Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 201916181

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201916181

Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment Ward 8 North of Belfast City Hospital (BCH) provided to the patient on 3 December 2019 and the subsequent follow-up care.

The investigation established there were failings in the patient's care and treatment in relation to the following:

- nursing care plan;
- implementation of a FallSafe Bundle including an inaccurate initial falls assessment;
- completion of Moving and Handling Care pathway;
- concerns about the patient's footwear not documented and raised with the family;
- management of the spillage; and
- and the completeness of OT Records.

I am satisfied that as a result of these failures in care and treatment, the patient suffered the injustice of being placed at a greater risk of a fall and subsequent injury and the loss of opportunity to have thorough OT assessments post fall. I also consider the complainant experienced the injustice of upset.

The investigation was unable to reach a conclusion in relation to the recommendation by the Occupational Therapist to utilise a sara stedy (a mobility aid).

The investigation established there were no failures in the care and treatment the patient received in relation to moving the patient post fall before doctor assessment or in the treatment provided post fall including provision of an x-ray.

The investigation also identified maladministration in the internal investigation of the fall, including the provision of inaccurate information to the complainant following the fall. As a result of this maladministration I am satisfied the patient and complainant experienced the injustice of loss of opportunity for a more robust incident investigation post fall, reduced opportunity for timely learning and risk reduction and upset. I am also satisfied it caused the complainant frustration and time and trouble by bringing a complaint to this office.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment and maladministration I identified.

I made recommendations for service improvements in relation to falls prevention, maintaining OT records and investigations of incidents.

I wish to acknowledge the seriousness of the patient's fall and the clear devotion the complainant and her family showed towards the patient. I also wish to emphasise that those issues that I have not upheld, or been unable to reach a decision on, in no way diminish the distress that I acknowledge the complainant experienced.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust) in relation to the care and treatment the staff of Belfast City Hospital (BCH) provided to the complainant's late mother (the patient) on 3 December 2019. The complaint also related to the patient's subsequent follow-up treatment.

Background

2. The patient was admitted to BCH Ward 8 North on 21 November 2019 with aspiration pneumonia[1] and an acute kidney injury. On admission, the patient was anaemic[2] and required a blood transfusion. During the patient's time in BCH she received antibiotic therapy, with benefit, to treat a left pleural effusion[3] and lung consolidation[4]. On 3 December 2019, the patient suffered a fall after using a commode and sustained a compression fracture[5] of L3[6]. Following the fall, the spinal team advised she wear a thoraco-lumbar spinal orthosis (TLSO) brace[7] for mobilisation. The patient was discharged from BCH on 4 January 2020 for rehabilitation to Meadowlands, Musgrave Park Hospital (MPH) and sadly passed away on 11 February 2020. A chronology detailing the events leading to the complaint is contained at Appendix eight to this report.

Issue of complaint

3. The issue of complaint accepted for investigation was:

Issue 1: Whether the patient received appropriate care and treatment from Ward 8 North in Belfast City Hospital on 3 December 2019 and appropriate follow up thereafter.

INVESTIGATION METHODOLOGY

[1] Occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the oesophagus and stomach.

[2] Suffering from Anaemia - a medical condition in which the red blood cell count or haemoglobin is less than normal

[3] A build-up of fluid between the left lung and the chest wall.

[4] Consolidation of material in the lungs due to solid and liquid material in the areas of the lungs that would normally be filled with air or gas.

[5] A compression fracture occurs when the bone collapses, particularly in short bones such as the vertebrae in the spine.

[6] The third lumbar vertebra.

[7] A spinal brace that is custom made to control the curve of your spine.

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

5. I obtained independent professional advice from the following professional advisors (IPA):

- **Consultant Physician,** MB, MSc, MD, FRCP, FRCPE, FRCPI, Dip Card, RPMS, with over 30 years and an accredited geriatrician since 2001. (C IPA).

- **Senior Nurse,** RGN, BA (Hons); MA, with twenty years nursing and managerial experience across both primary and secondary care. (N IPA).

- **Occupational Therapist,** BSC (Hons) in Occupational therapy, MSc in Advanced Occupational Therapy practice with a focus on older people, with Clinical expertise in older people, frailty, falls and dementia in particular having practices in acute and community inclusive of role of falls co-ordinator, principal therapist form complex rehabilitation and clinical lead for occupational therapy for older adults. (OT IPA)

The clinical advice received is enclosed at Appendix three to this report.

6. The information and advice which informed my findings and conclusions are included within the body of my report. The IPAs provided me with 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the

circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[8]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling

8. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- The Nursing and Midwifery Council's (NMC) Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (the NMC Code);
- The College of Occupational Therapist, Professional Standards for Occupational Therapy Practice, 2017, (OT Professional Standards);
- The National Institute for Health and Care Excellence's (NICE) Falls in older people: assessing risk and prevention, Clinical Guidance 161, June 2013 (NICE CG161);
- The Royal College of Physicians, The FallSafe care Bundle, July 2011 (FallSafe Bundle);
- The Belfast Health and Social Care Trust's, Manual Handling Policy and Procedural Arrangements, December 2018 (Trust's Manual Handling Policy);
- The Belfast Health and Social Care Trust's, Falls Reduction & Prevention Policy, August 2011 (Trust's Falls Policy);
- The Belfast Health and Social Care Trust's, Procedure for Reporting and Managing Adverse Incidents, January 2018, (Trust's Incidents

[8] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

Procedure); and

- The Belfast Health and Social Care Trust's Policy and Procedure for the Management of Comments, Concerns, Complaints and Compliments, March 2017 (the Trust's Complaints Policy).

9. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied I took into account everything that was relevant and important in reaching my findings.

10. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the patient received appropriate care and treatment from Ward 8 North in Belfast City Hospital on 3 December 2019 and appropriate follow up thereafter.

Detail of Complaint

11. The complainant raised concerns about the number of staff who helped the patient use the commode, including assisting her to and from her bed to the commode. She also raised concerns that the patient was unaided at the time of the fall and said the patient and nursing staff had differing accounts as to how the patient landed on the floor. The complainant believed that the risk of a spillage on the floor at the time of the incident was not managed. She also complained about the nursing staff's decision to move the patient, after the fall, before a doctor's assessment.
12. The complainant also raised concerns about the patient's use of the stedy[9] to get to the bathroom later that morning, after her fall. She believed that the occupational therapist's (OT A) recommendation to use the stedy was incorrect given that the patient was in a great deal of pain and had difficulty using it. This resulted in a hoist being used to help her off the toilet and back to bed. She also complained that the

[9] A patient transfer aid that promotes safe transfers and transport of semi ambulant patients.

patient had to request an x-ray to be carried out. She said that even though the patient had complained to medical staff about being in pain, nothing was done for over six hours. The complainant also raised concerns about how the Trust recorded and communicated accidents and said that information[10] on the most recent accident, at the entrance to Ward 8 North, was not kept up to date.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following policies/guidance:
    - GMC Guidance;
    - NMC Code;
    - OT Professional Standards;
    - NICE CG161;
    - FallSafe Bundle;
    - Trust's Manual Handling Policy;
    - Trust's Falls Policy;
    - Trust's Incidents Procedure; and
    - Trust's Complaints Policy.

    Relevant extracts of the guidance and standards referred to are enclosed at Appendix two to this report.

Trust's response to investigation enquiries

14. I made written enquiries of the Trust about the issues the complainant raised. The Trust's responses to my enquiries are enclosed at Appendix four to this report.

Staff statements

[10] The Trust have advised this information is known as the Safety Thermometer.

15. The Trust provided written statements from Health Care Assistant A (HCA A) and Staff Nurse B (SN B). Relevant extracts from the staff statements are enclosed at Appendix five to this report.

Clinical records

16. The patient's clinical records were considered. Relevant extracts from the clinical records are enclosed at Appendix six to this report. The Trust also provided additional records including an incident form, staff training records, and completed audits/risk assessments. These documents were also considered and relevant extracts are enclosed at Appendix seven to this report.

Relevant Independent Professional Advice

Assistance provided to patient prior to and at time of fall

17. The N IPA advised '…*In line with local standards the moving and handling assessment should be completed on admission and reviewed if the patients' needs change or if they are transferred to another area or if new equipment is used…The FallSafe bundle should be used for patients who are 'at risk' of falling. This would include patients with a history of falls within 12 months prior to admission. This patient was documented as having fallen approximately three months prior to admission…*' She further advised that *'…the initial assessment is inaccurate because it states that the patient is independent in mobilising…This is incorrect as the patient used a walking stick prior to admission which (according to the moving and handling assessment) was not available. In the absence of her walking aid she would need assistance with mobilising.*' She also advised there were omissions *'...these relate to identifying the patients individual falls risk factors and addressing them (as per FallSafe and NICE)*.

18. The N IPA advised that the *'…FallSafe bundle should have been implemented on admission and reviewed after the patient had fallen… Furthermore, more planning was needed to reduce the likelihood of falls (clearly stating how many people to transfer her, clearly stating if she used the commode or toilet, clearly identifying that the call bell was in reach and that adequate footwear was used etc); this would have necessitated a falls care plan and the Trust used the FallSafe bundle for this purpose.*

19. The N IPA further advised that at the time of the fall *'…The patient was not wearing any footwear. This increases the risk of falling. Falls prevention policies focus on 'modifiable risk factors' which are the things that you can change as opposed to those that you cannot change like a person's age. Ensuring that a person is wearing suitable footwear before they mobilise reduces their risk of falling…'* She went on to advise that '*One member of staff should have been assisting [the patient] in line with the OT's assessment on 28th…'*

20. The N IPA detailed the checks that should be completed prior to assisting a patient from their bed to a commode given the time of the day when the fall occurred. She advised staff *'…should check for environmental hazards, including any items on the floor (discarded footwear / spills / clutter) that the patient could fall or slip over. You should ensure that the call bell is to hand before you give the patient privacy to use the commode.'* She also advised that the same checks should be completed before assisting the patient back to their bed form the commode. The N IPA further advised that any such completed checks were not documented within the patient records. However *'…It is documented within the incident report that after using the commode the floor was wet with urine… Given this evidence it is apparent that the floor was not checked prior to transferring the patient from the commode to the bed…'* and *'…This should have been identified before transferring the patient back to bed, as should the lack of footwear. However, it should be noted that it was a HCA who assisted the patient and that delegation would have been from the staff nurse as per the NMC (2017). Had a clearly documented falls plan have been in place it would have stated adequate footwear and avoidance of slip hazards. The HCA would have been expected to follow this plan.'* The N IPA also advised that it *'…would not be reasonable to turn the bay lights on at 06:30. When a commode is used in the patients bedspace, their individual overhead light can be turned on to give adequate lighting.'*

21. In relation to any assistance given to the patient when she was getting up off the commode, the N IPA advised the HCA's statement says *'…that she supervised the patient when she stood up from the commode…it is reasonable to supervise the patient whilst she stood up. If she became unsteady then support and reassurance*

could have been given.' In relation as to whether the patient should have been left alone whilst on the commode she advised *'It is important to accept an element of risk in order to respect dignity and privacy. Furthermore, a patient that is observed constantly becomes a patient who is fearful of being alone. This patient was living alone without a package of care prior to her admission. She mobilised around her home with a walking stick. The aim would be to get her back to baseline prior to discharge. Independent commode use would be a small step towards achieving this aim.' The* N IPA further advised what is considered reasonable practice to ease the fall of a patient. *'It is considered safer to guide the patient to the floor during a fall rather than attempt to catch or break their fall….'*

22. The N IPA concluded *'…Falls care planning was omitted despite falls risk from admission and a fall during [the patient's] admission, individual risk factors were not identified (use of commode early morning, …no spills and adequate footwear)…There should be further falls management training for all staff members on this ward area… This is because they failed to recognise a fundamental aspect of falls prevention – that is that this patient was very clearly at risk of falls. They then failed to implement preventive actions (FallSafe) to reduce her individual risks of falling….It would appear from the facts known thus far this fall could have been prevented.'*

Moving of patient before doctor assessment

23. The N IPA advised that following the patient fall the HCA present should *'…alert the staff nurse who would be expected check for obvious injuries. The patient can be transferred back to bed if it is safe to do so (if she is alert and mobile with no obvious injuries). A doctor should then be called to perform a medical review. Physiological observations should be taken at this time (NEWS). Neurological observations are only required if the patient has hit her head or if the fall is unwitnessed, they were not applicable in this case. An incident report should be completed and the falls care plan should be updated. This is in line with national guidance…In addition to this; the family should be informed after any safety incident…'*

24. In this instance the N IPA advised that 'NEWS[11] was taken: *"NEWS 1" is documented. This is low risk of deterioration… The patient was checked for injuries by the staff nurse and was hoisted back to bed. She complained of pain in her lower back and was offered analgesia (codeine) which she refused… These actions were in line with national guidance…and were therefore reasonable.'* Following the fall the N IPA advised that *'…An incident report was completed…The family were informed. however this was not until the afternoon…'*

Use of stedy

25. The OT IPA advised that the OT completed an initial review of the patient on 28 November 2019. An initial interview and assessment '…*gives an understanding of previous level of function and an understanding of current level of function. An analysis of the differences is made and a treatment plan is formulated thereafter.'* The OT identified the patient's previous level of function but was unable to assess her current level as the patient '…*declined functional assessment...'* The OT IPA goes on to advise that '…*Documentation starts to look at package of care being considered with no evidence to support why.'*

26. In relation to OT session following the fall the OT IPA advised that the OT *'…reviews transfers with assistance of 2 as nursing staff (Nurse and healthcare staff) had reported difficulty with the transfer. Transfers to chair with assistance of another Occupational therapist documented. No documentation of transfers to toilet or difficulties getting back off of [sic[the toilet. There is no evidence of any functional assessment prior to this [fall] by occupational therapy to confirm a transfer method of assistance of 2 from an occupational therapy perspective.'* The OT IPA also advised on the documented record in relation to this session. '…*No documented consent for activity recorded. No documentation that occupational therapist was aware of the fall, no documentation that analgesia had been given prior to transferring. Occupational therapist found that patient was leaning backwards and complaining of pain in lower back. Occupational therapist queried this was behavioural in nature. Bartel[12] [sic] score completed. Identified as a rehabilitation candidate. Occupational therapy assessment proforma not fully*

[11] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs
[12] Score/scale used to measure performance in activities of daily living

completed and sensorimotor components inaccurately completed with details of medical diagnosis. No recording of pain, motor control muscle strength, gait pattern, sitting balance, sensation. No screening of cognition baseline aside from stating alert and orientated.'

27. In relation to this post fall session the OT IPA further advised *'…The lack of documentation from the occupational therapist about knowledge of fall and checking for pain relief prior to actively moving the patient was not appropriate. At the point of the assessment by the occupational therapist, there was no documentation to state a need for an xray or concern that weight bearing activity may exacerbate the situation. Therefore, it is reasonable to commence a weight bearing activity such as standing. (If a patient is struggling with this activity and assistance from 2 persons, then it is reasonable consider the use of a mobility aid to support transfers from one location to another such as a sara stedy...) '…The patient was transferred and completed a weight bearing activity prior to a fracture being identified. It is unknown if this activity impacted on that result but is not something that is recommended where a suspected fracture is considered.*

28. On the use of the stedy the OT IPA advised *'In isolation, the decision to utilise a sara stedy for transfers based on fatigue, leaning back and pain appears to be a sound clinical judgement. Choosing to utilise this post fall without any knowledge of the fall and no attention to pain levels stated by the patient is not acceptable. These should have been checked prior to moving the patient. There is no supporting documentation from occupational therapy to support this occurred. The occupational therapist should have been aware of the fall and if the medical entry in the patient's notes was read, this would have occurred. Combining this with complaints of pain, in a patient who was documented as alert and orientated and nil concerns had been raised with cognition thus far, should have been a red flag to pause and seek clarification. There is nil documentation in the occupational therapy entry that analgesia had been administered prior to the session.*

29. The OT IPA advised that the OT also carried out a review on 4 December 2019, with a plan *'…to liaise with MDT, continue ward based rehabilitation and monitor discharge plans…'* She went onto advise that there was '…*No documented*

evidence of now being aware of fall on previous day or that x-ray had been requested. No documented plan to assess further a query about behavioural impact on need for assistance of 2 persons to transfer. Checklist of problems and plan with no evidence of assessment to identify the problems.'

30. In relation to the OT's records of care provided the OT IPA advised

'• *There is no evidence in the occupational therapy notes to demonstrate that the occupational therapist was aware of the fall and had checked prior to initiating any physical load bearing or musculoskeletal position changes.*
- *There is no evidence in the occupational therapy notes to demonstrate that the occupational therapist had read the medical entry written before the occupational therapy entry detailing the fall.*
- *There is no evidence in the occupational therapy entry that there was a check to ensure (although not reported or recommended in the medical entry) an xray would be required as complaining of pain post fall.*
- *There is little evidence to support that a full functional assessment of the individual was carried out by occupational therapy. There are numerous tick boxes on a checklist but no detail of occupational performance to outline the findings. There was no cognitive assessment and there was a query made around the difficulty to transfer as being behavioural with no assessment to support such findings.'*

31. The OT IPA also identified the following learning:-
    - '*Occupational Therapy entries must reflect that they had read the entries previously, checked vital signs and there is no medical reason not to proceed with an intervention and this is clearly documented.*
    - *A checklist of identified problems without supporting evidence from a functional assessment, clinical observations or liaison with wider MDT members is insufficient.*
    - *Although, not detailed in the medical review post fall initially, it is advisable that occupational therapy check no x-ray is required and document that they had this discussion (and with who) in the patient's medical records prior to commencing a plan of action with the patient.*
    - *All occupational therapy entries must detail exact detail of activity and clear consent to proceed with what activity. There is a lack of detail around the consent.*

- *There is a clear disregard for the pain and how this was impacting the patient's ability to transfer. No cognition assessment was completed by the occupational therapist to indicate that there was difficulty in accuracy of information. The core principle of client centred practice applied by occupational therapy as a profession was not demonstrated and the patient's reports of difficulty or pain were considered as behavioural.*

32. The OT IPA concluded that '*The occupational therapist's documentation is not full and evidential of full activities that were completed. There is no mention of actually taking the patient to the toilet and the purported events that occurred. The occupational therapy entry does not support that the occupational therapist checked previous MDT entries prior to commencing occupational therapy treatment. The occupational therapy episode of care in this instance was incomplete and of a substandard level.'*

Treatment provided in 6 hours post fall, including X-ray request

33. The C IPA advised '…*It is apparent that the medical examination following the fall was not immediate…'* as '…*The precise timing of the examination is not available because there is only an ex post facto record made at 0800 hrs…However, in the absence of obvious head injury, an immediate examination would not necessarily have added value. Thus, the timing of the examination in less than 90 minutes following the fall is reasonable… From the notes, it was however a thorough and complete examination…'* He went on to advise that given the finding of the examination '*The plan was to provide analgesia as and when required. Codeine 30 mg was written up. This was adequate.'* The C IPA also advised that at 13:30hrs the CT2 doctor '…*had noted that the patient was complaining of pain, had local tenderness and was struggling to bear her own weight on standing up. Therefore, he asked for an x-ray. There is no record that the patient requested the x-ray…The x-ray was requested the same day when it was found that there was a clinical indication for it. This was appropriate and patient would not have suffered any ill effects from this delay. In fact, in some circumstances, delaying taking an x-ray will allow the fracture line to become better delineated on x-ray.'*

34. The C IPA further advised that the x-ray showed '*There was a vertebral crush fracture (VCF) of the third lumbar vertebra…'* He also advised '*Pain from a VCF can be severe and may sometimes last for up to three months. Management is by using analgesia including opiates, as necessary. Subsequently the spinal SHO suggested using a TLSO in order to provide a degree of stability. This was appropriate; it was provided and used. The management of her VCF is in keeping with standard practice…It is not possible to conclude from the evidence in the medical notes that the fall that she suffered in hospital had any impact on the overall prognosis of this already frail lady who had background heart failure and chronic kidney disease.'* In relation to the care provided to the patient by the doctors the C IPA advised that *'Overall the treatment provided…was correct and reasonable…'*

35. The N IPA advised that *'…codeine was offered but refused. Lidocaine patch was administrated at 16:00.'*

Recording and communicating of accidents

36. The N IPA advised *'An incident form (Datix) should be completed as soon as possible after the fall by the nurse involved or witness to the incident. The Datix should then be reviewed within 24 hours but no later than 7 days, by the nominated manager (usually the ward sister). This ensures that timely investigation of the incident can occur. All incidents are given a classification code and are graded to identify the actual impact on the patient, the actual or potential consequence for the organisation and the likelihood of recurrence. Grading establishes the level of risk. The fracture to the patients spine was a 'moderate' grading and therefore is a reportable incident… This incident also could happen again given that the patient was documented as always using the commode at that time of the morning and was documented as unsteady on her feet on the day of the fall…Incidents that are moderate risk rating such as this, must be investigated at senior level and an action plan developed.'*

37. The N IPA also advised that '*At the time the report was written by the staff nurse there was thought to be no injury sustained,… however this was not the case and the day after it was determined that the fracture was acute and from the fall… The incident form should have been updated once it was determined that the fall had*

caused the fracture….Noting that the Datix was signed off on 10.12.2019. This is within the 7 days but is also after the fracture was known to be associated with the fall. This should not have been signed off until it was updated to reflect that harm to the patient had been caused and actions…were instigated.' The N IPA further advised that Trust should recognise and act on the fact that *'…a senior member of ward staff…signed off the inaccurate Datix report on10/12/2019 and did not recognise the lack of falls prevention and did not recognise the harm sustained by the patient….'*

Complainant's response to draft report

38. In response to the draft report the complainant raised concerns in relation to the following issues:-

When Spillage occurred or if it was properly managed.

39. The complainant believed that if nursing staff did not see the spillage it was not therefore properly managed. She further stated that the advice of the N IPA, that the floor was not checked properly prior to transferring the patient from the commode to bed, was further evidence that the spillage was not properly managed.

Footwear

40. The complainant disagreed with the Trust's response in relation to the patient's slippers. She stated staff did bring the type of slippers the patient had to the family's attention. However the patient had Mule slippers, not sling backs as *'…mules were the only slippers [the patient's] feet could get into due to the severe swelling in her feet and ankles. Whilst they [the Trust] did not document this…recommended slippers were bought and brought into hospital. However, the nursing staff had great difficulty fitting these. These slippers remained on the ward until patient's transfer.'*

How patient landed on the floor

41. The complainant highlighted the inaccurate information that had been provided to the family after the patient's fall and believed this reinforced the patient was not gently guided to the floor when she started to slip.

OT recommendation to use sara stedy post fall

42. The complainant believed that the advice given by the OT IPA provided evidence that the OT disregarded the patient's report of pain and the recommendation to use the *'…Stedy in this instance was flawed, causing unnecessary pain.'*

Request for an x-ray

43. The complainant disagreed with the record of the Assistant Ward Manager, dated 3 December 2019 at 16:00 that stated, the patient's daughter had asked for the x-ray to be delayed. She also re-iterated that the patient had requested an x-ray even though the clinical record did not document such a request.

Use of Back Brace

44. The complainant stated that information regarding the use of the back brace on the patient was inaccurate. She stated that *'…due to the handling and associated pain, [the patient] couldn't tolerate it. It was never fitted and sat on the chair or on floor beside bedside [sic] locker.'*

In general

45. The complainant was extremely upset at the patient being labelled *'Behavioural'* and queried if this lead to the poor treatment she received as a result. The complainant believed the Trust's mistakes left an already frail 86 year old patient in even more pain and discomfort in her final months. The complainant went on to say that the investigation report confirmed that the patient did give an accurate account of her events.

Trust response to draft report

46. OT A wished to apologise to the family for distress caused She explained that. *'It is likely that I was made aware of the patient's fall earlier that morning via the morning MDT meeting and would have sought clarification prior to mobilisation - this is something that I do as standard practice. For whatever reason, I did not document this and I appreciate that I did not meet the standards of proficiency required of me. For me, this incident has stressed the importance of good record keeping. I have contacted my OT Team Lead and requested that I attend the next available training opportunity in Record Keeping Training.'*

Analysis and Findings

47. I wish to acknowledge the complainant's concerns that the patient was labelled *'Behavioural'*. On review of the clinical, nursing and OT records I wish to reassure the complainant that this was not a term used by either the clinical or nursing staff during their assessments and was a term used only by OT A. I note the OT IPA advised that OT A queried if the patient's back pain was *'…behavioural in nature*...' and I would expect this to have been addressed further within OT A's records. Consideration of OT A's records is set out in paragraphs 74 to 78 below.

Assistance provided to patient prior to and at time of fall

48. The complainant was concerned about the incident involving the use of the commode and subsequent fall.

i. Nursing assessments

49. I note from clinical records that the initial nursing assessment was completed on 19 November 2019 in the Royal Victoria Hospital. This included a Moving and Handling and Falls assessment. The assessment recorded that the patient used a mobility aid, the mobility aid was not available on the ward, she had a history of falls in the last 12 months and the FallSafe bundle was not implemented. I also note the assessment documents the patient as mobilising independently as well as being independent with walking stick prior to admission. I further note the patient's nursing need is documented as *'…Pain in back Pain control…, assistance with toileting… mobility is poor.'* However, I note there is no documentation within the nursing records to indicate that this assessment was reviewed upon admission to BCH on 21 November 2019. I further note the patient's 'moving and handling assessment' was updated on 3, 7 and 15 December 2019.

50. I note the Trust's comments that *'On admission on 19 November 2019…The nurse has noted that the patient mobilized independently with the aid of a walking stick. There was therefore no indication to complete a Care Pathway for the Moving and Handling of Patients form at that time…'* I also note its comments that the change in the patient mobility *'…should have triggered the need for the completion of a Care Pathway for the Moving and Handling of Patients form for the patient…'* I further note its comments that even though a moving and handling assessment was

updated and reviewed post fall *'…staff should have taken the opportunity following the patient's fall to complete a Care Pathway for the Moving and Handling of Patients form…'*

51. I note the N IPA's advice that *'…the initial assessment is inaccurate because it states that the patient is independent in mobilising…This is incorrect as the patient used a walking stick prior to admission which (according to the moving and handling assessment) was not available. In the absence of her walking aid she would need assistance with mobilising.'* I further note her advice that a *'…FallSafe bundle should have been implemented on admission and reviewed after the patient had fallen… Furthermore, more planning was needed to reduce the likelihood of falls…'*

52. I also accept the N IPA's advice that the initial nursing assessment/care plan for the patient, completed on 19 November 2019, is inaccurate. The patient's mobility aid was not available on the ward and I am unable to determine if this became available. Given the patient's history of falls, the need for support whilst mobilising and the absence of her mobility aid, I accept the N IPA's advice that '…*more planning was needed to reduce the likelihood of falls …'* by means of implementing the FallSafe bundle. I also note Trust's recognition that the changes in the patients mobility should have triggered *'…the completion of a Care Pathway for the Moving and Handling of Patients form for the patient…'*

53. Both the Trust's Falls Policy and NICE CG161 highlight the human cost of patient falls to the patient as well as to family members and carers. The purpose of the Trust's Falls Policy is to reduce the risk of patients falling. I note staff are charged with identifying the risk factors and undertaking appropriate interventions that will reduce the likelihood of patients slipping, tripping or falling. The importance of undertaking appropriate Falls risk assessments is also emphasised in NICE CG161.

54. I accept the N IPA's advice that the patient's fall could have been prevented. I considered the inaccuracies in the nursing care plan, dated 19 November 2019, the failure to review this care plan on admission to BCH on 21 November 2019, the failure to implement a FallSafe Bundle, and the failure to complete a Care Pathway for the Moving and Handling of the patient, a failure in the patient's care and

treatment. As a consequence of these failures I consider the patient sustained the injustice of being placed at a greater risk of a fall and subsequent injury. I also consider the complainant experienced the injustice of upset.

55. However, I acknowledge the C IPA's advice that '…*It is not possible to conclude from the evidence…that the fall that [the patient] suffered in hospital had any impact on the overall prognosis…'* I also note and welcome the Trust's comments that it *'…regrets the missed opportunities to complete the appropriate Care Pathway for the Moving and Handling of Patients form when the patient's mobility changed…'* Staff are now aware *'…of the importance of ensuring all patients have a pathway in place if assessment demonstrates this...and/or when prompted by a change in the patient's mobility.'*

ii. Assistance given to and from the commode, including slipper use

56. I note from the nursing records that the patient, while on Ward 8 North usually received the assistance of one member of staff to use the commode. I also note that on 23 November 2019 the nursing records documents *'…Assistance of 1-2 to use the Commode…'* I note the Trust's comments that '…*nursing records indicate that the patient's mobility fluctuated and the patient began to require the assistance of 1 or 2 staff at times…'* and that the patient *'…requested to use the commode at approximately 0640hrs on the morning of 3 December 2019....'* I further note that on review of the staff statements and documentation, the Trust commented that '*only 1 nurse assisted the patient out of bed and was with the patient when she fell…'* I also note the Trust's comments that '…*the patient was not wearing any footwear at the time…'*

57. I note from staff statements that the HCA A said '…*The patient was an assistance of one member of staff..'* and she *'…assisted the patient from sitting in bed to sitting at the side of the bed…'* She explained that she *'…would always ask patients to put their slippers on….*' However, she could not recall why they were not on this time. I note she left the patient on the commode to give her privacy and returned when the patient buzzed. I also note the HCA A said the patient was able to stand up from the commode with her supervision but she did not '…*notice at this time that the floor was wet…'* I note SN B stated that she '*heard the patient and*

HCA A calling out…' and '…*saw the patient was sitting on the floor [HCA A] was supporting her back to protect her head. [HCA A] said, while assisting her from the commode [the patient] had lost her balance and slipped on the floor…[Patient] did not wear the slippers because slippers were sling backs and not safety [sic] to wear...'*

58. I note the N IPA's advice that at the time of the fall *'…The patient was not wearing any footwear… Had a clearly documented falls plan have been in place it would have stated adequate footwear…'* I further note her advice that leaving a patient whilst on commode for privacy would be a small step in achieving the aim of getting the patient back to her baseline prior to discharge ie mobilising around her home with a walking stick. Although the Trust commented that the patient had inappropriate footwear, I note there is no evidence of this within the patient's care plan nor any evidence that the Trust advised the patient or family of the need to provide more appropriate footwear.

59. Given the available evidence I accept that there was one member of staff, HCA A, providing assistance to the patient and this was in line with the patient's requirements at the time. I also accept the N IPA's advice that it was reasonable for HCA A to leave and give the patient privacy whilst using the commode and to supervise her while she stood up. However, I am concerned about the inaccurate information provided to the complainant post fall regarding staff numbers providing assistance at the time of the fall. I will examine this further in paragraphs 89 to 91.

60. I accept the patient was not wearing any slippers at the time of the fall. Although the patient's nursing care plan documents she had suitable footwear I note SN B's suggestion that the patient only had inappropriate slippers and therefore they were not safe to use. I further note the complainant's comments that staff did bring this to the family's attention and alternative footwear had been provided but staff had difficultly fitting them. However, I am clear that if staff found difficultly in fitting any new footwear they should have, in line with the FallSafe Bundle, taken steps to ensure *'…Appropriate footwear is available and in use.'* I consider it a failure that any concerns about the patient's footwear were not documented and raised again with the family which would have allowed them the further opportunity to provide an

alternative for the patient. Further, as the N IPA advised, had a falls plan been in place, ie Falls Safe Bundle, the risk of inappropriate footwear, could have been addressed earlier in the patient's stay. I consider this failure and injustice is addressed in paragraphs 53 to 55 above.

61. I welcome the learning identified by the Trust that staff must assess the suitability of footwear on admission and record same within the nursing documentation and, that family members will '…*be asked to provide alterative footwear if the footwear brought into hospital is unsuitable and unsafe..'* Also, that staff will now '*…maintain presence of 2 staff when a patient's mobility is fluctuating between 1 and 2 staff to ensure safety…'*

iii. Urine on the floor

62. I note the views of the complainant regarding the management of the spillage. I also note the Trust's comments that *'…After using the commode [the patient] was assisted to stand up by one member of staff… unfortunately, there was urine on the floor and as she stood up, she started to slide to the floor….'* I note HCA A stated '…*I didn't notice at this time that the floor was wet, otherwise I would have asked the patient to wait while I dried the floor* …'

I also note SN B stated that it was after assisting the patient back to bed she noticed the floor was wet with urine, and *'Once the patient was on the commode spillage occurred accidently…'*

63. I note the N IPA's advice that it *'…would not be reasonable to turn the bay lights on at 06:30. When a commode is used in the patients bedspace, their individual overhead light can be turned on to give adequate lighting.*' I further note the N IPA's advice *'…the floor was not checked prior to transferring the patient from the commode to the bed…'* and *'…This should have been identified before transferring the patient back to bed…' '…Had a clearly documented falls plan have been in place it would have stated…avoidance of slip hazards*. *The HCA would have been expected to follow this plan.'*

64. I acknowledge both the N IPA's advice, that the spillage should have been identified before the patient transferred from the commode to the bed and, the statement of

HCA A that she did not *'…notice at this time that the floor was wet…'* I accept the Trust has adequate procedures in place to identify and deal with slip hazards and that the level of lighting was acceptable at the time of the fall. However, based on the available evidence I am satisfied that when the patient was getting up from the commode the floor was wet and it was not properly managed. I consider this a failing. As a consequence of this failure I consider the patient sustained the injustice of being placed at a greater risk of a fall and subsequent injury. I also consider the complainant experienced the injustice of upset. I would again refer to the failure identified in paragraphs 53 to 55 to have a FallSafe Bundle which would have assisted in minimising any falls risk.

iv. How patient landed on the floor

65. I note from the clinical records the Assistant Ward Manager documents the patient said she *'…got from the commode and fell with a thump to the floor.'*
I also note the Trust's comments that as the patient *'…started to slip to the floor, staff assisted her lowering to the floor and attempted to ease her fall…. As the member of staff became aware that [the patient] was slipping to the floor, she assisted her to the floor into a seating position…'* I further note the actions of HCA A when the patient started to fall that she *'…assisted in lowering her to the ground,…called for help…. supported the patient as she was sitting on the floor…'* I also note the information that is provided to staff during practical/face to face training about the principles of managing a falling person and the manual handling training records of HCA A and SN B.

66. I note the N IPA'S advice that it was reasonable *'…to supervise the patient whilst she stood up…'* from the commode and that *'…It is considered safer to guide the patient to the floor during a fall rather than attempt to catch or break their fall….'*

67. I acknowledge the divergent accounts of the patient and HCA A as to how the patient landed on the fall and the concerns of the complainant that provision of previously inaccurate information by the Trust reinforced the patient's account of events. As the account of HCA A does not directly address how severely the patient landed on the floor and given the training principles of managing a fall, I accept the patient's account of events. I also wish to highlight that the HCA A has

not had any refresher practical manual handling training since 2014, although I note she completed E learning manual handling training more recently, in April 2019. I would ask the Trust to consider reviewing when all HCAs and ward staff have had practical manual handling training and provide additional practical/face to face training when in a position to do so given current COVID 19 restrictions. I would also ask the Trust to remind staff that any statements provided following an incident should be written as close to the time of the incidents as practicable and contain as much detail as possible.

68. I acknowledge the divergent accounts of the patient and HCA A as to how the patient landed on the fall and the concerns of the complainant that provision of previously inaccurate information by the Trust reinforced the patient's account of events. As the account of HCA A does not directly address how severely the patient landed on the floor and given the training principles of managing a fall I accept the patient's account of events. I also wish to highlight that the HCA A has not had any refresher practical manual handling training since 2014, although I note she completed E learning manual handling training more recently, in April 2019. I would ask the Trust to consider reviewing when all HCAs and ward staff have had practical manual handling training and provide additional practical/face to face training when in a position to do so given current COVID 19 restrictions. I would also ask the Trust to remind staff that any statements provided following an incident should be written as close to the time of the incidents as practicable and contain as much detail as possible.

Moving of patient before doctor assessment

69. The complainant was concerned that nursing staff moved the patient after the fall before a doctor's assessment. I note from the nursing records written at 07:00 following the fall, the patient *'…didn't hit head. One member of staff was with her (HCA) Hoisted into Bed. Checked all over body. No injuries noted. Clinical observations taken…'* I further note SN B's statement that she *'…assessed the patient…[the patient] said she pain in her back and didn't hit her head… Clinical observations taken. Informed the night coordinator…Coordinator informed the medical staff.'*

70. I note the N IPA's advice that the staffs' actions prior to the doctor's assessment actions *'…were in line with national guidance…and were therefore reasonable.'* I further note her advice that *'…the family should be informed after any safety incident…*and '…*The family were informed…however this was not until the afternoon…'* However, I note from the nursing records that both the Deputy Ward Sister and the Assistant Service Manager apologised for this oversight. The incident form documents the reasoning for the oversight and that staff were reminded to contact next of kin regarding incidents.

71. On consideration of the available evidence I accept that it was appropriate for staff to move the patient before a doctor's assessment. Therefore, I do not uphold this element of complaint. I also recognise that staff accepted that the patient's family should have been informed earlier of the incident. I would ask the Trust to provide a further reminder to staff, that next of kin should be informed of incidents as soon as possible after they occur to prevent additional stress to family members.

Use of stedy

72. The complainant raised concerns about the patient's use of the stedy to get to the bathroom later that morning, after her fall. She said that the OT's recommendation to use the stedy was incorrect given that the patient was in a great deal of pain and had difficulty using it. This meant that a hoist was used to help her off the toilet and back to bed. I also note the complainant's views that the advice of the OT IPA provides evidence that the use of the stedy post fall was inappropriate. I note from clinical records that the OT reviewed the patient initially on 28 November 2019 and post fall on 3 and 4 December 2019. I also note that post fall, on 3 December 2019, the OT recommends *'..assx2 + Stedy today…'* I also note the Trust comments that *'…The Occupational Therapist had recommended the Stedy as the safest means of transfer for [the patient] to the bathroom as this time…'* I further note OT A's comments that '*It is likely that I was made aware of the patient's fall earlier that morning via the morning MDT meeting and would have sought clarification prior to mobilisation - this is something that I do as standard practice. For whatever reason, I did not document this…'*

73. I note the OT IPA's advice on the use of the stedy *'In isolation, the decision to utilise a sara stedy for transfers…. appears to be a sound clinical judgement. Choosing to utilise this post fall without any knowledge of the fall and no attention to pain levels stated by the patient is not acceptable…There is no supporting documentation… to support this occurred. The occupational therapist should have been aware of the fall and if the medical entry in the patient's notes was read, this would have occurred. Combining this with complaints of pain,…should have been a red flag to pause and seek clarification. There is nil documentation in the occupational therapy entry that analgesia had been administered prior to the session.'*

74. I note the OT IPA's advice about the OT review of the patient on 3 December 2019 that there was a '…*lack of documentation from the occupational therapist about knowledge of fall and checking for pain relief prior to actively moving the patient…' 'There was no cognitive assessment and there was a query was made around the difficulty to transfer as being behavioural with no assessment to support such findings'* I further note her advice that *'…there was no documentation to state a need for an xray or concern that weight bearing activity may exacerbate the situation. Therefore, it is reasonable to commence a weight bearing activity such as standing (If a patient is struggling with this activity and assistance from 2 persons, then it is reasonable consider the use of a mobility aid…'* I also note her advice that carrying out a weight bearing activity *'…is not something that is not recommended where a suspected fracture is considered…'* and *'…The patient was transferred and completed a weight bearing activity prior to a fracture being identified. It is unknown if this activity impacted on that result...'*

75. I also note the OT IPA's advice that '*The…documentation is not full and evidential of full activities that were completed…The…entry does not support that the occupational therapist checked previous MDT entries prior to commencing occupational therapy treatment. The occupational therapy episode of care in this instance was incomplete and of a substandard level.'* I also note the detail provided by the OT IPA about the poor quality of OT's documentation in paragraph 30 above as well as the learning identified in paragraph in 31.

76. Given the available evidence I accept the OT IPA'S advice that the clinical entries by the OT A, are not '…*full and evidential of full activities that were completed…'* I consider these entries are therefore not in line with the OT Professional Standards which require records to provide a comprehensive, accurate and justifiable account of all that is planned or provided for service users. They also require that evidence and rational for all actions be recorded. I am critical that OT A did not complete records in accordance with these standards. In my view clinical notes should precisely record the dates on which examinations referred to are performed in order to ensure clarity for those clinicians who will later rely on the information that is recorded in the patient's medical record.

77. I am also concerned about the OT IPA's advice that the patient's reports of pain were queried as behavioural with no documented assessment to support these findings. I accept the OT IPA's advice that given the fall and the patient's complaints of pain, clarification should have been sought by OT A before any decision was made to utilise a sara stedy. However, even given the comments of OT A in paragraph 72 above, due to the poor records, I am unable to determine if OT A any sought clarification from clinicians.

78. I should be able to ascertain whether a recommendation made by an OT is supported by a full assessment and consideration all the relevant factors. Due to the poor record keeping I have been unable to do so in this case which I consider a failure. On the balance of the evidence I cannot conclude that it was reasonable for the OT to recommend that the patient use the sara stedy post fall. I also consider the lack of documentation a failure in the patient's care and treatment. As a consequence of this failure I consider the patient sustained the injustice of loss of opportunity to have thorough OT assessments post fall.

79. I also note and welcome the apology of OT A to the family for any distress caused as well as the learning identified by her.

Treatment provided in six hours post fall, including X-ray request

80. The complainant was also concerned that the patient had to request an x-ray to be carried out. She said that even though the patient had complained about being in

pain to medical staff, nothing was done for over six hours. I further note the complainant's disagreement with clinical record that the patient's daughter requested a delay in the x-ray being carried out and her re-iteration that the patient had asked for an x-ray even though no request was documented with the records. I note from clinical records that a post fall assessment was carried out and codeine 30mg was prescribed. After a further medical review at 13:30 a hip and lumbar spine X-ray were requested. I further note that patient initially refused pain relief however 30mg of codeine was administered at 11:35 and 15:35, with a Lidocaine patch placed at 16:00. I also note the Trust's comments that after the fall '…*the medical staff noted [the patient] had some lumbar tenderness but did not feel an X ray was required at that point in time. [The patient] was assessed by the nursing staff during their medication round shortly after 08:00hrs and when carrying clinical observations at 10:30hrs. [The patient] was offered but reluctant to take prescribed analgesia until 11:15 when she took Codeine 30mg. She was reviewed again at 13:10hrs by the medical team. As her lower back remained tender, the medical team ordered X-rays of the back.,,'*

81. I note the C IPA's advice that timing of the medical examination post fall was *'…reasonable… thorough and complete…'* The plan to provide analgesia '…*was adequate.'* I further note the C IPA's advice that '…*There is no record that the patient requested the x-ray…The x-ray was requested the same day when it was found that there was a clinical indication for it. This was appropriate and patient would not have suffered any ill effects from this delay…'* I also note the C IPA's advice that *'Overall the treatment provided…was correct and reasonable…'* On consideration of the evidence, including the complainant's re-iteration that the patient requested an x-ray, I accept the C IPA's advice that the initial medical examination, the prescribing of analgesia, and the timing of the x-ray request were appropriate. Therefore, I do not uphold this element of complaint.

Recording and communicating of accidents

i. Ward Safety Thermometer

82. The complainant raised concerns about how the Trust recorded and communicated accidents and stated that the information on the most recent accident, at the entrance to Ward 8 North, was not kept up to date. I note from the documents the

Trust provided, that at the safety briefings given to staff, following the incident, the patient's fall was highlighted. I further note the Trust's comments about the 'Safety Thermometer' and that it '…*gives information on dates when the last fall occurred.* I also note its comments that falls on Ward 8 N were updated *'…on the Ward 8 South board.'*

83. Given the available evidence I am satisfied that the accident was communicated internally to staff via staff briefings. I acknowledge the Trust's comments that Ward 8 North's falls were recorded on the 8 South board. However, I have no reason to disbelieve the complainant that out of date information was present at the entrance of Ward 8 North. I accept the Safety Thermometer, which provides information to visitors to the Ward, was not updated. I consider this a service failure. However, I do not consider the patient or complainant suffered any injustice as a result. I would ask the Trust to reflect as to how they will ensure such information is kept updated in the future, in particular if both Wards' falls are to be displayed together, so any new information is seen by all visitors. I welcome the Trust's apology in relation to the 'Safety Thermometer' information being out of date at the time of the patient's transfer to MPH.

ii. Internal investigation of fall

84. Concerns about the internal investigation, into the patient's fall, were highlighted by the N IPA and the Trust's response to investigation enquiries.

85. I note from the clinical records that the Assistant Ward Manger advised both the complainant and her sister that *'…that there were 2 nurses assisting [the patient] to the toilet.* I further note the nursing record 3 December 2019 at 07:00, the Trust incident approval form ref W235948, and staff statements also document that one member of staff was with patient. I also note the '*gradings*' given under the various headings on the Datix form as set out at Appendix six to this report.

86. I note the Trust's comments that ' *… Incidents including trips and falls on a ward are recorded on the Trust's Datix Reporting system…This fall was risk graded as "low" with no further internal investigations required to be undertaken at the time..'* I also

note its comments that given orthopaedic advice was sought following the fall*,* *'…staff could have reviewed the risk grading of the incident at that time…'*

87. I note the N IPA's advice that *'The fracture to the patients [sic] spine was a 'moderate' grading and therefore is a reportable incident…Incidents that are moderate risk rating such as this, must be investigated at senior level and an action plan developed.'* I also note the N IPA's comments that '*At the time the report was written by the staff nurse there was thought to be no injury sustained,… however this was not the case and the day after it was determined that the fracture was acute and from the fall… The incident form should have been updated once it was determined that the fall had caused the fracture….'* I further note her comments that the Datix form *'…should not have been signed off until it was updated to reflect that harm to the patient had been caused and actions…were instigated.'*

88. Given the available evidence I am satisfied the Trust completed and signed off an incident form relating to the patient's fall, in line with the timescales within its Incidents Procedure. However, I accept the N IPA's advice that the incident form should have been reviewed and updated once the consequences of the fall were determined or, at the very least, when the form was signed off, on 10 December 2019. I also accept the N IPA's advice that had the incident form been updated, the incident would have had a moderate risk rating and would then have been investigated at senior level and an action plan developed. I acknowledge the Trust also accepts that on reflection the incident should also have been updated. I consider the lack of updating or reviewing the Datix incident form as maladministration. Furthermore, I consider that if such information is not put into "the system" it will adversely affect the commitment of the Trust to encourage the reporting of adverse incidents so that it *'…can learn from incidents and take actions to reduce the risk of reoccurrence'* thereby minimising risks to patients.

89. I also considered the information provided to the complainant and her sister following the patient's fall on 3 December 2019 and in the Trust's letter to the complainant on 14 February 2020. Given the information within the nursing records, Datix form and staff statements, it is clear that information about the numbers of staff assisting the patient to the commode was inaccurate. It is my view this was

because of an inadequate review of the incident by senior staff, either in the days following the fall or after the complainant submitted a written complaint to the Trust.

90. The Third Principle of Good Administration *'Being open and accountable'* requires bodies to ensure that information or advice they provided *'is clear, accurate and complete…'* The Trust's Complaints Policy states complainants should *'…receive open, honest…responses…'* I consider that the inaccurate provision of information to the complainant was not in line with the Trust's Complaints Policy or the Principles of Good Administration. I am satisfied that this constitutes maladministration.

91. I consider as a result of the maladministration identified, the patient and complainant experienced the injustice of loss of opportunity for a more robust incident investigation post fall, reduced opportunity for timely learning and risk reduction and upset. I am also satisfied the failures caused the complainant frustration and time and trouble by bringing a complaint to this office. I can also recognise how this maladministration has also undermined the complainant's trust and confidence in Trust.

92. I note and welcome the Trust's apology for the confusion caused by the differing accounts of the incident between the information that was provided by staff at the time of the event, to the complainant and, initially to this office and the subsequent staff statements.

CONCLUSION

93. I received a complaint about the actions of the Trust in relation to the care and treatment Ward 8 North of BCH provided to the patient on 3 December 2019 including follow-up treatment provided.
94. The investigation of this complaint did not identify failures in the relation to the following matters:
    i. Assistance given to the patient going to and coming off the commode;
    ii. Moving the patient post fall before doctor assessment; and
    iii. Treatment provided post fall including provision of x-ray.

95. However, the investigation established failures in the care and treatment in relation to the following matters:
    i. Inaccuracies in the nursing care plan, dated 19 November 2019
    ii. Review of the care plan on admission to BCH on 21 November 2019;
    iii. Implementation of a FallSafe Bundle;
    iv. Completion of Care Pathway for the Moving and Handling of the patient;
    v. Concerns about the patient's footwear not documented and raised again with the family;
    vi. Management of spillage on floor; and
    vii. Completeness of OT Records.

    I am satisfied that as a result of these failures, the patient sustained the injustice of being placed at a greater risk of a fall and subsequent injury and the loss of opportunity to have thorough OT assessments post fall. I also consider the complainant experienced the injustice of upset.

96. The investigation found the following maladministration:
    i. failure to update or properly review and grade the Datix incident form of the patient's fall;
    ii. Failure to investigate the fall fully; and
    iii. Providing of inaccurate information to the complainant following the fall.

    I am satisfied that as a result of this maladministration, the patient and complainant experienced the injustice of loss of opportunity for a more robust incident investigation post fall, reduced opportunity for timely learning and risk reduction and upset. I am also satisfied the failures caused the complainant frustration and time and trouble by bringing a complaint to this office.

97. The investigation was unable to make conclusions about the recommendation of OT A to use the sara stedy post fall.

Recommendations

98. The Trust apologised for the confusion caused by the differing accounts of the incident between the information that was provided by staff at the time of the event,

to the complainant and, the subsequent staff statements.

99. I recommend within one month of the date of this report:

i. The Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for loss of opportunity upset and distress experienced by the patient and the complainant and, the frustration and time and trouble caused to the complainant as a result of the maladministration and failures in care and treatment identified;

ii. The Trust discusses the findings of this report with the nursing teams, both in RVH and BCH, involved in the patient's care as well as the OT team; and

iii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints, at ward level, of the need to provide accurate information to complainants, and the importance of ensuring all staff involved in the complaint are spoken to, even if this occasionally means responses are delayed

100. I further recommend, for service improvement and to prevent future recurrence, the Trust:

i. Provides evidence that staff on Ward 8 are fully aware of the importance of ensuring all patients have a moving handling and falls plans in place when assessment demonstrates this is required and/or when prompted by a change in the patient's mobility;

ii. Provides evidence that staff now assess the suitability of footwear on admission as well as suitability of any alternatives provided and record same within the nursing documentation and that family are asked to provide suitable alternatives if required;

iii. On Ward 8 North, for patients who have been transferred from other wards or hospitals, carry out a random sampling audit of patient's care plans, to ensure that care plans have been reviewed and mobility/ assistance requirements have been accurately identified, and identify any further learning. Any findings should be reported to this office;

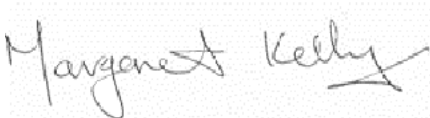
iv. Provides evidence OT A has been reminded of the importance of maintaining comprehensive records which should include evidence and rational for all actions taken. Demonstrate she has reflected on the relevant findings of this

report including how her future practice may be improved. Provide evidence of attendance at Record Keeping Training; and

v. Carry out a random sample of Datix forms, involving fall incidents on Ward 8 North, to ensure incident reports accurately reflect the level of harm sustained by the patient and that there has been an investigation when a patient has sustained harm.

101. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

102. The Trust accepted my findings and recommendations. I also wish to acknowledge the complainant's attentiveness and devotion to the patient's care and treatment when on Ward 8 North.



MARGARET KELLY
Ombudsman **28 March 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.