HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Management of unwitnessed falls and subsequent deterioration of respite patient

Introduction

1. This Office received a complaint from Consultant/Solicitor Mr A on behalf of Mr B's family regarding the care provided to him at Rawene Hospital (operated by Hokianga Health Enterprise Trust), located in the Northland region.

2. Mr B was admitted to Rawene Hospital in October 2021 for respite care. Sadly, he died while in hospital from a head injury sustained in a fall. Mr B's family raised concerns with Rawene Hospital. Although Rawene Hospital acknowledged that the care provided did not meet an appropriate standard and advised that corrective actions had been taken, the family remained concerned about the adequacy of these measures.

3. In light of these concerns, this report considers:

- The adequacy of Mr B's falls risk assessments.
- Nursing assessment and response to changes in Mr B's condition.
- Nursing assessment and monitoring of urinary changes.
- The consent process for restraint.

4. I have found that Rawene Hospital breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

5. I have made recommendations to Rawene Hospital aimed at improving its systems and care and reducing the likelihood of similar events occurring in the future.

6. I extend my sincere condolences to Mr B's family and friends on their loss. I hope that this report provides some clarity regarding the care provided and reassurance that the concerns raised have been carefully considered.

Timeline of events

7. Mr B, aged 84 years at the time of the events, had several comorbidities, including osteoporosis, spinal conditions, reduced circulation, prostate enlargement, and cataracts. As a result, he was physically vulnerable, with reduced mobility and vision and an increased risk of falls and injury.

8. The following section outlines the key events in relation to Mr B leading up to his passing in early November 2021.

27 October 2021

9. On 27 October 2021, Mr B's general practitioner (GP) reviewed him following a two-to-three-week decline characterised by increased confusion, reduced interaction with family, worsening mobility, pain with no clear cause, and worsening incontinence. Mr B was

admitted to Rawene Hospital the same day for inpatient assessment and respite care, including a review of his support needs. Mr B's family told the Health and Disability Commissioner (HDC) that, when he was admitted to Rawene Hospital, 'Mr B's wife had asked for a side rail to be placed on his bed, because she knew that Mr B could fall.'

2 November 2021

10. On 2 November 2021, while at Rawene Hospital, Mr B sustained two unwitnessed falls, one resulting in a head laceration. He subsequently experienced an acute decline and was transferred to the local public hospital where a large, inoperable intracranial haemorrhage was confirmed.

5 November 2021

11. Following confirmation of the inoperable intracranial haemorrhage, Mr B was transferred back to Rawene Hospital on 5 November for palliative care. That evening, he sustained a further fall, after which his condition continued to decline. Sadly, not long after, Mr B passed away.

The adequacy of Mr B's falls risk assessments

12. Mr B was admitted into Rawene Hospital on 27 October 2021; however, documentation shows that his falls risk assessments and nursing care plan were completed several days after his admission.

13. Clinical documentation recorded differing assessments of and conflicting statements about Mr B's mobility. Medical documentation noted that he required assistance with mobility because of frailty, whereas a physiotherapy assessment dated 28 October 2021 recorded that he was independent with a walking frame.

14. The clinical records also document factors relevant to falls risk, including urinary and faecal incontinence because he had difficulty reaching the toilet in time, and lumbar spine pain.

15. Early documentation indicated that Mr B was able to manage meals, medications and mobility relatively independently and that he was able to communicate effectively with staff.

Nursing assessment and response to changes in Mr B's condition

16. On 1 November 2021, at 10pm, it was documented that Mr B was unable to walk, despite no prior issues with mobility.

17. At 2.45am (2 November 2021), Mr B was found beside his roommate's bed in a 'frozen' position and appeared confused. The progress notes do not specify whether Mr B was standing or lying on the floor when he was discovered, and so this incident was not documented as a fall.

18. At 6am, Mr B was recorded as appearing confused and trying to get out of bed to use a urinal; however, he was unable to weight bear or pass urine. His blood pressure was recorded as 190/94mmHg (high).

19. At 6.45am, Mr B was found on the floor following an unwitnessed fall. He was confused and attempted to go to the toilet. Nursing notes do not record whether Mr B did pass urine at this time, and neurological observations were not done.

20. At 9am, Mr B had another unwitnessed fall, resulting in a laceration of his head and reporting a lack of strength in his left arm. Neurological observations were not commenced immediately but were completed later following a review by the GP.

Nursing assessment and monitoring of urinary changes

21. On 2 November 2021, at approximately 6am, Mr B was noted to be having trouble passing urine.

22. There is no documented evidence that this change in his ability to pass urine was further assessed or investigated, such as through a bladder scan or clinical review. At that time, a call bell was provided, along with regular staff checks, a sensor mat and access to a urinal bottle.

23. At approximately 6.45am, Mr B experienced an unwitnessed fall. The clinical records do not indicate that his difficulty with urination was followed up prior to this fall. While urinary retention may have contributed to the fall, other factors were also present, including a chest infection as well as possible delirium.

The consent process for restraint

24. On 5 November 2021, Mr B returned to Rawene Hospital following the diagnosis of the inoperable intracranial haemorrhage. At that time, he was noted to be confused, agitated, and at risk of acting impulsively. His family were present during the day and into the evening.

25. There were opportunities throughout the day to obtain consent for the use of a bed rail, but there was no record that this was discussed with the family or that consent was obtained.

26. Later that evening, Mr B experienced a further fall. Following this, his bed was repositioned against a wall, and a bed rail was put in place.

27. The clinical records indicate that consent for the use of a restraint had not been obtained prior to this fall.

Response from Rawene Hospital

28. Rawene Hospital acknowledged Mr B's family's concerns and recognised 'that this remains a deeply challenging and emotional process, and we extend our sincere aroha and respect to the whānau for their patience and engagement throughout this investigation.'

In-house clinical advice

29. Clinical advice was sought from Nurse Practitioner (NP) Isabella Wright (Appendix A), who identified the following departures from the accepted standards of care:

- **Moderate departure** in relation to Mr B's falls risk assessments.

- **Moderate to severe departure** in relation to the nursing assessment of and response to changes in Mr B's condition.
- **Moderate departure** in relation to the nursing assessment and monitoring of urinary changes.
- **Moderate departure** in relation to the consent process for restraint.

Response to provisional opinion

Rawene Hospital

30. Rawene Hospital was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

31. Rawene Hospital acknowledged the seriousness of the matters raised and the impact of these events on Mr B's whānau.

32. Rawene Hospital told HDC that it has 'undertaken substantial work since 2021 … [and] has implemented significant corrective actions and system improvements. These include revised policies and procedures, strengthened falls prevention and post-fall response processes, improvements to restraint assessment and consent practice, increased staff education, greater governance oversight, and the introduction of enhanced quality and audit systems.'

Mr A (on behalf of Mr B's whānau)

33. Mr B's family were given the opportunity to respond to the timeline of events section of the provisional report, and their responses have been incorporated into the report where appropriate.

Decision – breach

34. The key issue here is whether Rawene Hospital provided Mr B with an appropriate standard of care in November 2021. NP Wright identified several issues with the care provided by Rawene Hospital and that it fell below the accepted standard of care. I have considered her advice in forming my opinion.

The adequacy of Mr B's falls risk assessments

35. I am critical that appropriate falls risk assessments and care planning were not completed in a timely manner following Mr B's admission to Rawene Hospital on 27 October 2021. Although documentation indicates that Mr B was relatively independent in the initial days, there were clear underlying risk factors, including frailty, incontinence, and pain, that increased his risk of falls and required early identification and planning.

36. I am further critical that the clinical documentation contained inconsistencies regarding Mr B's mobility status, with differing accounts from medical and physiotherapy assessments. This lack of clarity would have made it difficult for staff to accurately determine the level of supervision and assistance required.

37. In my view, the failure to complete timely and accurate risk assessments, together with the absence of an individualised care plan that reflected Mr B's risk factors, resulted in inadequate falls prevention measures being implemented. I consider that the poor quality

and incomplete nature of the documentation contributed to the suboptimal care and increased risk of harm.

Nursing assessment and response to changes in Mr B's condition.

38. Mr B demonstrated clear and repeated changes in his condition, including confusion, altered behaviour, unsafe attempts to mobilise, and multiple unwitnessed falls within a short timeframe. These were significant indicators of clinical deterioration and escalating risks.

39. I am critical that these signs were not recognised or acted upon appropriately. Despite multiple opportunities, there was a failure to recognise and respond to this pattern of change. In particular, there is no evidence that a comprehensive assessment was undertaken following the initial signs of confusion and altered behaviour. Following the unwitnessed falls, neurological observations were not completed in a timely manner, and there is limited evidence of escalation or implementation of additional safety measures.

40. In my view, this represents a failure to recognise, assess, and respond to changes in Mr B's condition, resulting in repeated falls and missed opportunities to intervene.

Nursing assessment and monitoring of urinary changes.

41. I have considered the adequacy of the nursing follow-up of Mr B's change in urinary function. I am critical that Mr B's difficulty passing urine at 6am was not further assessed or investigated. A change in urinary function is a clinically significant finding and required timely assessment to identify and manage any underlying cause.

42. Although general safety measures were in place, such as providing Mr B with a urinal bottle and access to his call bell, these did not address the underlying issue. There is no evidence that Mr B's urinary retention was clinically reviewed or that appropriate interventions, such as a bladder scan or escalation to a doctor, were considered.

43. Mr B's unwitnessed fall occurred approximately 45 minutes later. Although I acknowledge that his fall was likely influenced by multiple factors, I consider that the failure to assess and respond to his urinary difficulties increased the likelihood that he would attempt to mobilise unsafely. In my view, this represents a failure by nursing staff to respond appropriately to a change in condition that could have contributed to his fall.

The consent process for restraint

44. I am concerned that consent for the use of a bed rail was not obtained prior to Mr B's fall on 5 November. Given his condition at the time, including confusion, agitation and an increased risk of unsafe movement, the use of a bed rail was a reasonable and foreseeable intervention to support his safety.

45. I consider there were opportunities during the day to discuss this with Mr B's family, who were present, and to obtain appropriate consent. This did not occur.

46. As a result, a bed rail was not in place at the time of Mr B's last fall. It was only introduced after the fall had occurred. In my view, earlier consideration of restraint, together with appropriate discussion and consent, may have reduced the risk of this fall.

Conclusion

47. I consider that the care provided to Mr B fell below the standard of reasonable care and skill required under Right 4(1) of the Code, which states that 'Every consumer has the right to have services provided with reasonable care and skill.'

48. There were multiple missed opportunities to identify and respond to Mr B's safety. Appropriate falls risk assessments and care planning were not completed in a timely manner, and known risk factors, including frailty and continence needs, were not adequately reflected in his care. Clinical documentation regarding Mr B's mobility status was inconsistent, which reduced clarity for staff and affected their ability to provide appropriate supervision and assistance.

49. In addition, there was a failure to recognise and respond to changes in Mr B's condition, including confusion, altered behaviour, and unsafe attempts to mobilise. These changes were not adequately assessed or escalated.

50. Further, Mr B's urinary difficulties were not followed up with appropriate clinical assessment or intervention, despite representing a significant change in condition.

51. Finally, consent for the use of a bed rail was not obtained in a timely manner, despite opportunities to do so while family were present. This meant that a reasonable safety intervention was not in place at the time of his fall.

52. When considered together, these omissions represent a pattern of inadequate assessment, monitoring and response to Mr B's needs. In my view, this amounted to a failure to provide services with reasonable care and skill, and therefore I find Hokianga Health Enterprise Trust in breach of Right 4(1) of the Code.

Changes made since events

53. Rawene Hospital has made the following changes:

- Reviewed and redeveloped its policies and procedures relating to assessment, care planning, falls prevention and restraint minimisation.
- Provided staff education and training on assessment, documentation and falls risk prevention.
- Focussed on improving restraints processes and practice and developed a new restraints policy.

Recommendations

54. I recommend that Rawene Hospital (operated by Hokianga Health Enterprise Trust):

a. Provide a formal written apology to Mr B's family for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b. Provide further staff education on the timely completion of falls risk assessments and care planning on admission. Evidence of staff training by way of staff

attendance records is to be provided to HDC within six months of the date of this report.

c. Provide staff education on the recognition and escalation of changes in a patient's condition, including confusion and unsafe attempts to mobilise. Evidence of staff training by way of staff attendance records is to be provided to HDC within six months of the date of this report.

d. Provide staff education on the assessment and management of urinary retention, including when further assessment and escalation are required. Evidence of staff training by way of staff attendance records is to be provided to HDC within six months of the date of this report.

e. Provide staff education on post-fall management, including the requirement for neurological observations following unwitnessed falls. Evidence of staff training by way of staff attendance records is to be provided to HDC within six months of the date of this report.

f. Provide a copy of the current restraint policy and evidence of the processes implemented to improve restraint practice, including how these changes have been communicated to staff. This evidence is to be provided to HDC within six months of the date of this report.

g. Undertake a random audit of clinical documentation of 15 patients over the past 6 months to ensure records are clear and consistent and support safe care and report on the outcome of this audit. The result of this audit is to be provided to HDC within six months of the date of this report.

Follow-up actions

55. A copy of this report with details identifying the parties removed, except the clinical advisor on this case and Rawene Hospital (operated by Hokianga Health Enterprise Trust), will be sent to HealthCERT and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: In-house aged care advice to the Deputy Commissioner

The following in-house aged care advice was obtained from NP Isabella Wright:

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Rawene Hospital. In 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.

1. **Documents reviewed**
   The response and clinical documentation from Hauora Hokianga, including Hokianga Health (primary care) and Rawene Hospital – Hokianga Health Enterprise Trust (Northland).

   All clinical documentation provided by Health New Zealand | Te Whatu Ora Te Tai Tokerau, as well as letters from lawyer Mr [A].

2. **Complaint**
   A complaint was received from lawyer [Mr A], acting on behalf of [Mr B]'s family, to Rawene Hospital following [Mr B]'s death. Despite whānau meetings with Rawene Hospital and an internal investigation and full audit by Health New Zealand | Te Whatu Ora Te Tai Tokerau, whānau remain unsatisfied with the outcomes of a nominal financial contribution and feel the corrective actions identified by Rawene Hospital have not been adequately addressed or implemented.

3. **Review of clinical records**
   For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

4. **Clinical advice**
   I note the events occurred during the COVID-19 pandemic period 2020-2022 and would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams and health service providers during this time.

   <u>Background</u>

   Mr [B] was an 84-year-old gentleman with complex co-morbidities including osteoporosis, cervical spinal stenosis, benign prostatic hypertrophy, lumbar spinal stenosis, peripheral vascular disease, bilateral cataracts, ectropion R eye, blepharoconjunctivitis. Additionally, a history of AAA repair in August 2003, R Ilio-popliteal graft in 2001 and more recently L3 4 laminectomies, bilateral carpal tunnel release and cervical laminoplasty.

   On the 27 October 2021, [Mr B] was seen by his GP, brought in by his wife and stepdaughter following a 2–3-week decline, especially increased confusion which the

family struggled to manage at home. [Mr B] had an increased faecal and urinary incontinence, confusion and reduced verbal interaction. As well as increased difficulty with mobility and pain without an obvious cause. The GP arranged for an inpatient admission and an assessment at Rawene hospital following urinalysis (to rule out urinary tract infection) and baseline observations that did not yield definitive answers.

[Mr B] was admitted to Rawene hospital on the 27 October 2021 for inpatient assessment and respite care, to review overall function with the view to increasing allocated care hours through homebased supports. While at Rawene hospital, on the 2 November 2021 he sustained two unwitnessed falls, one of which resulted in a head laceration, this was followed by acute decline and subsequent transfer to Whangarei Hospital on suspicion of a brain haemorrhage. A large intracranial haemorrhage was confirmed as inoperable, thus [Mr B] transferred back to Rawene hospital on the 5 November 2021 for palliative care. That evening he sustained a further fall, resulting in continued decline. He passed away [in early] November 2021.

Question: Provide comment on the falls risk assessments and care plan compliance on admission as identified by the provider and confirmed by Health New Zealand | Te Whatu Ora audit report.

The documented evidence reviewed indicated that the nursing care plan and risk assessments were completed several days following admission on 27 October 2021. There was inconsistency in assistance required with mobility: doctor documenting assistance with mobility due to frailty and the physiotherapist assessment (on 28 October 2021) was independent with walking frame.

No indication of mobility concerns at this time; however, due to documented issues with incontinence due to delay in reaching toilet, pain in lumbar spine, there was an underlying risk. Overall, [Mr B] was relatively independent in the initial days with meals, medications, and mobility. He was able to communicate effectively with staff, and the documentation reflects satisfactory care during the initial period.

From the evidence reviewed to respond to this question, it appears the clinical documentation evidenced poor execution, inaccurate information and incomplete documentation that may have contributed to sub-standard falls prevention management and would be viewed similarly by my peers. A lack of timely assessments and individualised care plan is considered a moderate deviation from accepted practice.
Departure from accepted practice: Moderate

Question: Provide comment on nursing assessment following all presentations of altered baseline, for [Mr B] from 0245 hrs to 1200 hrs on 2 November 2021 upon transfer to [the local public] Hospital and whether this meets the minimum standard of nursing care.

The review of documentation indicates the following:

1 Nov 2021 at 2200 hrs: [Mr B] was unable to ambulate following no issues of mobility prior hence a sensor mat or other should have been considered.
2 Nov 2021 at 0245: [Mr B] had been noted *as found beside roommates bed* (it is not specified he was standing or lying on the floor in the progress notes) only of confusion, 'frozen' stature and this is not documented as 'a fall' perse. Then in the provider response it states at 4.30am found trying to get up to toilet, however this is not clear in the progress notes and the response is incorrect regarding 0600 hrs presentation.
2 Nov 2021 at 0600 hrs: A check was conducted where [Mr B] was trying to get out of bed to use the urinal but was unable to urinate or weight bear, noted to be confused with an elevated BP 190/94.
2 Nov at 0645 hrs: [Mr B] was rechecked and found on the floor, noted to be confused had tried to get up to the toilet, but fails to mention if he urinated (given previous difficulty voiding); this was noted as an unwitnessed fall. However, no neurological observations were commenced.
2 Nov 2021 at 0900 hrs: [Mr B] sustained a further unwitnessed fall with head trauma. Again, no neurological observations are evidenced immediately, despite a bleeding head laceration, and weakness of the left arm. The neurological observations were commenced later following a doctor's review; however, there is some evidence staff were checking limb strength.

The lack of neurological oversight after unwitnessed falls specifically; and other clinical exploration suggests that there may have been signs of a neurological event/ decline due to the progression of presentations from 2200 hrs on 1 November 2021.

From the evidence reviewed to respond to this question it appears the post-fall and clinical assessments of [Mr B] from the evening of 1 November until 2 November 2021 were not completed sufficiently and would be viewed similarly by my peers. A lack of appropriate assessments is considered a moderate/severe deviation from accepted practice. **Departure from accepted practice: Moderate/Severe**

Question: Do you consider clinical documentation indicates adequate nursing follow-up of [Mr B]'s alteration in urinary function as evidenced at 0600hrs 2 November 2021; and could this have contributed to the unwitnessed fall at 0645hrs.
The documented evidence on 2 November around 0600 hrs indicates that resident had difficulty urinating. He had an unwitnessed fall at 0645 hrs.
No documented evidence was found about any intention to investigate the urine retention such as a bladder scan. Call bell was provided, regular staff checks, sensor mat and a urinal bottle.
The urine retention might have been a contributing factor to the fall, but there was likely to have been multi-factorial causes, such as chest infection ([Mr B] was receiving antibiotics at the time), agitation, or delirium.

From the evidence reviewed to respond to this question, it appears that the clinical documentation indicates inadequate nursing follow-up of [Mr B]'s alteration in urinary function as evidenced at 0600hrs 2 November and this would be viewed similarly by my peers. A lack of appropriate assessments is considered a moderate deviation from accepted practice. **Departure from accepted practice: Moderate**

Question: Please comment on the concerns relating to the lack of restraint consent for [Mr B] and the relative impact on care following his return to Rawene Hospital on 5 November 2021.

There were opportunities on 5 November 2021 to ensure restraint consent was undertaken for a bed rail. Based on [Mr B]'s neurological condition on return, risk of impulsivity, agitation and confusion are consistent presentations expected following a large intracranial haemorrhage. The family were present during the day and at night, and there was no clear reason that restraint consent was to be obtained. As a result of insufficient interventions, [Mr B] sustained a further fall on the evening of 5 November 2021, where turning of the bed to utilise one wall and one bed rail was then actioned. This fall was preventable.

From the evidence reviewed to respond to this question, it appears that the clinical documentation indicates a lack of restraint consent for [Mr B], which contributed to another fall on 5 November following his return to Rawene Hospital, and this would be viewed similarly by my peers. A lack of consent is considered a moderate deviation from accepted practice.

Departure from accepted practice: Moderate

Question: Do the hospital's corrective actions align with current national care guidelines for falls risk prevention and Hauora Hokianga's policy for falls prevention?

Hauora Hokianga completed a robust internal auditing process and an investigation by Dr Clare Ward into the allegations of poor care delivery contributing to [Mr B]'s death on receipt of the initial complaint. Hauora Hokianga acknowledged 'deficits' in their care, which were appropriate to the nature of the complaint.

Corrective actions are evidenced, with clear indication as to the execution of these; however, at this stage, there is minimal evidence of follow-up and review of these interventions and whether this has improved practice.

On review of the Health New Zealand | Te Whatu Ora Te Tai Tokerau audit findings, these are consistent with the findings of the review of the clinical documentation.

The provider can consider alignment of the Falls Prevention Policy with the Frailty Care Guides,[1] if not already done so.

[1] Frailty care guides Aotearoa New Zealand | Te Tāhū Hauora Health Quality & Safety Commission

From the evidence reviewed to respond to this question, it appears that the hospital's corrective actions mostly align with current national care guidelines for falls risk prevention and Hauora Hokianga's policy for falls prevention and would be viewed similarly by my peers. A lack of consent is considered a mild deviation from accepted practice.

Departure from accepted practice: Mild

Dr Isabella Wright, RN, NP, Doctor of Health Science

Nurse Advisor (Aged Care)

Health and Disability Commissioner