Health Care Assistant, Ms C

A Rest Home/Hospital

A Report by the Deputy

Health and Disability Commissioner

(Case 06HDC16618)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer (deceased)
Ms B	Complainant/Mrs A's granddaughter
Ms C	Provider/Health care assistant
Ms D	Nurse manager, the Hospital
Ms E	Registered nurse
Ms F	Registered nurse
Dr G	General practitioner
Ms H	Health care assistant
Mrs I	Mrs A's daughter
Ms J	Nursing agency consultant
A Nursing Agency	Provider/Nursing agency
The Hospital	Provider/Rest Home/Hospital

Complaint

On 6 November 2006, the Commissioner received a complaint from Ms B about the services provided to her grandmother, Mrs A, by health care assistant Ms C.

The following issues were identified for investigation:

- *The appropriateness of the care provided to Mrs A by caregiver Ms C at a rest home/hospital (the Hospital) on 10 October 2006.*

- *The appropriateness of the care provided to Mrs A by the hospital between 10 and 12 October 2006.*

An investigation was commenced on 6 March 2007.

Information reviewed

Information received from:

- The Hospital
- A nursing agency
- Dr G
- Ms C
- Ms B

Summary

Mrs A, an elderly woman with multiple medical problems, was a resident of an aged care facility (the Hospital). On the morning of 10 October 2006, caregiver Ms C, an employee of a nursing agency, was preparing to bed-wash Mrs A, when Mrs A fell from her bed and onto the floor.

Ms C did not report the fall to the registered nurse overseeing her duties. Later that morning bruising appeared on Mrs A's head. When questioned, Ms C informed Mrs A's family and other clinical staff that Mrs A had knocked her head on a bedside cabinet as she was being washed. Over the next two days, bruising on both sides of Mrs A's head became more evident, and further bruising appeared on her right shoulder. Ms C subsequently admitted that Mrs A had fallen from her bed.

Information gathered during investigation

Background

Mrs A
In October 2006, Mrs A was 90 years of age. She had lived at the facility for approximately 15 years.

Mrs A suffered from multiple medical conditions including Parkinson's disease, bilateral equinus deformity,[1] depression, and anxiety. Mrs A's vision was impaired and her skin was fragile, requiring careful nursing care. Mrs A's mobility was restricted and, since May 2005, it had been documented in her mobility care and support plan that she required full assistance with activities of daily living. Mrs A's mobility plan, which was set out on a laminated card above her bed, indicated that she required two people to move her in bed. For transfers, she required two people and a standing hoist or a transfer belt (**see Appendix 1**).

Mrs A's movements when lying in bed were limited. She needed constant monitoring for pressure sores as well as full assistance to change position. As her movements were limited, the Hospital nursing staff considered that Mrs A was not at high risk of falls from her bed and she was not provided with bed rails for safety.

The Hospital
The Hospital is a registered charitable trust providing aged care. It has one site with two rest home facilities with approximately 150 residents, and a 78-bed hospital. In

[1] A condition where the sole of the foot is fixed in an abnormal position by tendon contraction and bent downwards at the ankle position, making it difficult to walk.

October 2006, one of the Hospital wards provided care for 16 patients, many with dementia and all with significant health problems requiring nursing care. Mrs A was one of these patients.

The Nursing Agency
The nursing agency (the Agency) provides casual, short-term or contract staff to the health sector. This includes registered nurses, specialist nurses, nurse assistants and caregivers. The Agency states that its staff are selected following a competency-based assessment interview. All potential employees undergo two professional reference checks and a Police check. All professional qualifications and practising certificates are verified by the Agency.

The Agency's contract with the Hospital trust states that "[t]he client will be responsible for all acts and omissions of any Temporary Candidate whether wilful, negligent or otherwise". The Agency does not provide on-site supervision of its employees.

Ms C
Ms C had previously worked part-time for about one year in a caregiver role at a hospital facility. However, she had limited training in healthcare and little experience caring for the elderly. The reference checks undertaken by the Agency indicated that Ms C's ability as a caregiver was excellent.

On 18 August 2006, as part of her orientation prior to starting work for the Agency, Ms C completed a basic three-hour occupational health and safety training induction session. This included information on the policies and guidelines relevant to the role of an Agency caregiver.

At the completion of this training, Ms C signed a "Temporary Nurse Declaration" form to confirm that she had received (and understood) the induction training. This outlined her agreement to familiarise herself with, and adhere to, all of a client's policies, procedures, and instructions concerning health and safety. Furthermore, she agreed to inform the Agency and the client as soon as practicable if she was involved in any accident or near miss at the client's premises.

On 21 August 2006, Ms C began work, on a casual basis, as a caregiver for the Agency. By 10 October 2006, Ms C had completed 26 duties (including ten shifts at the Hospital) without incident. Seven of her shifts at the facility were in the hospital. Ms C said she never received a formal orientation to the hospital site but she was familiar with the procedures for lifting and turning patients and reporting accidents. The Agency documented that the Hospital was satisfied with Ms C's work performance over this time.

The Hospital Trust provides new agency staff members with a copy of shift guidelines for registered nurses or health care assistants. This is done during their orientation. Copies are also displayed at every nurse's station for reference for all staff.

Responsibilities for caregivers include reporting and filling out accident/incident/near miss forms for their shift.

Services provided to Ms B

Incident of 10 October 2006
On 10 October 2006, as an employee of the Agency, Ms C was sent to work on Mrs A's ward as a health care assistant (HCA). Her shift commenced at 7am and ended at 1pm.

On duty that morning were one registered nurse, Ms E, and three HCAs providing care for 16 residents. The registered nurse was clinically responsible for the residents, and supervised the work of the HCAs. Ms C was the sole agency staff member on duty that shift, and was not familiar with the residents or staff on the ward. Ms C was allocated four residents to care for, one of whom was Mrs A.

Ms E provided Ms C with clear verbal instructions concerning her duties that morning. She told Ms C to sponge wash and dress Mrs A and then, with assistance, to move her from her bed to her chair. Ms E also advised Ms C that Mrs A required careful handling as her skin was particularly frail. Ms C was provided with a handover sheet that stated that moving Mrs A required two people to assist with a hoist.

Hospital nurse manager Ms D said that Ms C was also informed that all residents had mobility plans above their beds which listed their specific requirements, including the equipment used to lift them and the number of people required to move them safely.

Although Ms C's duties mainly involved her working alone, Ms E partnered her with another HCA, Ms H, to help with lifting residents. Ms C was expected to ask for assistance when she needed to lift anyone. Ms C said that, because she had missed the formal handover (as there had been some confusion about where she was to work), she was not introduced to her work colleagues, and this made it harder for her to approach them to ask for their assistance.

At 9am, Ms C started her duties with Mrs A, who was still in bed. Ms C said:

> "While I was taking [Mrs A's] pad off, I rolled her on her side, so she was facing the window. At this point [she] was close to the edge. I did not think she was going to fall, because she doesn't move. So, being careless, I left her in that position and went to wet the flannel to wash her bottom. While I was wetting the flannel I heard a big thump. I quickly ran to attend to [Mrs A] and found [her] on the floor …"

At the side of the bed from where Mrs A fell were a bedside cabinet and a small wash basin. Ms C said that as she was in the bathroom she did not see Mrs A fall, and therefore did not know whether she had struck anything as she fell. Ms C stated that Mrs A did not appear distressed. However, Ms C said she panicked at the sight of Mrs A lying partly clothed on the floor, and lifted her onto the bed. Ms C said that as Mrs

A was small and light, it was easy to lift her on her own without assistance. She did not use a lifting hoist.

Ms C said that Mrs A did not speak to her during her shift and she did not say anything when she fell. She lay still on the floor. Mrs A's progress notes document that from time to time she did speak briefly with the staff providing her care.

Ms C said that she was then called by Ms H to provide assistance in lifting one of Ms H's clients. On completion of this duty, Ms C returned to continue her care of Mrs A. Ms C stated:

> "I noticed a skin tear near her right ankle so I wetted the flannel to clean up the skin tear, by then it [stopped] bleeding, so I put on the stockings and shoes. I was too scared to call out to the other HCA for a lift, because of the nature of the incident, that she might see the skin tears and report on me, so I lifted her up on to her bucket chair on my own."

Ms C said that she did not see any other sign of injury to Mrs A and did not think that Mrs A had been badly hurt from her fall. Ms C said she understood that she was expected to report any accident or incident that occurred during her work at the Hospital. However, she did not do so because she knew that what had occurred was her fault, and she was afraid she would lose her job.

Between 10.30 and 11am, Mrs A's daughter, Mrs I, was visiting and noticed bruising on her mother's head. Mrs I asked Ms C if she knew how her mother had sustained this bruising, and Ms C said that Mrs A had hit her head on the bedside cabinet as she was being washed. Ms C said that she apologised directly to Mrs I concerning this.

Mrs I approached registered nurse Ms F and told her of Mrs A's injury. Ms F immediately informed Nurse Manager Ms D that Mrs A appeared to have hit her head as she had "marks" on both sides of her head. When Ms D discussed the incident with Ms C, Ms C denied any knowledge of Mrs A hitting her head, but said that she thought she may have done so on the bedside locker when she was being turned and washed.

At about 11.30am, general practitioner Dr G (who was already on site) was called by RN Ms E to review Mrs A. Dr G noted superficial bruising to both temporal regions, which did not extend to her eyes. He did not find any clinical evidence of a fracture, and noted that Mrs A's skin around the apparent injuries remained intact. Dr G recorded that he was satisfied that the injuries probably occurred while Mrs A was being washed.

Following Dr G's review, Ms D approached Ms C and asked her about Mrs A's injury. Ms C completed an incident report and recorded:

> "I went to turn [Mrs A] over and she bumped her head, bumped into the side drawer cabinet, I didn't notice bruising until I was approach by the RN."

Ms C also told Ms D that she had used a full body sling hoist on her own to move Mrs A into her chair. Ms D confirmed with Ms C that her instructions from RN Ms E on lifting had been clear and that she was aware that Mrs A required two people to lift her correctly.

At 1.10pm, nursing staff noted that Mrs A had a small skin tear on her right lower leg. At 6.45pm, a further incident report was completed by a registered nurse, as she had discovered further bruising on Mrs A's neck and the back of her head, and deeper bruising and a small skin tear on Mrs A's right shoulder.

Involvement of the Agency
Ms D informed the Agency on 10 October 2006 that an incident had occurred involving Ms C. On 11 October 2006, Ms D discussed this further with the Agency consultant Ms J, and expressed doubt about the credibility of Ms C's version of events. The consultant advised Ms D that she would arrange to meet with Ms C as soon as possible. On the morning of 12 October 2006, Ms D and Ms J met at the Hospital to discuss the incident, and for Ms J to view Mrs A's injuries.

On the afternoon of 12 October 2006, the Agency consultant interviewed Ms C at the Agency. Ms J reported that initially Ms C maintained that she did not know how Mrs A sustained her injuries, but on being informed of the seriousness of the incident Ms C provided a four-page handwritten incident report that described what had occurred. This confirmed that Mrs A had fallen from her bed and that Ms C had picked her up off the floor, and placed her back on the bed, and that later she had moved Mrs A from her bed to her chair without seeking other assistance or using any lifting equipment.

Additionally, Ms C described what had occurred when she was first questioned concerning Mrs A's injuries. Ms C stated:

> "Then I was approached by the R.N and asked about the bruising on [Mrs A's] head. I told her the wrong story … I was too scared and embarrass[ed] to tell her the truth, because of the nature of the incident and simply because I didn't follow the right procedures."

The Agency stated that Ms J immediately communicated the information to the Hospital so that they could provide Mrs A with an appropriate medical assessment.

On the afternoon of 12 October 2006, Dr G conducted a further review of Mrs A and noted:

> "More facts about [Mrs A's] injury have emerged since Tuesday. Bruising now apparent R shoulder-marked and skin tear on R ankle which has been well steristripped. Also bruising posterior aspect of shoulder R and small skin tear around acromion [part of the shoulder blade forming the highest point of the shoulder] and some local superficial bruising. No infection or [fracture] evident. Apparently fell out of bed while being sponged by one nurse when two were

> supposed to be used as per standing instructions. Bilateral temporal contusions have enlarged since Tuesday …"

Mrs A gradually recovered from her fall. A few months later she passed away.

Subsequent actions
Both the Hospital and the Agency investigated the matter.

Following Ms C's meeting with Ms J, the Agency informed Ms C that before they would consider providing her with further employment, she would be required to re-train in lifting procedures and incident reporting and receive ongoing supervision to assess her competency as a caregiver. Ms C was suspended from duty. She has not worked for the Agency since this incident.

The Agency, in a letter to the hospital dated 24 October 2006, noted that Ms C did not follow instructions concerning Mrs A's care, and did not correctly apply lifting procedures with Mrs A in line with the hospital policy. Additionally, Ms C did not report or inform anyone at the hospital that Mrs A had fallen from her bed while being washed.

The Agency provided Mrs A's daughter with a written apology, dated 15 November 2006. The Agency has since reviewed its incident and accident reporting system and instigated a change whereby all incidents are now reported directly to its branch or operations managers. The Agency has purchased a hoist for training purposes and altered its induction programme to include the use of this equipment, as well as conducting on-site observation of its employees' lifting practices.

The Hospital stated that it expects the nursing agency to provide them with documentation identifying the training received by the agency staff contracted to provide services. The Hospital now provides agency staff with a written handover concerning their duties, and checks that they understand how to manage their clients' mobility plans. Additionally, registered nurses will monitor agency staff more closely to see that they are performing their duties adequately.

Ms C provided the Agency with a written statement about what occurred following Mrs A's fall from her bed. At the end of her statement Ms C wrote:

> "I apologise sincerely to [Mrs A] and her family. I acted inappropriately to the incident and should have reported it straight away. I apologise for my carelessness, I did not mean for it to happen. I am sorry for the bruises and skin tears that I left with [Mrs A]."

Responses to provisional opinion

Ms C's response
Ms C initially agreed to provide a response to the provisional opinion and a full written apology to Mrs A's family. This has not been forthcoming despite repeated follow-up by this Office.

Ms B
Ms B said that Mrs A's family would accept a full written apology from Ms C as a resolution of their complaint. They did not wish the incident and their complaint to "blight the rest of [Ms C's] life". Ms B was disappointed that an apology had not been received.

Code of Health and Disability Services Consumers' Rights

The following Rights are applicable to this complaint:

Right 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of service.

This report is the opinion of Rae Lamb, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

Opinion: Breach — Ms C

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A was entitled to have caregiver services provided by Ms C with reasonable care and skill, and in compliance with the relevant standards. On the morning of 10 October 2006, Ms C had an obligation to ensure that Mrs A was safely positioned on her bed before leaving her unattended. Furthermore, on hearing Mrs A fall and then finding her lying on the floor, Ms C should have acted appropriately by calling for assistance, and subsequently reporting the fall.

Safe positioning and transfer
Ms C had prepared to sponge wash Mrs A in bed and rolled her onto her side. Ms C went to wet a flannel, leaving Mrs A close to the edge of the bed. Ms C thought that this was safe as Mrs A did not usually move. Ms C heard Mrs A fall and then found her on the floor. Ms C admits that it was careless to leave Mrs A at the edge of the bed.

Mrs A's mobility plan clearly stated that for moving in bed Mrs A required two people, and for transfers she required the assistance of two people and a standing hoist or a transfer belt. The mobility plan was written on a card situated above Mrs A's bed. Ms C knew this and she had assisted another HCA to lift a resident. Ms C had also been clearly instructed to move Mrs A from her bed to her chair with assistance, and the handover sheet provided to Ms C on 10 October 2006 stated that Mrs A required two people to assist with a hoist.

Nonetheless, on finding Mrs A on the floor, Ms C did not call for assistance. Instead, she lifted Mrs A on her own and placed her back on the bed. Once she had completed washing and dressing Mrs A, she manually transferred Mrs A from her bed into an armchair, again without seeking assistance.

Ms C said that she panicked at the sight of Mrs A lying partly clothed on the floor and lifted her onto the bed. She admitted that she did not call for assistance out of her fear that her HCA partner would see the skin tear on Mrs A's right ankle and report the fall. Ms C believed that if the incident were reported, she would face disciplinary action from her employer and her employment would be terminated.

Ms C failed to safely position Mrs A on the bed during a sponge wash, which resulted in a fall. She then twice moved Mrs A without the assistance of another person, as required by the mobility plan. In these circumstances, Ms C failed to exercise reasonable care and skill and breached Right 4(1) of the Code.

Reporting the incident
Ms C also had a duty to comply with the incident reporting processes and to ensure that the relevant hospital staff and Mrs A's family were promptly informed of the incident.

Ms C's declaration with the Agency (signed on 18 August 2006) included an agreement that she would inform the Agency and the client (the Hospital) as soon as practicable if she became involved in any accident at the client's premises. Furthermore, the Hospital Trust's guidelines for caregivers included a responsibility to report and fill out accident/incident/near miss forms for their shift.

Ms C understood her responsibility to report accidents and incidents. However, Ms C failed to inform the responsible nursing staff of Mrs A's fall. Shortly after the fall, she spoke to Mrs A's daughter, who questioned her about the bruising on Mrs A's head. Ms C failed to give an accurate account of the injury, saying that Mrs A had hit her head on the bedside cabinet. The nurse manager was subsequently informed, and Ms C again failed to accurately report the incident. It was not until Ms C's interview with The Agency consultant Ms J on 12 October that Ms C confirmed that Mrs A had fallen from her bed.

Ms C completed the incident report of 10 October 2006 only after she was questioned by the nurse manager. Furthermore, this incident report was false because Ms C stated that Mrs A had bumped her head on the side drawer cabinet when Ms C was turning her over in her bed.

A full and accurate report by Ms C at the time the fall occurred would have prompted an earlier, appropriate medical assessment of Mrs A, and facilitated the provision of appropriate care. Ms C was more concerned about what was likely to happen to her than whether Mrs A required medical attention following her fall. Ms C did not call for assistance when Mrs A fell because she was afraid she would lose her job. When questioned about the bruising to Mrs A's face, Ms C was too scared and embarrassed to admit her knowledge of events. This is no excuse. Ms C had a professional responsibility to report the incident to nursing staff and provide an honest answer to Mrs A's family. Ms C then chose to continue her deception, rather than admit to full knowledge of the incident.

Ms C acted dishonestly by failing to fully and accurately report the incident at the time it occurred and subsequently when she was questioned by hospital staff and family. In these circumstances, Ms C acted unethically and also failed to comply with the guidelines of the Hospital and the Agency. Accordingly, she breached Right 4(2) of the Code.

Ms C's failure to report Mrs A's fall resulted in the other providers being unaware of the full extent of Mrs A's injuries. This was compounded by Mrs A's inability to communicate freely with her carers about whether she was in pain.

Ms C's actions compromised the care Mrs A received. It was not until 12 October 2006 that the Hospital received a complete description of Mrs A's fall. Ms C's actions in not seeking assistance, or reporting Mrs A's fall, meant that Mrs A did not receive services that optimised her quality of life. Furthermore, by not promptly and truthfully reporting the incident to the registered nurse overseeing her duties or other staff members, Ms C deprived Mrs A of continuity of care. She failed to co-operate or to provide quality and continuity of service, and breached Right 4(5) of the Code.

Ms C's response
While the fact that Mrs A had a fall is very concerning, it is Ms C's response to the fall and her subsequent actions that are of greatest concern. She not only failed to report the fall immediately, she failed to report it accurately on more than one occasion. She also took action to cover up what had occurred. This is unacceptable. Furthermore, she appears to have little insight into the unacceptability of her behaviour after it occurred.

Despite promising an apology in response to this investigation, it has yet to be delivered. In light of the deceit and lack of insight, I am of the view that Ms C should be referred to the Director of Proceedings to consider whether further action should be initiated.

Opinion: No breach — The Hospital

On the morning of 10 October 2006, Ms C was provided with clear instructions from registered nurse Ms E about her duties as a caregiver. This included the requirement to call for assistance from another caregiver when she needed to lift a client. Ms C accepted that she was told that each client's mobility plan was above their bed and that these plans clearly listed specific requirements. Ms C understood that she was required to report any incident or accident that occurred during the course of her work, and that there was a requirement by the hospital that any incident should be clearly documented in an incident report. She understood that she was required to act professionally and exercise responsibility in the care of the residents.

Mrs A's injury was brought to the attention of the hospital nurse manager, Ms D, once the bruising to Mrs A's head became visible. Ms D immediately discussed this with Ms C and, based on her description of events, called in Dr G to examine Mrs A. Dr G conducted a physical examination based on the information provided initially by Ms C, that Mrs A had knocked her head whilst being turned.

When further injuries to Mrs A became apparent, including bruising to her neck and right shoulder, Dr G was asked to return to the hospital and review her again. Ms D also contacted the Agency and advised them that she doubted the version of events initially provided by Ms C as to how Mrs A had sustained her injuries.

I am satisfied that the Hospital provided Ms C with appropriate instructions concerning her care of Mrs A. I am also satisfied that another caregiver was available for Ms C to call for assistance when required to lift clients under her care. Furthermore, it is my view that the hospital took the appropriate steps to manage Mrs A's injuries from the time they were notified of the bruising. Accordingly, the Hospital did not breach the Code.

Other matter
The Hospital may wish to consider whether there is a need to review the management of patients identified as being physically frail. In particular, it appears that despite Mrs A being assessed as having limited mobility, in falling from her bed she demonstrated some capacity for movement. It would be prudent for the hospital to review the way it assesses whether bed rails are needed for residents of limited mobility but who are frail.

Vicarious liability — The Agency

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee's act or omission that breached the Code.

The Agency provided a copy of an agreement (Temporary Nurse Declaration) signed by Ms C to confirm that she had received induction training. This included her agreement to familiarise herself with, and keep to, all of the client's policies, procedures and instructions concerning health and safety. The Agency note that their contract with the hospital states that "the client will be responsible for all acts and omissions of any Temporary Candidate whether wilful, negligent or otherwise".

The Agency could not have foreseen or prevented Ms C's failure to provide Mrs A with an appropriate standard of care on 10 October 2006, or her failure to report the incident accurately on the same day. I am satisfied that once the Agency was informed of the incident, it took sufficient steps by interviewing Ms C as soon as practicable, and responding appropriately. In my view, the Agency is not liable for Ms C's breach of the Code.

I note that, in response to this incident, the Agency bought a hoist to use in its training induction programme and have extended this programme to include on-site observation of its employees' lifting practices.

Recommendation

I recommend that Ms C provide Mrs A's family with a full written apology, which describes what occurred when Mrs A fell, and the actions taken by Ms C.

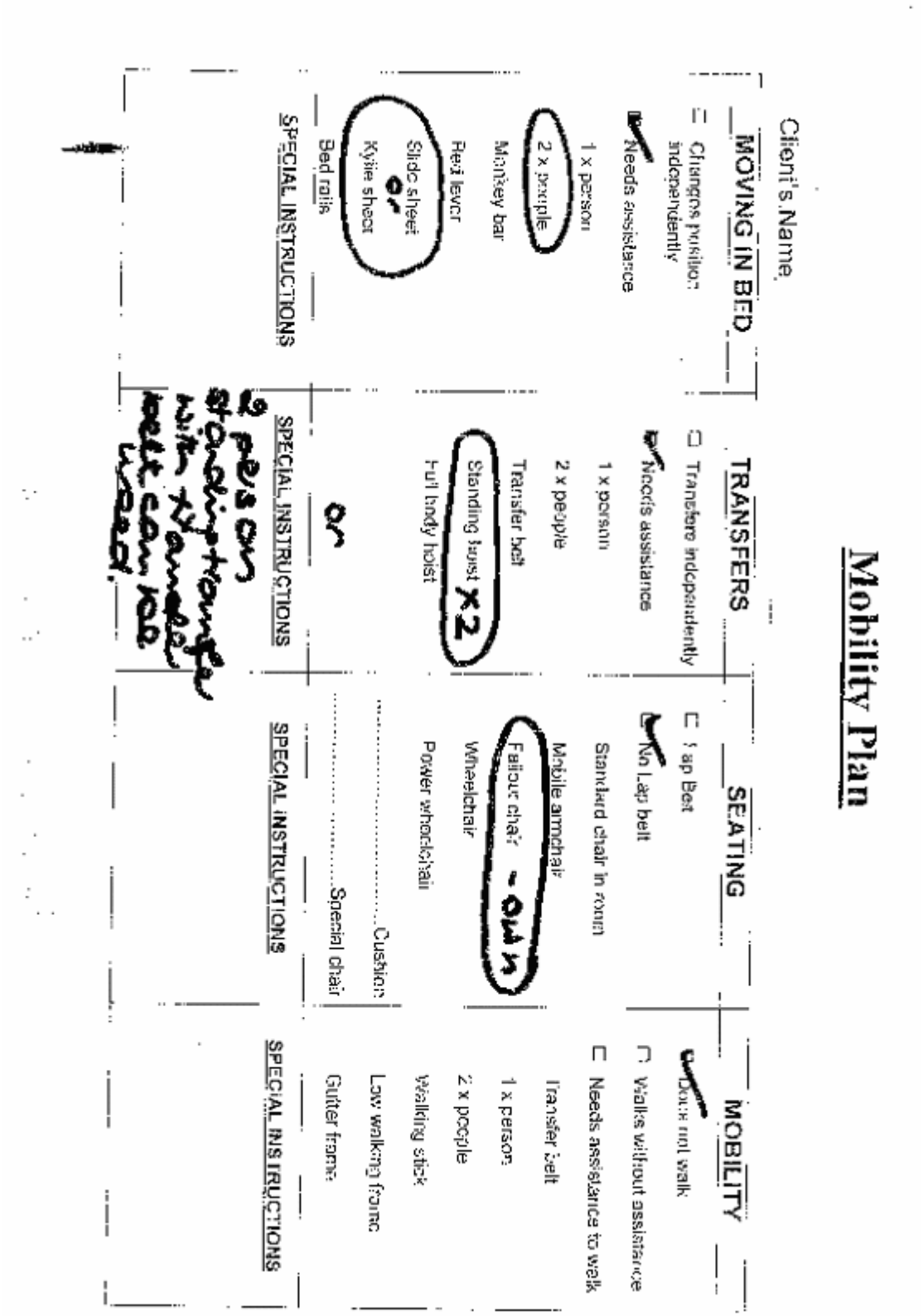
Follow-up action

- Ms C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further proceedings should be initiated.
- A copy of this report, with details identifying the parties removed, other than Ms C, will be sent to HealthCare Providers New Zealand.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue proceedings against Ms C.

Appendix 1:



Mobility Plan

Client's Name

MOVING IN BED
- Changes position independently
- Needs assistance
  - 1 x person
  - 2 x people
  - Monkey bar
  - Reij lever
  - Slide sheet or Kylie sheet
  - Bed rails

SPECIAL INSTRUCTIONS

TRANSFERS
- Transfers independently
- Needs assistance
  - 1 x person
  - 2 x people
  - Transfer belt
  - Standing hoist x2
  - Full body hoist

or

SPECIAL INSTRUCTIONS

2 pers on standing transfer with Kylie sheet belt can not be used

SEATING
- Lap Belt
- No Lap belt
  - Standard chair in room
  - Mobile armchair
  - Fallout chair - own
  - Wheelchair
  - Power wheelchair
  - ..... Cushion
  - ..... Special chair

SPECIAL INSTRUCTIONS

MOBILITY
- Does not walk
- Walks without assistance
- Needs assistance to walk
  - Transfer belt
  - 1 x person
  - 2 x people
  - Walking stick
  - Low walking frame
  - Gutter frame

SPECIAL INSTRUCTIONS

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.