Decision: CAS-14229-T4F7L5
4 June 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Failure to apply fall-prevention measures during hospital admission

1. On 13 September 2022, the Health and Disability Commissioner (HDC) received a referral from the Coroner regarding the care provided to Mrs A by Health New Zealand | Te Whatu Ora Te Matau a Māui, Hawke's Bay (Health NZ). Specifically, the referral relates to the management of Mrs A's falls risk after she was admitted to Hawke's Bay Hospital in April 2022 after a fall at home. I offer my condolences to Mrs A's family and friends for their loss.

## Information gathered

2. Mrs A, aged 88 at the time of events, had a number of comorbidities, including atrial fibrillation and hypertension (high blood pressure).[1] Her regular medications included rivaroxaban, felodipine, and furosemide.[2] She had a fall at home in June 2021 that resulted in a hip fracture and subsequently used a walking frame to help with mobility. In January 2022, after she had a fall getting into the shower, Mrs A was referred to community occupational therapy for review of her functional ability.

3. At approximately 8.30am on Friday 15 April 2022, Mrs A was seen by an Emergency Department (ED) doctor at Hawke's Bay Hospital ED after another fall at home.[3] She was hypertensive but had no loss of consciousness or indication of a head injury.[4] A subsequent X-ray and CT scan showed four rib fractures. ED clinical notes show that Mrs A was considered a falls risk but was independently mobile with the assistance of a walker. A decision was made to withhold Mrs A's rivaroxaban to reduce the chance of internal bleeding from her fractured ribs.

4. Hawke's Bay District Health Board's 'Falls – Reducing Harm Policy' (August 2018) outlines that Registered Nurses (RNs) (or delegates) are to assess and document all patients for their risk of falling within six hours of admission, and an individual care plan is then designed to mitigate any assessed risk. Clinical Nurse Managers (CNMs) (or Associate CNMs) must ensure assessments are completed and care plans are implemented. Neither a falls risk assessment nor a care plan were completed by nursing staff for Mrs A while she was still in the ED or at any point during her admission. As required by the 'Falls – Reducing Harm Procedure' (November 2018), Mrs A should also have been given a red wristband to wear, which indicates a patient is at risk of falling, but she was not.

---

[1] Atrial fibrillation is an irregular heart rhythm. Chronic atrial fibrillation can lead to blood clots forming in the heart. Mrs A also had type 2 diabetes and renal impairment. The use of insulin leads to peripheral neuropathy, which affects the body's ability to sense its own position and movements in space and tactile sensations, which made walking hazardous because of her decreased ability to perceive where her lower limbs were positioned.
[2] Rivaroxaban is an oral anticoagulant used to prevent the formation of blood clots; it can increase the risk of bleeding. Felodipine is primarily used to treat high blood pressure. Furosemide is used to reduce fluid overload, such as in oedema.
[3] Mrs A reported feeling unsteady, losing her balance, and hitting the left side of her back on the corner of a wooden chair.
[4] Health NZ stated that Mrs A remained normally alert and with stable vital signs (according to repeated observations) between 15 and 16 April 2022.

5. At approximately 3.30pm, Mrs A was admitted to the surgical ward under Consultant General Surgeon, Dr C, and commenced on a patient-controlled analgesic (PCA) pump (which allows patients to administer their own pain relief medication) because of her pain. Clinical notes between 15 and 16 April 2022 document that Mrs A required one or two staff to assist with transfers from bed to chair or with mobilising. Health NZ told HDC that nursing staff did not have any concerns about Mrs A in that she did not demonstrate any unpredictable behaviour. Health NZ stated that falls risk mitigation practices were in place (including access to a call bell, appropriate bed height, and keeping the room decluttered) but that 'due to the lack of falls risk assessment, further methods were not utilised'.

6. Mrs A had 'patient at risk' reviews on both 15 and 16 April, and – after a general medicine review on 16 April 2022 – the plan was for chest physiotherapy, a rehabilitation referral, and a review of Mrs A's blood pressure medication.[5] However, no chest trauma form was completed, which would have prompted referral to physiotherapy, which includes a mobility assessment.[6] In addition, because Mrs A was admitted over Easter weekend – during which there was a staffing deficit – no medication reconciliation[7] was completed. Health NZ also acknowledged that no allied health[8] referrals were completed for Mrs A but that she was scheduled for a full multidisciplinary team review before she was discharged home, which likely would have included allied health input.

7. On 17 April 2022, at approximately 12.15pm, Mrs A was noted to be hypertensive after a 'patient at risk' review and a House Officer review. Amlodipine and clexane were administered approximately five minutes later.[9] Later that day, Mrs A was seen by the Acute Pain Service, in accordance with the Chest Trauma Guideline.

8. At approximately 11pm, nurses heard a noise from Mrs A's room. She was found shortly afterwards face down on the floor beside her bed. She was initially unresponsive, then disoriented, agitated, and confused, with clear signs of a head injury and a laceration and bruising on the left side of her face. A CT scan performed shortly after midnight on 18 April 2022 showed intracranial bleeding and fractures to the left side of the face. As the brain injury was considered non-survivable, Mrs A was provided with palliative care; sadly, she later died.

---

[5] It was noted that Mrs A had previously experienced dizziness as a side effect of both felodipine and furosemide medications. Furosemide was not prescribed during Mrs A's admission.

[6] Hawke's Bay District Health Board's 'Chest Trauma Guideline (Adult)' (May 2019) outlines that any patient with chest trauma should undergo a physiotherapy review within 24 hours.

[7] Hawke's Bay District Health Board's 'Medicine Reconciliation' policy (August 2020) outlines that: 'The aim of medicine reconciliation is to have an accurate record of patients' medications to optimise their health care treatment and minimise medication-related adverse events and harm to patients. [….] Ideally medicine reconciliation will occur at all points of admission, transfer and discharge. However, initially, formal medicine reconciliation will only be undertaken on admission.'

[8] Allied health refers to a broad group of healthcare professionals who work alongside mainstream healthcare providers to prevent, diagnose, and treat diseases.

[9] Amlodipine is used to treat high blood pressure, and clexane is an anticoagulant used to reduce the risk of deep vein thrombosis in patients with poor mobility. Health NZ told HDC that, after two days of stable vital signs, it is accepted practice to treat a patient with reduced mobility with low-dose clexane to prevent blood clots.

9. Dr C stated that:

> 'If [Mrs A] had a permanent surveillance with a care assistant helping her to move out of bed, this accident would not have happened. As she was sharp mentally there was no indication for permanent surveillance, but her recent history of multiple falls should have alerted us of the risk of reoccurrence'.

10. Health NZ acknowledged that there were deficits in Mrs A's care 'as a result of not following policies and due process' and accepted that multiple issues may have contributed to Mrs A falling, including no risk assessment conducted by nursing staff and therefore no care plan being in place, use of a PCA pump, ongoing pain and the physiological impacts of that, no referral to physiotherapy, and no pharmacy review or medication reconciliation. Health NZ told HDC that it remains 'upset by our deficits in care and continue to offer our unreserved apologies to Mrs A's family on their loss.'

**Fall with Serious Harm Review**

11. A 'Fall with Serious Harm Review' (FSHR) completed on 24 August 2022 identified that 'normal process for falls management was not followed', including:

- no red bracelet was applied after the initial falls assessment in the ED;
- no physiotherapy referral was made;
- mandatory documentation (such as a falls management risk assessment, admission to discharge planner, and chest trauma form, which includes a referral to physiotherapy and a mobility assessment) was not completed. The FSHR stated '[i]f [the mobility assessment] had occurred, Mrs [A] would have been given priority referral over the holiday weekend and her mobility risks identified';
- inconsistent fall prevention measures were documented (eg, 1x assistance and 2x assistance for transfer, 'assistance' ticked);
- medication reconciliation was not conducted in accordance with policy. In particular, it was noted that Mrs A was taking more than four medications, including a PCA pump, which increased the risk of injury if she fell. A review from the pharmacist may have alerted nursing staff to the increased falls risk with an older patient who is using a PCA pump.

12. As noted at paragraph 6, the FSHR also identified a staffing deficit at the time and that there was a lack of training: only 52% of RNs on the ward and 66.7% of Care Associates (CAs) had received Patient Falls Training.

13. The FSHR made the following recommendations:

1. Remind and monitor staff of the use of the 'Adult combined risk assessment' and the Falls – Reducing Harm Policy;
2. Conduct a Team Critical reflection on the specific event;
3. Have the associated inpatient ward achieve completion of the online Ko Awatea learning package 'Reducing Harm from Falls' for 80% of RNs and CAs (subject to staffing needs during the COVID period).

**Responses to provisional opinion**

14. Mrs A's daughter was given an opportunity to respond to the 'Information gathered' section of the provisional decision and had nothing further to add.

15. Health NZ was given the opportunity to respond to the provisional decision. Health NZ accepted all the proposed recommendations and follow-up actions and provided a further update on the changes made since these events, which have been incorporated into the section below.

**Changes made**

16. Health NZ has provided updates on the FSHR recommendations and made some additional changes as follows:

- Recommendations 1 and 2 in the FSHR were completed as part of Health NZ's ward meeting in January 2023. The ward meetings are attended by staff on shift, and key messages from these meetings are shared with non-attending staff via the staff communications book.
- Recommendation 3 in the FSHR was met in February 2023, when over 80% of RNs and CAs completed the Reducing Harm from Falls online learning package. To maintain continued compliance, the CNM ensures that all new RNs and CAs complete the module during their orientation programme.
- The education and training records for all staff (RNs and CAs) have been reviewed to ensure that everyone has completed or has a plan to complete the Ko Awatea learning package 'Reducing Harm from Falls.'
- Weekly audits of risk assessment completion for all patients on the ward have been implemented. Where risk assessments have not been completed, the CNM communicates with the nursing staff to highlight the importance of completing the assessment and ensures that assessments are completed.
- Education for staff at regular ward meetings has also occurred, and this has been delivered in the context of Mrs A's fall to highlight the importance of completing, and possible harmful consequences of not completing, risk assessments for all patients.
- Compliance against falls risk assessments is audited monthly across the hospital. Findings are reported back to CNMs and Clinical Governance Groups to ensure high levels of compliance, which remain high.
- The Hauora Plan was introduced in 2025, and a field has been added to the daily care plan that focuses on fall prevention bundles.[10] The Hauora Plan also contains a 'Keeping Yourself Safe in Hospital' section that is provided to patients to improve patient and whānau awareness of falls risks.
- The Falls Management Policy and Guideline were refreshed in 2025 and are now linked to robust bundles of care in the Hauora Plan.
- 'Falls sensor mats' have been implemented across all inpatient areas.
- Health NZ is in the process of implementing an adapted risk assessment called 'FRAIL' in the ED on its TrendCare platform. It applies to all patients aged over 65 years, or

[10] A bundle of care is a set of interventions that, when used together, significantly improves patient outcomes.

55 years and Māori, with ED-specific care bundles to address both falls and pressure injury risks. The intention of the adapted risk assessment tool is to improve identification of patients at risk of falls and communication of risk to inpatient areas on admission.

- Health NZ is currently reviewing handover processes to ensure that any falls risks are clearly communicated on all handovers.

**Opinion: Health NZ – breach**

17. As a healthcare provider, Health NZ is responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code).

18. At the outset, it is important to note that HDC's role is not to determine the cause of Mrs A's death but rather to consider whether the services provided to her were of an appropriate standard at the time. In my view, there were deficiencies in care that highlight the importance of clinical staff being equipped to effectively recognise and respond to patients who are at risk of falling, with protocols in place to support the provision of good patient care.

19. Mrs A had a history of falls and, although this was considered in the ED, it was not considered when she transferred to the ward. I appreciate that when Mrs A presented to the ED on 15 April 2022, she had no mental deficiency, but her history of falls-related incidents should have been taken into account and assessed appropriately, as acknowledged by Health NZ.

20. In my view, there were multiple deviations from Health NZ policies and procedures in relation to Mrs A's care, as outlined in the FSHR. If these policies and procedures had been followed, it likely would have mitigated these events. I am therefore of the opinion that Health NZ is in breach of Right 4(2) of the Code. However, in making these comments, I acknowledge the significant changes Health NZ has made and consider the recommendations outlined in the FSHR to be appropriate remedial actions.

**Recommendations and follow-up actions**

21. I recommend that Health NZ provide a written apology to Mrs A's family for the failings identified in this report. This apology is to be sent to HDC for forwarding to the family within three weeks of the date of this report.

22. A copy of the final report, with details identifying the parties removed, except Health NZ Hawke's Bay Te Matau a Māui and Hawke's Bay Hospital, will be sent to the Health NZ National Office Ageing Well Team and the Health Quality & Safety Commission Te Tāhū Hauora and be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
**Deputy Health and Disability Commissioner**