLINICAL ADVICE — AGED CARE**

**CONSUMER:** [Mrs A]

**PROVIDER:** Calvary Hospital Southland, [public hospital]

**FILE NUMBER:** C21HDC00401

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Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Calvary Hospital. Preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

I have been asked to review the clinical documentation and advise on:

i. The adequacy of the management of the fall on 19 [Month3] including post fall assessments, documentation, family notification, and pain management
ii. The adequacy of falls prevention following physio assessment of 18 [Month3]
iii. The adequacy of Calvary Hospital's clinical procedures relating to falls management, incident management, and communication

**1. Documents reviewed**

- Internal review report
- Incident report of the fall dated 19 [Month3]
- Progress notes starting 4 [Month2]
- Provider response
- [Ambulance service] Care Summary 20 [Month3]
- Letter of response from Physio dated 30 November 2021
- Care staff's individual account of the events

**2. Review of clinical records**

My condolences to the family and friends of [Mrs A]. [Mrs A] was a [woman in her nineties] residing at Calvary Care Home where she received hospital level of care. She lived with multiple co-morbidities including osteoarthritis of the knees with a past left knee joint replacement and a past femur fracture repaired with internal fixation (2015), past fractured neck of femur (2016), atrial fibrillation, congestive heart failure, pacemaker, venous insufficiency, hypertension, stroke (7 months prior) diverticulitis, and symptoms of dissecting aneurysm (breathlessness and pain) managed conservatively with analgesics. She had an indwelling urine catheter. The clinical notes show she needed full assistance with activities of daily living and used to mobilise with assistance of two staff using a high gutter frame for short distances. Her main mode



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for mobilising around the facility was a wheelchair. Over time her ability to mobilise declined as her overall health deteriorated during [Month2] and [Month3]. The medical review on 27 [Month2] indicated that [Mrs A's] CHF caused the decline with low energy. She was well supported by her family who were very involved with her cares and visited most days.

On 19 [Month3] [Mrs A] experienced an assisted fall when she was mistakenly walked by staff resulting in her being hospitalised with fractures to her right knee and left hip the next day.

**i. The adequacy of the fall's prevention following physio assessments and instructions**

The Progress notes starting [Month2] show a decline in [Mrs A's] ability to mobilise. The physio assessment of 20 [Month2] includes as a cause of her poor weight bearing that [Mrs A] lacks the energy at the moment to stand. Instructions for transferring changed from her being able to do some steps to "*sling hoist transfers only*" between bed and chair or toilet and that great care is needed not to cause skin tears while transferring. This implies that she would not be standing or walking. [Mrs A's] care plan was updated with these instructions.

I note that on 20 [Month2] [Mrs A's] family raised with the RN concerns about "*her health status*". The family suggested "*it would be good to start getting [Mrs A] to go to dining room for meals as they were worried she is not eating*". "*Pain seemed to have been more settled and she didn't need morphine as often.*"

On 5 [Month3] the progress notes include a new Physio review indicating that [Mrs A's] condition improved and it was agreed to try walking. This was found to be too fatiguing still and the plan was to continue the use of the sling hoist. 7 [Month3] includes a conversation with family where the family expressed to be confused as they thought she was "definitely palliative". The RN informed the family she appeared to be "*stable and in no severe pain, only requiring regular Panadol, eating and drinking well and her mood is bright*".

11 [Month3] I note that HCA […] (name hard to read) writes in the progress notes "*mobilised short distance with LWF".* I did not find in the notes any changes to the Physio's instruction. It seemed these remained to only use sling hoist for transfers with no walking. Again on 14 [Month3] this HCA includes in the notes "*Mobilising short distances only with HGF and 2 carers. Struggles further than toilet to bed + very slow + shaky."* I did not find any change in instructions from the physio now allowing to support [Mrs A] to walk short distances. The care plan was not changed and instructions still included full sling hoist only. Other health care assistants document they use full sling for moving [Mrs A].

15 [Month3] caregiver […] (name hard to read) also includes in the notes that [Mrs A] mobilised short distances with assistance and the HGF, that she struggles and is unsteady. This was not in line with care plan instructions from the physio.



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On 16 [Month3] [Mrs A] received a review from the Palliative care nurse. The notes include that *'pre emptive end of life medication'* was previously prescribed, that [Mrs A] was at risk of having an acute decline again in the near future (confirming the palliative status) and that family was supportive of a comfort only approach.

Notes of 16 [Month3] include that [Mrs A] was unable to walk and the full sling hoist was used for transfers.

18 [Month3] the progress notes include a Physio review. [Mrs A] indicated a preference for a pivot transfer (stepping) with handling belt and two staff assist. The instructions going forward include the transfer via pivot (stepping) from chair to chair only and in capital letters "DO NOT WALK/MOBILISE" and to use sling hoist if her weight bearing ability declines. Her care plan was updated with these instructions on the same day.

19 [Month3] the notes include "*[Mrs A] had a skin tear on her inner left leg from her walking frame — [Mrs A] was lowered to floor and lifted with sling hoist"*. An incident report was completed which includes that she had this fall following 3 steps walking back from the toilet. "*Her legs gave out. she caught the inner left leg on her walking frame as she was lowered on the floor."* Individual staff accounts included that they lowered her to sit on the floor and that she did not fall on her knees.

In their response the provider explains that the Physiotherapist was always very thorough in her assessments and documentation with the unfortunate exception of the update of the last Manual Handling Sheet which is situated above [Mrs A's] bed. The instructions would have been handed over verbally however the provider cannot verify if this happened on this shift.

The response from Physiotherapist [Ms B] who completed the assessments and documentation includes that the instructions as per assessment on 18 [Month3] *"were documented in [Mrs A's] clinical progress notes and also her 'Patient Handling Requirements' which sit directly in front of the notes. On this form it said Do not mobilise as it was too much for [Mrs A]. A laminated mobility instruction card was placed on the wall above her bed which instructed: HGF, transfer belt, x2 assistants, pivot transfer only."* HGF stands for High Gutter Frame.

**Clinical advice:**
In residential aged care, care is provided by a number of care staff and clinicians who work a number of days and shifts and then have time off duty. Nursing/care documentation including progress notes, care plans, medical reviews, allied health reviews, etc. must be completed, be accurate, and timely to foster continuity of care across the different duties and care staff. Care staff who come on duty must at the beginning of their duty update themselves on the latest care instructions and changes in health status of residents by way of reading clinical notes, care plans and other relevant care instructions and by attending the "hand-over meetings".



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**It would appear that in this case a number of mild to moderate deviations from accepted practice led to [Mrs A's] fall and sentinel event.**

In this situation the Progress notes and Care plan was updated correctly and in a timely manner, however the instructions above [Mrs A's] bed were somewhat ambiguous because it includes the use of a gutter frame (HGF) with the intention to use it as a support when pivoting from bed to chair and not for walking. These care staff seem to have acted upon the chart above the bed (albeit misunderstood) only and not the care plan/progress notes updates with instructions "not to walk".

I note that care staff (HCA and EN) mistakenly assisted [Mrs A] with walking on 11 [Month3], on 15 [Month3] and on 19 [Month3] when she experienced a fall. It would appear they did not update themselves by reading the clinical notes. In addition, I am concerned that these care staff's progress notes entries expressing the difficulty [Mrs A] experienced when walking were not picked up by registered nurses or other staff as a concern for follow up. It would appear that the care home at the time had issues with hand-over of changes of care instructions to oncoming staff and with staff not always reading progress notes of previous shifts. **Together this would be viewed by my peers as a moderate to significant deviation from accepted practice.**

Since then, the provider introduced a "'traffic light" group of signs which can be easily understood and kept above all hospital level care beds. Other quality improvement initiatives are mentioned by the provider which I consider to be adequate for staff to be better informed about the mobilising and transferring instructions for residents. In addition to these improvements I recommend a strong reminder to all staff to update themselves every time they come on duty by reading entries made by their colleagues in progress notes and for RNs to act upon entries such as care staff identifying someone is very slow and shaky or entries of that effect.

**ii. The adequacy of the management of the fall on 19 [Month3] including post fall assessments, documentation, family notification, and pain management**

An incident report was completed post fall which reads that at 19.20 hrs [Mrs A] experienced an assisted fall after 3 steps walking back from the toilet. *"Her legs gave out. she caught the inner left leg on her walking frame as she was lowered on the floor."* The report includes that the RN assessed [Mrs A] for injury and transferred her then onto the bed with a sling hoist. The report does not include the extent of assessments and what the findings were other than vital signs taken. Vital signs at the time indicated a high blood pressure i.e. 171/111, other measures were within normal range. No follow up vital signs seem to have been taken to see if blood pressure stabilised. No description of other post fall observations were documented. The incident form includes that family was notified at 19.45 hrs of the fall and the skin tear. The incident form was further completed the next day at 13.30 Hrs by the clinical coordinator including that she was asked to review [Mrs A's] knee which she was rubbing. The document includes that the knee was swollen but not more than usual, no shortening of legs was noted. Staff were asked to monitor and give pain relief. I note that part of the incident form relating to an analysis for the causes of the incident



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and what preventative action is to be taken was not completed. Later a Section 31 notification was also completed and sent to the Ministry of Health.

The [ambulance service] Care Summary notes of 20 [Month3] include "*severe pain in right knee (10/10) post fall yesterday with obvious swelling to knee, unable to move knee and today unable to stand. Primary clinical impression was noted to be concussion of knee with secondary clinical impression of fracture to the right knee. Family and staff were present when the paramedics arrived*."

Analgesics documented in Medimap as given:

| |
|---|
| 19 [Month3] 23:37 hrs Codeine 30mg for left sided abdominal pain to good effect |
| 20 [Month3] 9:14 hrs Codeine 30 mg for sore back — effect not documented |
| 20 [Month3] 10:50 hrs Morphine 2.5mg for bilateral knee pain effect not documented |
| 20 [Month3] 13:45 hrs Morphine dose not documented, knee pain, no effect documented |

**Post fall assessments**

It is difficult to comment on the adequacy of the immediate post fall assessment completed by the registered nurse. The assessment outcomes documented were the taking of vital signs only and that she had "*full range of movement and didn't complain of pain*". It would seem that post fall there were no obvious signs of injury besides the skin tear and the swelling of [Mrs A's] knee (as usual) taking into account the [ambulance service] report of findings on 20 [Month3] and the medication records showing analgesics given for knee pain started on 20 [Month3] after 10:00 hrs only. Reviewing documentation of pain post 18 [Month3], [Mrs A] complained of abdominal pain and sore back (19 and 20 [Month3]) which was not unusual for her to receive analgesics for and later on 20 [Month3] about "serious" knee pain. Assessments lacked a follow up after 1 or 2 hours to see if anything changed. It is not unusual for post fall pain, swelling, bruises and other symptoms to appear with a delay. (In this case the repeated assessments may still not have revealed the severity of the injuries.) When on 20 [Month3] [Mrs A] complained of sore knees a comprehensive assessment was undertaken by the RN which was well documented. **Taking the above into account I consider the post fall assessments to have been a minor deviation from accepted practice.**

**Pain management**

The post fall assessment included a pain assessment. It was documented that [Mrs A] denied having pain. On 20 [Month3] the progress notes include that the analgesics



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(prn oral Morphine) was administered for knee pain twice (with 3 hours in between) to no effect. A pain score of 10/10 was documented in the progress notes by the RN. This was followed up with further observations and appropriately escalated to the clinical coordinator and ambulance called. **I consider post fall pain management to have been in line with accepted practice.**

**Clinical documentation**

Documentation of the incident, nursing assessments and outcomes was lacking and not in line with the organisation's policy/procedures and with accepted practice. Specifically, immediate post fall assessments undertaken, clinical reasoning and conclusions should be documented in the progress notes. Further the incident form could have been more detailed and the required investigation into the cause of the incident was not completed. Content of family communication was not documented.

**For these reasons I consider the documentation of the incident and clinical care to have been a moderate deviation from accepted practice.**

**Family communication**

Communication with family was documented to have occurred post fall, content of the communication and family reaction was not documented. The progress notes of 20 [Month3] include that "[*Granddaughter] to meet her at ED"*. It is not clear from the documentation what the content was of the communication with family at the time or who was called. I note from the ambulance report that family was present in the care home when the ambulance picked up [Mrs A] for transfer to ED. **From the documentation I conclude that Family communication occurred however it is hard to comment on the adequacy and sensitivity of this communication due to minimal documentation.**

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Health and Disability Commissioner'



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