HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Concerns regarding the management of a high falls risk consumer

## Complaint background

1. This Office received a complaint from Mr A about the care provided to his father, Mr B at Ballarat Care Home (Ballarat),[1] located in Rangiora, Canterbury region. The complaint concerns the management of Mr B's high falls risk.

2. I express my sympathy and heartfelt condolences to the family and friends of Mr B for their loss. I hope this report brings some closure for his family.

## Background

3. Mr B, aged 96 years at the time of the events, was admitted into Ballarat on 7 January 2022 at a rest home level of care. He had various comorbidities, including congestive heart failure and postural hypotension. He was particularly vulnerable because he also had age-related cognitive impairment and a fiercely independent nature, which resulted in risk-taking behaviours such as walking unaided.

4. On admission to Ballarat, his falls risk assessment revealed that Mr B was at a high risk of falling, but this was not documented in his care plan.

5. Progress notes recorded in the days after his admission referred to Mr B as being confused at times and occasionally trying to mobilise independently. However, Mr B's tendency to stand up unaided and mobilise was not documented in his care plan. There was no evidence that his family were invited to have input into the development of his care plans, which is in contravention of section D3.1(h) of the Age-Related Residential Care Services Agreement,[2] which states that service providers must 'acknowledge, value, and encourage the involvement of families/whānau in the provision of care.'

6. A sensor mat was placed next to Mr B's bed to alert staff if he tried to stand up on his own, but this was not documented in his care plan.

7. Mr B experienced two falls in January 2022, one on 8 January (the day after he was admitted) and the other on 19 January (less than two weeks later). Fortunately, Mr B was not significantly injured on either occasion, but the fall events highlighted that a physiotherapy review of Mr B's mobility was not undertaken either on admission or after the fall events on 8 and 19 January.

8. On 3 February 2022, staff assisted Mr B to sit up in readiness for his breakfast in his room. However, the sensor mat was not placed by his chair, and staff subsequently found him lying on his bathroom floor with a suspected fracture, so an ambulance was called. It was this

[1] Bupa Care Services New Zealand Limited (trading as Bupa Ballarat Care Home).
[2] A contract between Health New Zealand | Te Whatu Ora (Health NZ) and aged residential care providers for the delivery of services to older people.

event that highlighted that Mr B did not have a falls prevention plan to guide staff in keeping him safe and preventing him from falling.

9. Additionally, after Mr B's fall and before he could be reviewed by a registered nurse (RN), he was hoisted onto his bed. This was in contravention of Bupa's Falls Prevention and Management policy, which instructed that, when a resident is found on the floor, they should be assessed by a nurse before they are moved.

10. Following surgery for a hip fracture and rehabilitation in the local public hospital, Mr B returned to Ballarat at hospital-level care to reflect that he now required more support and was less independent than before his fall on 3 February 2022.

11. Mr B was commenced on a 30-minute intentional rounding chart[3] on 4 March 2022 to ensure that staff were monitoring him closely and could immediately assist him if needed.

12. Mr B was known to take a while to finish his meals. On 13 March 2022, staff assisted other residents back to their rooms after dinner, leaving Mr B to finish his meal. Around 6.45pm, Mr B had an unwitnessed fall in the dining room and was found on the floor with a chair on top of him.

13. It is unknown when Mr B was last checked before the fall because the rounding chart had not been completed since 8.30am that morning. Bupa stated that staffing levels were 'significantly impacted' by COVID-19 on that day and that staff prioritised their workload, which meant some of the paperwork – such as the rounding chart – was not completed.

14. Review of Mr B found that he was experiencing significant pain in his right leg, so a fracture was suspected, and an ambulance was called to take him to hospital.

15. Mr B returned to Ballarat on 17 March 2022, and his falls prevention plan was updated. Mr A told the Health and Disability Commissioner (HDC) that, on 20 March 2022, he had complained to Bupa about his father's care but noted that '[n]o subsequent action or change to care resulted from that complaint.'

16. On 31 March, Mr B was admitted to hospital because his health had deteriorated rapidly over the previous days, with a two-day history of vomiting and diarrhoea. Sadly, Mr B passed away in April 2022. Mr A is concerned that his father deteriorated rapidly due to dehydration.

**Response from Bupa Care Services**

17. In its response to Mr A, Bupa Care Services acknowledged the following failures in their care of Mr B:

- Mr B's high falls risk was not recorded in his care plan.
- Sensor mat usage was not documented in his care plan.

[3] Where staff are required to check on a resident every 30 minutes to ensure any needs are met promptly. The observations are recorded on the Intentional Rounding chart.

- There was no evidence that family had been involved in the development of Mr B's care plans.
- No physiotherapy review of Mr B's mobility was undertaken on admission or after his fall events in January 2022.
- No falls prevention plan was documented to guide staff on the management of Mr B's mobility.
- Bupa's Falls Prevention and Management work instruction/policy was not followed.
- Mr B's tendency to mobilise independently during the day or stand up unaided was not documented in his care plan.
- Intentional Rounding forms were not completed half-hourly from 8.30am on 13 March 2022.

**In-house clinical advice**

18. In-house clinical advice was sought from RN Hilda Johnson-Bogaerts (Appendix A), who identified the following departures from the accepted standards of care:

- **Significant departure** in relation to falls management
- **Moderate departure** in relation to care planning and encouraging family input.

**Responses to provisional decision**

*Bupa Care Services*

19. Bupa Care Services was given a copy of the provisional decision and given the opportunity to respond. It reiterated its sincere condolences on the death of Mr B and appreciated what a difficult time it has been for his family. Bupa Care Services also noted further changes they have made to its services since the event, which are outlined below.

*Mr A*

20. Mr A was given the opportunity to respond to the provisional decision. His responses have been incorporated where relevant in this report.

**Decision – breach**

21. The key issue here is whether Ballarat provided Mr B with an appropriate standard of care between 7 January 2022 and 8 April 2022 (inclusive). RN Johnson-Bogaerts identified issues with Bupa's management of Mr B's falls risk and inadequate care planning, with a lack of family input. RN Johnson-Bogaerts advised that, in these areas, the care provided by Ballarat fell below the accepted standard of care. I accept this advice.

22. I am critical that, although Mr B was identified as being at a high risk of falling, documentation was insufficient to demonstrate that appropriate monitoring and management strategies were implemented. There was no record of Mr B's tendency to mobilise independently and no documentation confirming the use of a sensor mat. There was no documented falls prevention plan, which meant that staff could not consistently recognise and respond to Mr B's high falls risk.

23. I also have concerns about the implementation of intentional rounding on 13 March 2022. Intentional rounding is a key strategy for reducing the risk of resident harm, and I am critical that the absence of intentional rounding records over an extended period on 13 March 2022 meant there was no evidence of Mr B being monitored as planned. Given Mr B's known high falls risk, this gap in recording is of concern, particularly as he was found severely injured after an unwitnessed fall later that day.

24. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that Bupa Care Services New Zealand Limited (trading as Bupa Ballarat Care Home) did not provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

**Changes made since events**

25. Bupa Care Services has made the following changes:

- Education and training on Bupa's national intentional rounding work instruction/policy has been completed.
- The findings and learnings from the events surrounding Mr B's falls have been shared with staff.
- VCare, an electronic system for all resident documentation, has been implemented. It also provides prompts around incidents, such as in the case of a fall. The prompts can include to complete a post-fall checklist, update the falls risk assessment, and assess the resident for pain.
- The Deterioration Early Warning System (DEWS), which helps in the timely identification and response to acute deterioration in a resident, has been implemented.
- The falls prevention and management policy has been improved.

**Recommendations**

26. I recommend that Bupa Care Services New Zealand Limited (trading as Bupa Ballarat Care Home):

a) Undertake further staff training on the responsibilities associated with completing intentional rounding forms, including the rationale for this type of monitoring, and the risks that can arise if intentional rounding is not adequately recorded. 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.

b) Undertake staff training on falls prevention and management. 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) Following completion of recommendations a) and b), undertake an audit of 10 residents who have an identified high falls risk to determine that appropriate documentation has been completed for these residents. A summary of the findings and corrective actions to be implemented are to be provided to HDC within 6 months of the date of this report.

27. In the provisional opinion, I recommended that Bupa provide a formal written apology to Mr B's family for the breach of the Code identified in this report. This apology has been received and forwarded to Mr B's family.

**Follow-up actions**

28. A copy of this report with details identifying the parties removed, except the clinical advisor on this case and Bupa Care Services New Zealand Limited (trading as Bupa Ballarat Care Home), 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.

Rose Wall
**Deputy Health and Disability Commissioner**

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

The following in-house aged-care advice was obtained from RN Johnson-Bogaerts.

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Ballarat Care Home – Bupa. 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.
2. I am asked to review the information on file and advise whether the falls prevention measures were adequate to minimise [Mr B]'s falls.
3. **Documents reviewed**
    - File review by navigator dated 6 March 2023 and 14 August 2023
    - Provider letter of response dated 28 September 2022 and 1 August 2023
    - InterRAI assessments
    - Admission booklet
    - Long-term care plan/Falls prevention (2 March 2022)
    - Medical notes
    - Nursing notes
    - Fall investigation report
    - Provider response letter to complaint dated 29 April 2022
4. **Review of clinical records and advice**

[Mr B] transitioned into Ballarat Care Home on 7 January 2022 to receive rest home-level care. At the time, he was 96. His medical history included myocardial infarction, congestive heart failure, chronic renal failure, colon cancer (with probable rectal cancer), atrial fibrillation, postural hypotension with syncope, cognitive impairment/dementia (EPOA [Enduring Power of Attorney] welfare not activated), hearing impairment, and increasing vocal cord atrophy. He was well supported by his family throughout his stay, with frequent visits from his wife.

A falls risk assessment conducted on 8 January 2022 by the RN revealed that [Mr B] was at a high risk of falling. This was appropriately documented in his admission documents, nursing assessment, and care summary. He was assessed as requiring the assistance of one person for daily activities and mobility and he was noted to have a fiercely independent nature.

The initial care plan included falls risk prevention measures such as assistance and supervision for mobility and the use of a walking frame. The progress notes from the initial days indicate that his transition to care was challenging, he appeared to be confused at times, and was tending to mobilise independently (high risk) during the day. A sensor mat was placed beside his bed to alert nurses when he mobilised so they could assist and minimise the falls risk. The nursing progress notes reflect this use of the sensor mat; however, in this situation, it would have been appropriate for the RN to develop a more comprehensive care plan covering 24-h falls prevention tactics to coordinate the falls prevention measures consistently across all shifts and all care staff.

[Mr B] experienced two falls without significant injury on 8 January 2022 and 19 January 2022, leading to a review by the general practitioner with some adjustment of medication. It was determined at the time that [Mr B] retained the ability to make decisions about his welfare, and thus, the EPOA was not activated.

On 3 February 2022, [Mr B] suffered an unwitnessed fall while unassisted going to the bathroom, resulting in a fractured hip and ribs. The fall investigation report completed by clinical manager […] revealed that the recommendation after the 19 January 2022 fall was to write a falls prevention plan, but this was not actioned. The investigation into the cause of the fall identified that staff had assisted [Mr B] that morning from his bed to the chair ready for breakfast but had not yet assisted him to the bathroom, and he did not have the sensor mat placed in front of him. Issues found by the report included: No physio review throughout admission, no care plan written, and care summary not updated with changes as they occurred.

The provider response of 1 August explains that because the Care Home was managing [a COVID-19] outbreak at the time, no physio assessment occurred. Bupa explained that they now reviewed their practice and enabled virtual consultations by the physiotherapist for such situations.

**In the circumstances, I consider the falls prevention measures during this first month of care to have been inadequate and a significant deviation from accepted practice. I have come to this conclusion because of the lack of care planning and care coordination by RNs even after this was identified as an issue during the investigation of a previous fall.** I note that Bupa identified staff shortages (Unit Coordinator and RN), and a difficulty with recruiting RNs at the time, as contributing factors.

As a result of the fall of 3 February 2022, [Mr B] was hospitalised and underwent surgery for a hip fracture. He returned to the care home on 1 March 2022, now requiring hospital-level care because of his increased dependency and high risk of falling. The family communication notes include a conversation wherein the family expressed their concerns regarding the safety strategies implemented, and nurses assured [them] that he will now always have the sensor mat. The progress notes include that [Mr B] now required assistance from two people for mobilising and activities of daily living. The notes from the (re-admitting) RN include that he 'requires a sensor mat at all times' and a physio review.

The documentation includes [Mr B]'s 'falls prevention plan' dated 2 March 2022. The focus of the plan is on alerting care staff anytime [Mr B] wanted to mobilise. This included measures such as keeping his call bell within reach at all times, using a chair sensor when sitting, and placing a sensor mat beside his bed or chair to alert nurses to his movement. The care plan also stipulates that he has a 'low bed' to be put in the lowest position to prevent him from standing up by himself, and 30-minute rounding checks by staff to be documented on a rounding chart. The RN is to ensure that the EPOA/family/whānau are informed of the falls risk and are kept updated. I did not find evidence of the care plan being discussed and agreed with the consumer/family.

The forwarded clinical documentation included completed rounding charts starting on 4 March 2022. The documentation includes a physio assessment completed on 4 March 2022, identifying a transfer and mobility plan for [Mr B] using a gutter frame and assistance from

care staff. Further physio progress notes show physio involvement every few days. These notes include that he struggled to follow instructions.

On 13 March 2022, [Mr B] had another unwitnessed fall. He was found in the lounge with his chair on top of him. He sustained a further fracture below his right hip prosthesis and was transferred to the hospital, where he underwent surgical interventions. When investigating this fall, it seemed that [Mr B] was left as the last person in the dining room, as he was known to prefer to take his time to eat and drink. It was found that the 30-minute rounding chart had not been completed since 0830 hours. Reviewing the documentation, I did not find the full 'falls investigation report'. Bupa explained that staffing levels that day were severely impacted by COVID-19, and they had to prioritise their workload, meaning rounding charts were not completed as required. Bupa did not include in their response what their reasoning was for prioritisation of work during this time and how severe the staff shortages were on the day.

[Mr B] returned to the care home on 17 March 2022. The falls prevention plan was updated, and physio input was provided. Transfer from bed to chair was now recommended by the physio to be by hoist because [Mr B] was unable to sit due to pain.

The notes show that his health deteriorated rapidly, and he was acutely admitted to the hospital on 31 March 2022 after experiencing 'coffee grounds' vomit and diarrhoea for two days. [Mr B] passed away [in] April 2022.

Reviewing the falls prevention plan, I consider it to be comprehensive. However, I have some reservations that the care plan and care notes did not address the concerns and nervousness expressed by the family. Person-centred care as a standard encourages care providers to partner with the consumer and their family. Rather than dictating care, healthcare providers are to listen, teach, and partner with the consumer, building a care plan together that aligns with the resident's/family's goals. I did not find evidence that [Mr B] and his family were given the opportunity to discuss and agree with the care plan and care interventions and have their concerns addressed.

**In conclusion, I consider this falls prevention plan/care plan while [Mr B] was receiving hospital-level care to have been adequately addressing the falls risk; however, it could have been improved by better integrating the family's observations/concerns and care goals. I did not find evidence that the care plan was developed in partnership with the consumer/next of kin and family. In the circumstances, including staff shortages due to the COVID-19 pandemic, I consider the falls prevention measures to have been a mild to moderate deviation from accepted practice.**

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
**Nurse Advisor (Aged Care)**
Health and Disability Commissioner