

Assessment of falls risk
17HDC01195, 30 September 2019

District health board ~ Falls ~ Assessment ~ Information ~ Right 4(4)

An elderly man was admitted to a public hospital following two days of abdominal pain and having not passed a bowel motion. He had a history of cognitive impairment, Parkinson's disease, hypertension, and prostatism. The man was taking cilazapril and doxazosin — two drugs that are known to cause hypotension.

The man underwent surgery for a closed loop small bowel obstruction. That day, a falls risk assessment was completed and the man was assessed as having a low risk of falling. Subsequent falls risk assessments assessed the man as a medium risk for falls.

The man experienced delirium and hallucinations and removed his urinary catheter, and was started on quetiapine (which also can cause hypotension).

The man was discharged. The medical notes record that the man's wife was educated in managing a urinary catheter at home. However, there was no clear documentation of what was discussed with the man and his family about the District Nursing Service, or what the family was told about assisting the man at home.

A few days later the man returned to the emergency department and was admitted to the urology ward with leakage around his urinary catheter, haematuria, and lower abdominal discomfort. A falls risk assessment completed that day recorded the man as being a high risk for falls. At 4.54pm, the man fainted while he was in the bathroom. Later that evening, the man was given several medications, all of which can cause hypotension. No medicine reconciliation was carried out.

At around 1.30am, the man was found to be hypotensive. Soon afterwards, he had an unwitnessed fall, which resulted in forehead lacerations and an unstable cervical spine fracture. The man later developed a retropharyngeal haematoma, and died a few days later.

Findings

It was held that by failing to ensure that the man's falls risk was assessed appropriately and actions taken to prevent a fall, and for failing to ensure that the man was receiving appropriate medication for his needs, the district health board failed to provide the man with the services required to minimise the potential harm to him, and, as a result, breached Right 4(4).

It was also considered that information about the referral to the District Nursing Service prior to discharge and in relation to catheter education needed to be communicated more effectively to the man and his family.

Recommendations

It was recommended that the DHB provide an update in relation to the effectiveness of the changes made following these events; carry out an audit of medicines reconciliation to show when it occurs following a patient's admission; and provide an apology for the family.