Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Belfast Health and Social Care Trust

NIPSO Reference: 18500

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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.

TABLE OF CONTENTS

Page

SUMMARY

I received a complaint about the actions of the Belfast Health and Social Care Trust, (the Trust). The complainant's mother fell while on Ward 8 in Belfast City Hospital. The complainant said that the fall should have been prevented and believed it caused her mother's death the next day

I identified failures in care and treatment in relation to the following:

(i) Failure to consider the patient's individual risk factors, including her recent attempt to climb out of bed, confusion, and multiple recent transfers;

(ii) Failure to nurse the patient in high-low bed, set on the lowest setting, with bed rails down; and

(iii) Failure to replace the patient's catheter within a reasonable timeframe after her fall out of bed on the morning of 11 October 2014.

I have also found maladministration in relation to the following matters:

(iv) Failure to properly establish whether the issue of complaint regarding the patient's catheter would be considered as part of the SEA investigation, or as part of the regular complaints handling process; and

(v) Failure to properly consider the patient's attempts to climb out of bed the night before her fall, her transfers, and the use of a high-low bed set in the lowest possible position;

In relation to the failures I have identified in this case, I recommend the Trust issues the complainant with an apology in accordance with the NIPSO guidance on apology. This is in respect of the distress, frustration, uncertainty, and the time and trouble of pursuing her complaint.

THE COMPLAINT

1. The complainant said the Trust failed to prevent her mother's fall while in Ward 8 in Belfast City Hospital. She also complained that her mother (the patient) did not receive proper care following her fall and that these factors caused her death the next day.

Issues of complaint

2. The issues of the complaint which I accepted for investigation were:

Issue 1: Were the appropriate and reasonable steps taken to prevent the patient from falling on the morning of 11 October 2014?

Issue 2: Did the patient receive appropriate care following her fall?

Issue 3: Was there a link between the fall on 11 October 2014 and the patient's death?

Issue 4: Was the SEA report conducted in accordance with proper procedure and were conclusions reasonable?

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

4. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- A Consultant Respiratory Physician with 22 years' experience, including dealing with acute medical emergencies; and
- A Registered General Nurse, BSc (Hons) Nurse Practitioner, MA Health Services Management, Dip. COPD, Dip. Asthma, V300 Non-medical

prescriber. This IPA has 17 years' experience across primary and secondary care.

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

Relevant Standards

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.

8. The general standards are the Ombudsman's Principles[1]:

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

9. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional judgement functions of those organisations and individuals whose actions are the subject of this complaint.

10. The specific standards relevant to this complaint are:

- BHSCT Serious Adverse Incident (SAI) Procedure – April 2014 (The Trust's SAI Procedure)
- HSCB Procedure for the reporting and follow up of Serious Adverse Incidents (April 2010) (The HSCB's SAI Procedure)
- Adult Urinary Catheterisation and Change of Suprapubic Catheter Policy Excluding Women in the Maternity Ward Setting
- Belfast Health and Social Care Trust's Bedrails Risk Balance Tool
- 8 South Safety Briefing

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

- Hospital Transfer of Patients and their Records within the Belfast Trust.
- NICE endorsed clinical guidelines: '*Falls in Older People; assessing risk and prevention*.' (The NICE Guidelines)
- MHRA's December 2013 guidance on the safe use of bed rails (The MHRA Guidance).

11. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

THE INVESTIGATION

Issue 1 Were appropriate and reasonable steps taken to prevent the patient from falling on the morning of 11 October 2014?

Detail of Complaint

12. The complainant believed that proper precautions were not put in place to prevent her mother from falling out of her bed. She queried whether staff had taken appropriate measures to protect her mother and prevent her from falling. She complained that the safety assessment was not properly carried out when her mother was transferred onto Ward C.

Evidence Considered

Relevant Protocols

13. I have reviewed the NICE Guidelines. In particular, I note that NICE CG (section 1.2.2.4) states that falls interventions should:
    - *Promptly address the patient's identified individual risk factors for falling in hospital, and*
    - *Take into account whether the risk factors can be treated, improved, or managed during the patient's extended stay.*

14. I have also reviewed the MHRA Guidance. In particular, section 3.2 'Risk Assessment' which states:

> *'Risk assessments should be carried out before use and then reviewed and recorded after each significant change in the bed occupant's condition, replacement of any part of the equipment combination and regularly during its period of use, according to local policy. It is unlikely that one type of bed and bed rail will be suitable for a wide range of users with different physical sizes and needs.'*

15. According to the MHRA Guidance, the points to consider during a risk assessment include*:*

> *• is the person likely to fall from their bed?*
> *• if so, are bed rails an appropriate solution or could the risk of falling from bed be reduced by means other than bed rails (see section 4.5)?*
> *• if not an appropriate solution, can an alternative method of bed management be used?*
> *• could the use of a bed rail increase risks to the occupant's physical or clinical condition – for example, if an active but disorientated bed occupant tries to climb over it?*

16. Section 4.5 'Alternatives' states '[a]*lternatives to bed rails may be considered, such as:*

> *• 'netting' or mesh bed sides*
> *• ultra 'low height' beds*
> *• positional wedges*
> *• alarm systems to alert carers that a person has moved from their normal position or wants to get out of bed.*
> *• fall mats*

17. I have carefully considered the requirements of this policy in my assessment of the facts relating to the patient' fall.

Trust's Response

18. In its 15 June, 2018 response, the Trust stated that a safety assessment and falls risk assessment were carried out on 9 October while the patient was on

Ward 7C, Royal Victoria Hospital (RVH). The Trust have acknowledged that their SEA investigation revealed that there is no evidence of these assessments being carried out after the patient was transferred to Ward 8 South, Belfast City Hospital.

19. In its October 2018 response, the Trust stated that the patient *'was nursed in Section C of the ward, the closest part of the ward to the nurse's station. Despite no history of fall this area within the ward was deemed the most suitable area for elderly patients as it is in view of the nurses' station'*. The Trust stated that it '*was decided to use bed rails on 8 October following a bed rail risk balance tool assessment as the risk of injury from falling from bed outweighed the risk of bedrails'.*

Clinical Records

20. I have reviewed the Bedrails Risk Balance Tool completed on 8 October 2014. At 16:45 on Ward 7C. It was concluded that the *risk of injury falling from bed outweigh[ed] the risks of bedrails'*. The decision was therefore made to nurse the patient with bedrails in place. I have also reviewed the '*Plan of Care of Patients at risk of Falls'* (Falls assessment) that was completed on 9 October 2014, before the patient was transferred to Belfast City Hospital.

21. The nursing entries at 12.10 pm and 19.00 pm on 9 October 2014 reflect that the patient was *'pleasantly confused'*. After her transfer to Ward 7D, the medical records reflect that on the night of 9 October 2014, the patient, in her confused state, '*attempted to get out of bed herself'.* Earlier, she had gotten out of bed *'with the assistance of two nurses'*. It was noted that the patient could not stand unaided.

22. The records reflect that the patient was transferred to Ward 8 South, Belfast City Hospital at 19:00 pm on 10 October 2014. Her NEWS[2] score was 2. There is no record of 'Falls Risk' or 'Bed Rail' assessments being carried out following the patient' transfer to Ward 8 South at Belfast City Hospital. The next morning

[2] National Early Warning Score: Determines the degree of illness and prompts critical care intervention.

at 6:00am, the nursing notes reflect that the patient was found *'on the floor'* after falling out of bed.

SEA Investigation Findings

23. A Significant Event Audit (SEA) was conducted by the Trust, in part, to review the circumstances surrounding the patient's fall. I have reviewed the SEA report and note that the SEA concluded that '*the patient fell accidentally while trying to get out of bed'*.

24. The SEA identified several 'safe practice points' in relation to the patient fall. In particular, the SEA noted that the patient was nursed in *'the preferred location of acutely unwell patients and patients with a tendency to wander, or suffer from confusion, as they can [be] directly observed by staff'.* As noted above in the Trust's response to enquiries, the SEA could find *'no evidence'* of the safety and mobility and falls risk assessments being carried out upon the patient' arrival to Belfast City Hospital.

Independent Professional Advice (IPA)

25. I have obtained independent professional advice (IPA) from a Registered Nurse Practitioner for the purposes of this investigation. The IPA was asked to comment on whether appropriate steps were taken to prevent the patient from falling out of bed.

26. The IPA advised that the NICE Guidelines *'state that falls interventions should:*

- *Promptly address the patient's identified individual risk factors for falling in hospital and*
- *take into account whether the risk factors can be treated, improved or managed during the patient's expected stay.'*

27. In relation to the particular *'risk factors'* applicable to the patient, the IPA advised that *'[the patient's] main individual risk factors were that she was confused, had reduced mobility, was trying to get out of bed independently and was moved [(transferred)] on two occasions.*' The IPA advised that *'[t]hese risk factors should have been identified and addressed in order to reduce the risk of*

her falling, however these risk factors were not identified on the patient 'Plan of Care for Patients at Risk of Falls'.

28. The IPA explained that *'hospitals are confusing places for people with dementia and interventions aimed at reducing confusion include the reduction of ward transfers (where possible) and also avoiding transfers at night'.* Where transfers cannot be avoided, aspects of the patient's environment that could affect the patient's risk of falling should be *'systemically identified and addressed'.* The IPA noted that the Trust's own policy requires nurses to ensure that *'all appropriate nursing documentation is completed and up to date and accompanies the patient'.* In relation to the patient, the IPA advised that *'when considering her confusion and attempts to climb out of bed on the night before she fell, the use of bed rails should have been reassessed'.* The IPA referenced *'the MHRA Guidelines* which states that *'those at greater risk of harm are patients who are confused, but mobile enough to climb over bedrails, which applies to the patient.'*

29. The IPA advised that because of these risk factors, *'[b]ed rails should not have been used on the patient, rather she should have been nursed in a high-low bed set at the lowest level so that if she successfully got out of bed independently, she would be less likely to suffer any harm'*.

30. The IPA also commented on whether these measures would have prevented the patient from falling out of bed. In referencing the Royal College of Physician's Audit Report 2015, the IPA noted that '*95% of all falls are unwitnessed and research has shown that multiple interventions performed by MDT's and tailored to individual patients can reduce falls by only 20-30%*.' This advice was shared with the Trust who declined to comment.

Analysis and Findings.

31. I have carefully considered this issue of complaint. In particular, the responses provided by the Trust, the relevant protocols, the SEA investigation's findings, and the advice of the Nursing IPA. I have considered the Falls Risk assessment and Safety and Mobility assessment that were carried out on the patient on 8 October 2014.

32. I note that as part of its SEA investigation, the Trust determined that bedrails were up and in place during the patient's time on Ward 8 South. I also note that this decision was taken as a result of these assessments carried out on the patient on 8 October.

33. I note that the Trust's SEA investigation and the Nursing IPA advice arrived at similar conclusions regarding updating the patient' 'safety and mobility' and 'falls risk' assessments. Both the SEA investigation and the Nursing IPA have concluded that these assessments should have been repeated when the patient was transferred to Ward 8 South in the City Hospital. Accordingly, as these issues were appropriately considered as part of the SEA investigation, I have declined to make any finding in addition to the recommendations and conclusions in the SEA report.

34. However, I also note that IPA has identified an additional failing relating to the use of bedrails on the patient bed which was not identified or assessed as part of the SEA investigation. Specifically, the Nursing IPA has concluded that bedrails should not have been used to nurse the patient. According to the Nursing IPA, proper consideration of the patient' individual risk factors within the context of the NICE Guidelines and the MHRA's Guidance, would have demonstrated that the use of bedrails was not appropriate management for the patient. Following her assessments on 8 October 2014, the records and the IPA advice establish that the patient was transferred twice, and was noted to have attempted to get out of bed in her confused state. I have considered the NICE Guidelines, referenced by the Nursing IPA. These guidelines require that care providers *'promptly address the patient's identified individual risk factors for falling in hospital and take into account whether the risk factors can be treated, improved or managed during the patient's expected stay'.* I have further considered the MHRA Guidance on the safe use of bed rails. In particular, section 3.2 'Risk Assessment' which states:

> *'Risk assessments should be carried out before use and then reviewed and recorded after each significant change in the bed occupant's condition, replacement of any part of the equipment combination and regularly during its period of use, according to local policy.*

35. In considering this issue, I note that there is no indication in the medical records, the Trust's response, or the SEA report that the patient's individual risk factors were considered in determining that bedrails should be used. I note that after the decision was made to nurse the patient with bed rails up on 8 October 2014, the patient was moved twice. I further note that after the decision to use bedrails was made, it is documented that the patient attempted to climb out of bed. I note the Nursing IPA's advice that, *'when considering [the patient's] confusion and attempts to climb out of bed on the night before she fell, the use of bed rails should have been reassessed.'* As the decision to use bed rails was never reassessed, these individual risk factors were never considered by the Trust's staff in determining how best to care for the patient.

36. I have carefully considered the IPA's analysis of the NICE Guidelines, which requires assessment of patients' individual risk factors. For the patient, the Nursing IPA has identified that her risk factors were her confusion, her multiple attempts to get out of bed the night before her fall, and the fact that she had been moved to different wards several times within a few days. I note that the medical records and guidelines referenced by the Nursing IPA support her conclusions. I also note that the Trust declined to comment on the advice provided by the IPA.

37. I accept the advice of the IPA that bed rails should not have been used on the patient and that the patient should have been nursed in a '*high-low bed set at the lowest level so that if she successfully got out of bed independently, she would be less likely to suffer any harm'.* In reaching this decision, I have had regard to the NICE Guidelines and the MHRA Guidance which states that *'[r]isk assessments should be carried out before use and then reviewed and recorded after each significant change in the bed occupant's condition, replacement of any part of the equipment combination and regularly during its period of use, according to local policy'.'*

38. Accordingly, I find that the Trust failed to consider the patient' confusion, multiple transfers, and recent history of attempting to climb out of bed as part of its decision to nurse the patient with bed rails instead of ensuring that the patient was nursed in a high-low bed set at the lowest level. I consider this

constitutes a failure in care and treatment. **I therefore uphold this element of complaint.**

39. In relation to the impact these failings had on the patient, I have had regard to the statistical research provided by the IPA. I have noted that the IPA has described research demonstrating that assessments that are *'tailored to individual patients can reduce falls by only 20-30%'*. I accept the statistical evidence provided by the IPA and I am persuaded that had an individualised risk assessment, as described above, been carried out on the patient, this would have reduced her risk of falling by between 20-30%. Accordingly, I find that the patient suffered the injustice of an increased risk of a fall as a result of the Trust's failure to consider all appropriate risk factors in continuing to care for the patient with bedrails in place.

Issue 2: Did the patient receive appropriate care following her fall?

Details of Complaint

40. The complainant said that following her mother's fall, she should have had an x-ray and a brain scan. As the fall was unwitnessed, the complainant states that her mother may have hit her head and without a scan there was no way of knowing if she had sustained any trauma to her brain. Similarly, the complainant believes her mother should have received an x-ray following her fall as she believes there was no way of knowing if she broke any bones without a scan.

41. The complainant also believed her mother should have had her catheter replaced earlier after the fall. As a result of falling out of bed at approximately 06:00, her catheter became dislodged and was not replaced until 16:00.

Medical Records

42. I have reviewed the medical entries following the patient' fall up until the time of her death. The doctor on duty (Doctor A) documented at 06:30 that the patient stated '*she tried to get up to go to the toilet and fell backwards landing on buttocks and lay on left hand side. Denies hitting head, loss of consciousness, chest pain, palpations'.* Dr A also noted that the patient stated she had

'dizziness while trying to get out of bed'. He noted that the patient was *'found at side of bed by nurses. No witnesses to fall.'* He also noted that the patient was *'bright and alert'.* I note that Dr A carried out a physical and neurological examination and noted '*no tenderness over bony prominences except for left greater trochanter*[3]*. Patients states pain also extends up from left femur into lover back'.*

43. I note that no X-ray was ordered following this fall. However, Dr A ordered an ECG[4], took a set of observations, and left instructions that the staff should contact him if the patient deteriorated neurologically. At 09:35 a consultant saw the patient and noted that her breathing had *'improved'* and she was feeling *'not too bad'.* I note that following her fall, the medical records reflect that the staff were planning to discharge the patient.

44. I have also reviewed the incident report that was generated as a result of the patient's fall. This report notes *that 'patient fell out of bed over cot side and was found on the floor'.* In terms of action taken at the time of the incident, the incident report notes *'clinical observations taken. Hospital at night contacted. Dressing applied to skin tear on left arm.'* Dr A also noted that the patient had a glasgow coma score of 14/15 and that she was *'bright and alert'.*

45. I have reviewed the records following the fall. I have noted the entries regarding the patient's catheter. In particular, I have noted that the complainant informed the nurse that a *'[self retaining catheter] had been in for a number of months and was to prevent skin breakdown and increased [shortness of breath] on mobilising from bed'.* I note that the medical records indicate that the patient was re-catheterised at 16:00.

Trust's Response

46. In its 15 June 2018 response to enquiries, the Trust described the steps that were taken by Doctor A who documented that the patient '*stated that she tried to get up to go to the toilet and fell backwards landing on her buttocks and she*

[3] The trochanter is an anatomical portion of the femur near its joint with the hip bone.

[4] An electrocardiogram (ECG) is a test which measures the electrical activity of your heart.

the lay on her left hand side'. The Trust also noted that, as per the medical records, *'the patient denied hitting her head, she did not lose consciousness and denied any chest pain or palpations*'. The Trust's response also noted that the patient *'was found at the side of the bed by nursing staff and there were no witnesses to this fall'*. The patient was documented as being *'bright and alert'* whilst being assessed.

47. The Trust stated that Dr A *'carried out a detailed neurological examination which involved a full body assessment of her power, strength and reflexes'.* The Trust also noted that '*the patient also received a physical examination of her body to establish if she had sustained any cuts or bruises or had any bony* prominences' and that '*the patient stated she had pain extending up from her femur into her lower back'.* The Trust noted that the medical records document that *'[m]easurements of [the patient'] left leg were carried out and there appeared to be no swelling of the left leg nor bruising or external rotation. Bruising was noted to her left and right arm. She had a cut to her upper right arm and this area was steri-stripped'.* Based on this evaluation, the Trust stated there was *'no clinical indication to carry out an X-ray'.*

48. After the patient was evaluated following her fall, the Trust's response also outlined the steps that were taken to monitor her. The Trust noted that clinical observations demonstrated that the patient '*was hemodynamically stable*[5]*'* and that *'the plan of care was to have sitting and lying blood pressure taken to eliminate postural drop*[6]'. The trust further noted that blood pressures were *'conducted 4 hourly until 14:00 hours on 11 October 2014'.* Following her neurological examination, the Trust noted that instructions were given *'to inform medical staff if there was any deterioration'.* The Trust have also noted that a troponin was also carried out '*with the instruction that if this was raised a further troponin level was to be carried out in six hours, to eliminate a cardiac event*'.

49. The Trust have also commented on the replacement of the patient's catheter following her fall. The Trust stated that '*the staff nurse apologised that … that a*

[5] A patient is hemodynamically stable if they show no sign of difficulty with blood circulation.

[6] Postural hypotension: A drop in blood pressure (hypotension) due to a change in body position.

replacement catheter had not yet been inserted and it is documented that a replacement urinary catheter was then inserted and no apparent trauma was noted. The Trust stated also stated that '*[t]he Staff Nurse who spoke to the complainant on 11 October 2014 at 13:00 hrs has documented that she reassured [the complainant] that no trauma had occurred when the urinary catheter had become dislodged. Urinary Catheters are designed such that in the event of the catheter being pulled out the retaining fluid is not released. The catheter is flexible to ensure that no trauma occurs'.*

SEA Investigation

50. The SEA report noted that the patient NEWS Score was 6 at 22:00hrs on the 11th October *'primarily due to a tachycardia of 130 bpm. There is no evidence within the nursing notes of the nurse responsible for the patient alerting medical staff to this matter. Following the NEWS Score of 6 on 11 October, observations were not recorded for another two and a half hours. This is divergent from the recommended clinical response to this NEWS trigger which states that 'increase frequency to a minimum of hourly. Registered nurse to urgently inform the medical team caring for the patient.'* Following the SEA investigation, these matters were further explored with the *'responsible staff nurse'* and a *'separate investigation was carried out in line with the Trust's disciplinary process'.* The Trust have confirmed that the matter was investigated and action was taken in line with the Trust's disciplinary procedures. I note that the SEA did not address the complainant's concerns regarding the catheter becoming dislodged.

IPA Advice

51. The Nursing IPA described the steps that should be taken following a fall of this kind from a nursing perspective. The IPA stated *'[i]n accordance with national guidance, the patient should have had a medical review following her fall.'* The purpose of the assessment is '*not only to assess for injuries'*. The IPA referenced NPSA 2007: 'Slips, Trips and Falls in hospitals' and commented that *'national guidance states that falls can be a sign that the patients' condition has deteriorated further and thus each fall should trigger a review of whether further interventions could reduce the risk of the patient falling again, including medical*

assessment where appropriate.' The Nursing IPA also noted that '*in accordance with good clinical practice, [the patient] should have had her physiological observations recorded and any injuries documented on a body chart.* The Nursing IPA also commented that *'following a fall, the patient's falls care plan should be updated to minimize the risk of further falls.'* In relation to updating the falls care plan, the IPA noted that *'[s]adly, the patient died within 24 hours of sustaining her fall and her care plan was not updated within this timeframe.*

52. Although the Nursing IPA noted that the patient's family were not informed about her fall in a timely manner, the IPA commented that *'the clinical care that the patient received after her fall (physiological observations, identification of injuries and medical review) was in line with national guidance and an incident form was completed.'* In relation to the patient's catheter becoming dislodged, the Nursing IPA has noted that *'the catheter came out at 6.00 am and was not resited until 16:00 pm after [the patient's] daughter raised her concerns.'*

53. The Nursing IPA was asked to comment on the care provided to the patient regarding her catheter. The IPA noted that '*the patient' continence care was not structured because there was no documented rationale for leaving the catheter out, it therefore appears that it was 'overlooked'.* The Nursing IPA emphasised that the patient *'only had her catheter resited due to her daughter's concerns and insistence'.* The Nursing IPA noted that there were two reasons for the patient having a catheter. The first was *'related to shortness of breath on mobilising which was managed by continence pads.'* and *'the risk of skin breakdown due to urinary incontinence was the other rationale for the catheter'.* The Nursing IPA commented that '*in the absence of a documented reason for using continence pads,'* the catheter *'should have been resited sooner'.*

54. The Nursing IPA commented that '*this was a long term catheter that the patient had in place for many months rather than a temporary measure.'* In assessing the impact to the patient as a result of the delay in resiting the catheter, the IPA noted that '*there [was] no evidence of skin damage from the ten hours that the patient was without a catheter.'* I note that the IPA concluded that although

there was a delay in resiting the catheter, *there was no apparent impact [of] the delay'.*

55. Additional IPA advice was obtained from a Respiratory Consultant, who reviewed the evaluation performed by Dr Hutchinson. The Respiratory Consultant IPA noted that Dr A '*thoroughly reviewed'* the patient and *'found the patient complaining of pain in the arm and leg but with no suggestion of a head injury. Formal neurological examination and orthopaedic examination showed no significant injuries and therefore appropriately no further investigation was undertaken at that point, the wound laceration being treated with steri-strips.'* This IPA was asked to comment on whether the assessment by the Foundation 1 doctor (Dr A), who determined that no X-rays or scans were needed, was appropriate. The IPA again noted that *'the patient had a thorough clinical review and appropriate steps were taken'.* The IPA explained that *'[i]n view of the reassuring findings, no further imaging was required and appropriate care was given to the laceration on the arm'.* The IPA was further asked to comment on whether appropriate care was given following the fall. The IPA commented that *'[f]ollowing this event, a consultant ward round was undertaken where the patient was found to be in a stable state and generally clinically improved despite the earlier adverse events. No further assessment was thought necessary at this senior review and a plan was put in place with a view to discharge'.*

Analysis and Findings

56. I have carefully considered this issue of complaint. In particular, the responses provided by the Trust, the relevant protocols, the SEA investigation report, and the Respiratory Consultant IPA's advice. I note that in his analysis, the IPA commented that *'there was physiological deterioration prior to [the patient'] collapse and recognition, escalation and intervention at this stage may have altered her outcome'.* I note that the Trust's SEA has already identified that nursing staff failed to identify that the patient was deteriorating and have dealt with the relevant staff in line with its disciplinary policy and have put appropriate learning in place. Accordingly, as this matter was appropriately considered by the SEA Investigation, I have made no additional findings or recommendations

in relation to this issue. Instead, my investigation has focused on the remaining issues surrounding the patient care after her fall. In particular, I have considered the evaluation performed on the patient after her fall, the decision not to perform an x-ray, and the complaint regarding the patient catheter.

57. I have reviewed the Trust's response, the SEA investigation report, the relevant medical records and the IPA advice regarding the evaluation of the patient after her fall. I have had regard to NPSA 2007: Slips, Trips, and Falls in Hospitals. I have considered the Nursing IPA's description of the steps that should typically be taken following a fall of this kind. In addition to the national guidance, I have also considered the Nursing IPA's advice regarding what constitutes *'good clinical practice'* in this instance. The Nursing IPA noted that *'the patient should have had her physiological observations recorded and any injuries documented on a body chart.'*

58. In considering the medical records, I note that following her fall, the patient was evaluated by Dr A, who documented his evaluation at 06:30. He carried out a neurological evaluation and noted that the patient stated '*she tried to get up to go to the toilet and fell backwards landing on her buttocks and lay on her left hand side*'. I also note that he commented that the patient *'denied hitting her head, loss of consciousness, chest pain, [or] palpations'.* I note that his evaluation showed that the patient was '*bright and alert'* with a Glasgow Coma Score of 14/15. I note that in its response, the Trust have described this as a *'detailed Neurological assessment'.*

59. I have considered the advice of the Respiratory Consultant IPA, who reviewed the assessment of Dr A who carried out the assessment on the patient. This IPA noted that the patient complained of *'pain in the arm and leg, but with no suggestion of a head injury'.* This IPA also noted that *'[f]ormal neurological examination and orthopaedic examination showed no significant injuries'.* In light of these findings, the IPA determined that '*appropriately, no further investigation was undertaken at this point'.* I note that in relation to the decision not to order any radiological studies, such as an x-ray, the Respiratory IPA concluded that *'[i]n view of the reassuring findings, no further imaging was required and appropriate care was given to the laceration on the arm'.*

60. I note that both IPAs commented on the physiological evaluation carried out by Dr A. In relation to identification of the patient injuries and her medical review, the Nursing IPA concluded that *'the clinical care that the patient received after her fall was in line with national guidance'.* The Respiratory Consultant IPA similarly concluded that the patient had *'a thorough clinical review and appropriate steps were taken'.*

61. I accept the advice of both IPAs who agree that the patient received appropriate care immediately following her fall. Based on the advice of the IPAs, I accept the Trust's position that the patient received a *'detailed neurological assessment'.* I accept that not every patient will require imaging in every circumstance after a fall and that this decision should be based on the medical evaluation. As there was no indication that the patient had potentially suffered any break, and the records indicate that she denied hitting her head, I accept the advice of the Respiratory Consultant IPA that there was no indication to carry out any medical imaging following the patient's fall. I therefore consider that the evaluation performed by Dr Aand the decision not to request any medical imaging, was reasonable.

62. However, I also note that the Nursing IPA has advised that *'following a fall, a patient's fall care plan should be updated to minimise the risk of further falls'.* The Nursing IPA also commented that *'national guidance states that falls can be a sign that the patient's condition has deteriorated further and thus each fall should trigger a review of whether further interventions could reduce the risk of the patient falling again, including medical assessment where appropriate'.* By the time the patient passed away on the morning of 12 October 2014, her risk of falling had still not been re-evaluated despite her fall on the morning of 11 October 2014. The Trust's staff were under a continuing obligation to ensure that the patient's risk of falling was appropriately assessed. Her fall on the morning of 11 October 2014 should have trigged a review of her falls risk assessment. Accordingly, I find that the Trust failed to properly reassess the patient's risk of falling after her fall on the morning of 11 October 2014. This constitutes a failure in care and treatment.

63. I have also considered the complaint about the time taken to resite the patient's catheter. I note that the medical records are clear that her catheter became dislodged at the time of her fall, at approximately 06.00. I note that the records also indicate that the catheter was resited at 16.00. The time taken to resite the catheter was approximately ten hours. I have had regard to the entry in the medical record indicating that the catheter was only resited as a result of the complainant informing the nursing staff that it needed to be done. The Nursing IPA was asked to comment on the time taken by the trust to resited the patient's catheter. I have considered the IPA advice on this issue. In particular, I note the IPA commented that '[*the patient's] continence was not structured because there appears to be no documented rationale for leaving the catheter out, it therefore appears that it was 'overlooked'.* I also note the IPA's opinion that the patient '*only had her catheter resited due to her daughter's concerns and insistence.'*

64. I note that the Trust's response and the medical records indicate that the staff nurse apologised to the patient for their oversight. Based on the staff nurse's apology and the IPA advice that *'[i]n the absence of a documented rationale for using continence pads; [the catheter] should have been resited sooner',* I consider that there was an unreasonable delay in resiting the patient's catheter. This constitutes a failure in care and treatment.

65. Having found that there was a delay in resiting the catheter, I have considered the impact of this delay. I have considered the medical records which indicate that the complainant conveyed two reasons for the patient having a urinary catheter. These reasons have also been reflected in the IPA advice. The first was '*related to shortness of breath on mobilising which was managed by continence pads*' and '*the risk of skin breakdown due to urinary incontinence was the other rationale for the catheter*.'

66. I have considered the Trust's response and the medical records noting that the patient did not sustain any trauma as a result of the catheter coming out or being resited. I have also considered the Nursing IPA's advice that *'there is no evidence of skin damage from the ten hours that the patient was without a catheter*.' The IPA concluded that '*there was no apparent impact [of] the delay.'*

67. I accept the IPA's advice that there was no impact as a result of the delay in resiting the catheter. However, I also accept that the complainant was significantly distressed due to the significant delay in resiting the catheter. Accordingly, I find that the patient suffered the injustice of distress and frustration as a result of the Trust's failure to timely resite her catheter as soon as possible following her fall.

68. I consider that after the patient fell she was appropriately assessed by Dr A and that there was no requirement for further scans or x-rays as the complainant believes. However, my investigation noted two areas where the care and treatment of the patient was not to the required standard. First, the patient's catheter should have been resited as soon as possible after the fall; and second, the patient falls risk assessment should have been reviewed after the fall. **I therefore partially uphold this issue of the complaint**. I also note the finding of the SEA investigation that the nursing staff failed to notify the appropriate medical staff and repeat observations every hour when the patient's NEWS Score was 6.

Issue 3 Was there a link between the fall on 11 October 2014 and the patient's death?

Details of Complaint

69. The complainant believed that her mother's fall on 11 October caused or contributed to her death on 12 October. She believed that because her mother passed away less than 24 hours after she fell out of bed and no scans were taken, it is likely that the two events are linked.

Trust's response.

70. In its 15 June 2018 response, the Trust noted that the patient' ECG '*was showing her in Atrial Fibrillation*[7]*.'* The Trust explained that '*[t]here was a PR interval which was prolonged and the medical staff queried 1st degree heart*

[7] An irregular and often rapid heart rate that can increase your risk of heart-related complications.

block and no STEMI[8]. A troponin[9] was also carried out with the instruction that if this was raised a further troponin level was to be carried out in six hours, to eliminate a cardiac event.'

71. The Trust has stated that the coroner was informed of the circumstances surrounding the patient death and was told about the fall. The coroner was satisfied for a death certificate to be issued with the cause of death listed as a myocardial infarction due to severe COPD[10] and Congestive Cardiac Failure (Atrial Fibrillation).

Medical records

72. I have reviewed the relevant medical records. I note that the patient was admitted with *'acute shortness of breath.'* Her medical history was significant for *'non-infective exacerbation COPD',* Atrial Fibrillation *'Congestive Cardiac Failure'* and a *'poor baseline'.*

73. In addition to reviewing the patient's medical history, I have also considered the events leading up to her death on the morning of 12 October 2014. In particular, I note that the patient medical records reflect that at 05.00, she was noted to be *'quite chesty'*, with a respiratory rate of 36, O2 saturation of 90% on 2 litres of Oxygen, and her blood pressure was 76/42. She was also noted to be *'cold and clammy'.* An ECG revealed that the patient was in Atrial Fibrillation with a heart rate of 50-70 beats per minute. At 06.00, the family were informed that the patient had suddenly deteriorated and were asked to attend. At 06:30, it was noted that the registrar had been informed. The medical records reflect that the patient had decreased O2 saturation and blood pressure. The notes indicate that the patient was '*semi-conscious'*, with *'no cardiac output'.* A cardiac arrest was called at which time the family arrived and the patient passed away.

74. The records reflect that the on call consultant spoke with Foundation 2 Doctor (Doctor B) and conveyed that he felt no post mortem was indicated. At 12.35

[8] ST-Elevation Myocardial Infarction (STEMI)

[9] a complex of three regulatory proteins that is integral to muscle contraction in cardiac muscle

[10] Chronic Obstructive Pulmonary Disease

pm Dr B spoke with the Coroner's office who were *'happy for death certificate to be issued: a) myocardial infarction; due to b) Severe COPD'.* A death certificate was issued with a cause of death listed as myocardial infarction due to severe COPD. I note that Doctor B recorded a discussion between her, a Staff Nurse, and the family members. Dr B recorded that the patient's *'respiratory symptoms were improving and that her deterioration overnight was acute occurring over a 30 minute period making a cardiovascular event highly likely given her longstanding respiratory and cardiovascular conditions.'*

SEA Report

75. The SEA report described the circumstances surrounding the patient's death, noting that *'at 6:30 [on] the morning of 12 October [the patient's] condition deteriorated rapidly. The registrar on call has noted that she suffered acute desaturation, was tachypneic[11], in slow AF (Atrial Fibrillation) at 46 bpm just prior to the arrest. [The patient] had also been noted to have been tachycardic[12] during the night and a change in colour and shortness of breath had been noted by the nursing staff… An ECG was carried out and a new T-wave inversion was noted. [She] deteriorated further and a cardiac arrest was called.'* The SEA concluded that the cardiac arrest was called at 6.45 am after CPR had been attempted for 14 minutes. The SEA noted that the family *'believes their mother's death was linked to the fall'.* On this point, the SEA concluded that '[*the patient's] sudden deterioration was acute and was highly likely to be a cardiovascular event such as a myocardial infarction given the patient longstanding respiratory and cardiac conditions.'*

IPA Advice

76. IPA advice was obtained from a Respiratory Consultant regarding the cause of the patient's death. Specifically, this IPA was asked to comment on whether or not her fall the morning before her death was in any way related to her death. I have reviewed the Respiratory Consultant IPA advice on this issue. The IPA has noted that while *'[i]t is understandable that family members would be concerned that the fall would have precipitated the subsequent rapid*

[11] abnormally rapid breathing.

[12] a heart rate that exceeds the normal resting rate.

deterioration in the patient's clinical condition' he did not find *'any evidence of causation of that type'.* This IPA reviewed the relevant medical records and noted that the patient was *'very elderly with complex severe comorbidities'.*

77. The Respiratory Consultant IPA noted that the patient was documented as *'largely bed or chair bound and clearly requiring care very frequently through the day'* and commented that *'[m]ultiple recent hospital admissions would have been an adverse prognostic factor and on this admission the patient's DECAF[13] score was 3'.* The IPA noted that this DECAF score meant that the patient was in *'the higher risk category for death with a predicted mortality of 15.3%'.* The IPA also noted that the patient had suffered a fall in hospital the month prior.

78. The IPA commented that the patient's medication therapy was consistent with a patient who was suffering from severe COPD. These medications included Salbutamol[14] nebulisers, saline[15] nebulisers, Seretide[16] and Tiotropium[17] by inhalation and long term oxygen therapy. The IPA also noted that the patient was taking medications for heart failure including Digoxin and Isosorbide Mononitrate. She was also taking Oramorph[18]. The IPA noted that the patient's medication profile suggested *'longer term palliation in keeping with a patient with end stage COPD whose prognosis was extremely limited.'* In relation to the patient rapid deterioration on the morning of 12 October, the IPA noted that *'On the morning of 12 October, [the patient's] condition severely clinically deteriorated. ECG changes including T wave inversion were noted and her atrial fibrillation slowed before the patient entered an aysystolic[19] cardiac arrest'.*

79. The IPA concluded by stating that based upon his review of the events preceding the patient's death, her clinical condition and medication profile, he

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[13] Predicts in-hospital mortality in acute COPD exacerbation.

[14] Used to relieve symptoms of asthma and COPD

[15] A mixture of sodium chloride in water.

[16] Used in the management of asthma and chronic obstructive pulmonary disease.

[17] Used for maintenance treatment of chronic obstructive pulmonary disease.

[18] Morphine – a pain medication.

[19] The absence of ventricular contractions.

could *'find no evidence that the fall 24 hours preceding the acute deterioration in the patient's clinical state contributed to her demise, there being no causative mechanism'.*

Analysis and Findings.

80. I have carefully considered this issue of complaint. In doing so, I have reviewed the relevant medical evidence and IPA advice outlined above to determine whether the evidence establishes a causal link between the patient's fall and her death approximately 24 hours later. I have analysed the patient's medical history, the circumstances surrounding her fall and the events leading up to her death on the morning of 12 October 2014.

81. In considering the events on the morning of 12 October 2014 preceding her death, I note that the medical records show that the patient deteriorated rapidly in the hours before her death and that an ECG showed that she was in Atrial Fibrillation with *'a heartbeat of 50-70 beats per minute'.* I further note that the patient had decreased 02 saturation and blood pressure at 06.30. The medical records from this time reflect that the patient was *'semi-conscious'* with *'no cardiac output'.* I have considered the SEA report. In particular I note that the SEA records that '*[t]he registrar on call has noted that she suffered acute desaturation, was tachypneic, in slow AF at 46 bpm just prior to the [cardiac] arrest'.*

82. I have had regard to the IPA advice provided by the Respiratory Consultant. This IPA reviewed the medical records, the patient's medications, and SEA report. In considering the IPA's advice, I have had regard to his analysis of the patient's medical history. The Respiratory Consultant IPA commented that the patient's medications and medical history were suggestive of *'longer term palliation in keeping with a patient with end stage COPD whose prognosis was extremely limited.'* I note that the patient medical records indicate that she was *'admitted with acute [shortness of breath]'* and that she had a *'poor baseline',* with a history of *'non-infective exacerbation COPD.'* I have also considered the patient death certificate, which records a cause of death as myocardial infarction due to COPD.

83. Although I note and accept the advice of the IPA that '*it is understandable that family members would be concerned that the fall would have precipitated the subsequent rapid deterioration in the patient's clinical* condition', I also accept the IPA's conclusion that there is no '*evidence of causation of that type'.* I accept the advice of the IPA who noted that the patient was *'very elderly with complex severe comorbidities'*. I am persuaded by the IPA's analysis of the records and his conclusion that *'there is no evidence to suggest that [the patient's] fall had any relationship to her subsequent demise'.* I accept the IPA's analysis that *'the patient was an elderly person with multiple comorbidities conferring a very poor prognosis in any circumstance.'* In support of this analysis, I note that the patient' is documented in the medical records as having a history of COPD and was taking medications for heart failure. Based on his review of the medical records, the IPA also concluded that the patient's medical history was significant for a history of severe exacerbation COPD and also determined that the patient suffered a myocardial infarction. This analysis is consistent with the cause of death as noted on the death certificate.

84. I am persuaded that there is no evidence in the medical records, the SEA report, or the IPA advice that suggests any causal connection between the patient's fall and her death. Accordingly, based upon my consideration of the medical records and the IPA advice, I have not established a link between the patient's fall on the morning of 12 October 2014 and her subsequent death. **I therefore do not uphold this issue of complaint.**

Issue 4: Was the SEA conducted in accordance with proper procedure and were the conclusions justified?

Details of Complaint

85. The complainant said that the SEA investigation did not properly evaluate the circumstances surrounding her mother's fall. She disagreed with SEA report's conclusion that the bed rails were up and in place and that her mother's fall was not related to her death. She also complained that the SEA investigation failed to consider or review the circumstances surrounding her mother's catheter becoming dislodged. She has also complained that no apology was ever received from the Trust regarding the failings identified in the SEA report.

86. In considering this issue of complaint, I have had regard to the procedures used by the Trust for conducting its SEA inquiry. In particular, I have considered whether the Trust properly consulted with the patient's family about the issues to be investigated as part of the SEA. I have also considered whether the SEA panel consisted of the appropriate personnel, and whether the Trust's conclusions were reasonable and based upon a proper analysis.

87. I note that the SEA's analysis and conclusions regarding the cause of the patient's death, were addressed previously in this report. The remaining conclusions and recommendations within the SEA report are discussed under this issue of complaint. In particular, I have considered the complainant's concerns about how her mother's fall occurred and whether there was any impact as a result of her mother's catheter coming out. I have also considered the SEA's recommendations regarding the failure to properly reassess the patient's risk of falling and the failure to escalate her NEWS score on the night before her death.

Trust's Response to Enquiries.

88. The Trust have stated that the SEA was carried out in accordance with SEA guidance. The Trust noted that *'in addition to several phone calls, [the] Service Manager for Medicine, Mr […] and [the] Sister in Charge of Ward 8 South, met with the complainant on up to five occasions to discuss the patient's admission and details leading up to her death.'* I note that the Trust have stated that it was *'open and transparent in all aspects of the patient' care and at each meeting […] apologised most sincerely for the distress caused to the complainant and her siblings as a result of any failings in the Trust's care.*' The Trust also stated that it *'would be happy to provide the complainant with a further apology in writing.'*

SEA Report

89. As part of my investigation, I have considered Section 5.4 of the *'*SAI Procedure, which provides guidance for the Involvement of relatives in investigations. Pursuant to this Procedure, *'it is important that teams involved in investigations … ensure sensitivity to the needs of [relatives] involved in the incident and agree appropriate communication arrangements where appropriate. The investigation team should provide an opportunity for [relatives] to contribute as is felt*

necessary.' The level of involvement should depend on the nature of the incident and the relatives' wishes to be involved. Section 6.1 sets out the timescales for completing an SEA and states that *'SEA reports must be completed using the SEA template and submitted to the HSCB within 4 weeks (6 weeks be exception) of the SAI being notified'.* The SAI Procedure also states that *'the Investigation Team should be multidisciplinary and should have an independent chair. The degree of independence of the membership of the team needs careful consideration and depends on the severity/sensitivity of the incident and the level of investigation to be undertaken. However, best practice would also indicate that investigation/review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice'.*

90. I have also considered Section 7.1 of the SAI Procedure which provides guidance for SAI investigations that overlap with the Complaints Handling Process. This section states that in instances where there is both and SAI and a complaint, *'the relevant HSC organization must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI investigation and there may be aspects of the complaint which will not be part of the SAI investigation and can only be investigated under the Complaints Procedure. It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to an SAI investigation. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organization investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated…'*

91. Section 8.0 of the SAI Procedure states that *'[t]he key aim of this procedure is to improve services and reduce the risk of incident recurrence…'* Appendix 5 of the SAI Procedure provides guidance for completing the SEA form. Under the section '*What Happened?'* the form advises '[d]escribe in detailed chronological order what actually happened…' Under the section '*Why did it happen?'* the form

states '*Describe the main and underlying reasons contributing to why the event happened…'*

SEA Investigation and Report

92. The complaint was received on 30 October 2014. On this day, the complainant met with representatives from the Trust. On 3 December 2014, the Trust wrote to the complainant indicating that an SEA was to be conducted regarding the issues raised in her complaint. I refer to the Trust's letter to the complainant dated 11 March 2015, indicating that the Trust's investigation had been concluded and apologised that it had been a lengthy process. However, following the conclusion of the investigation, additional issues were noted by the SEA members that required investigation. I refer to a letter on 3 April 2015, which notes that *'[r]egrettably, when writing the details of our SEA notes into the report, I came across something that to my recollection we may not have noticed during the SEA meeting'.* It went on to describe how the patient's NEWS Scores were not properly recorded and her condition was not properly escalated. For this reason, the decision was made to reconvene the SEA.

93. I refer to an email on 22 July 2015. I note that this email indicates that he spoke with the complainant and *'apologised unreservedly for the length of time that it has taken to get the investigation around her mother's death completed and that it is indeed ongoing'.* It indicated that he *'went over the issues within the complaint with the complainant to provide some details on what the investigation had revealed.'*

94. The SEA Investigation was chaired by the Associate Medical Director for Acute/Unscheduled Care). Also present were the Assistant Service Manager, Medicine, a Consultant Physician, the Governance and Quality Manager, Acute and Unscheduled Care, and a Sister. The SEA report was sent to the complainant on 14 September 2015. The Terms of Reference were noted as follows:

- *To carry out an investigation […] using National Patient Safety Agency validated methodology.*
- *To use a team approach to the review.*

- *To examine the complete episode of the incident including the management of the circumstances preceding, during and following the incident.*
- *To identify how the incident was initially managed by the multi-professional team and how it was subsequently managed.*
- *To highlight any areas of good practice.*
- *To highlight learning points and to make appropriate recommendations to reduce the risk of a similar occurrence.*
- *To report the findings and recommendations of the review to the patient's family, senior staff and the Health and Social Care Board.*

95. I note that the SEA's '*What Happened?'* section has detailed the events surrounding the patient's fall and subsequent death. I also note that this section outlined the questions the patient's family wanted to be answered. In relation to the issues of the complainant's complaint, the relevant questions were:

    - When did the patient fall?
    - How did it happen? the complainant believes this happened after visiting on Friday night after visiting (10th October)
    - Did the catheter come out at the time of the fall.

96. The SEA also noted that '*[t]he family believes their mother's death was linked to the fall'.* The SEA concluded that '*following examination of the nursing and medical notes and direct accounts form the nursing staff on duty' …* '*the patient fell accidentally whilst trying to get out of bed.'* The SEA also found that *'bed rails were in place following completion of a 'Bed rails risk balance tool.'* In relation to the patient's cause of death, the SEA found that *'the patient's sudden deterioration was acute and was highly likely to be a cardio-vascular event such as a myocardial infarction given the patient' longstanding Respiratory and Cardiac Conditions.'*

97. There were seven recommendations following the completion of the SEA investigation. Notably, the investigation found that '*following the NEWS score of 6 on the 11th October, observations were not recorded for another two and a*

half hours. This is divergent from the recommended clinical response to this NEWS trigger' and recommended following up with the relevant nursing staff about this issue. Other recommendations were implemented following the completion of the SEA investigation. NEWS scores are audited by Ward Sisters and by independent staff and all staff attended NEWS training with Certificates available on the ward. The Trust also confirmed that falls and all audits are discussed at monthly ward meetings and the Ward has commenced 'End of Bed' handovers and the Ward Safety Brief is discussed at the beginning of each shift to alert all staff to any patients at risk of falls.

98. A meeting was held on 21 October 2015 between the patient's family and the SEA investigation team to discuss the SEA findings. With reference to the issues raised by the complainant about her mother's catheter the minutes record as follows:

Point 11 – What happened to the Catheter when the patient fell.

- *[…] explained that her mother's catheter would have been attached to the other side of the bed and she wanted to know what happened when her mother fell.*
- *[…] explained that at the time of the fall the catheter would have pulled out however as there is a safety device the patient would not have experienced any pain.*
- *It was also explained that there is now a safety briefing every morning and evening and families are informed if a family member has had a fall.*

99. Following the SEA, the Trust have confirmed that it has dealt with the relevant staff who failed to escalate the patient's deteriorating conditions in line with its disciplinary policy and have completed reflections for their own portfolios in relation to this incident.

IPA Advice

100. Nursing IPA was requested to review the SEA analysis, and conclusions and recommendations. The Nursing IPA reviewed the medical records and gave her opinion on the conclusions and recommendations reached by the SEA. The

Nursing IPA stated that although *'there is no evidence within the medical and nursing documentation to demonstrate that bed rails were up when the patient had her unwitnessed fall, it is documented on the incident form.*

101. In relation to the SEA's conclusions, the Nursing IPA noted that *'[t]he Trust appear to support the use of bedrails (pg 5). The SEA should have identified that the patient had been attempting to climb out of bed the night before her fall and that bedrails were no longer appropriate for her'*. The Nursing IPA also reviewed the SEA recommendations and noted that *'the SEA did identify that the patient's NEWS Score was not repeated in a timely manner on the evening of 11 October 2014 (it was repeated after two and a half hours rather than one hour which is expected in line with local policy). However, this was not a ward-wide issue and thus the service improvements already identified [in the SEA] are reasonable'.* The Nursing IPA also noted that in relation to fall prevention, *'the SEA's service improvements are reasonable (points 3, 4 and 5). However, the Trust should ensure that falls care plans are completed and updated by ward staff. This can be achieved through senior nurse auditing of documentation'.*

Analysis and Findings

102. In considering this issue of complaint, I have had regard to the HSCB's SAI Procedure. In considering whether appropriate personnel were consulted to carry out the SEA. I note that the policy requires that the SEA be chaired by someone from *'outside the service area'* and otherwise be made up of a local multidisciplinary team. The SEA was chaired by a consultant in elderly care and the SEA team members consisted of an Assistant Service Manager, a consultant in respiratory medicine a Ward Sister and a Governance and Quality Manager. I am satisfied that the selected members of the SEA team and chairperson were consistent with the Trust's SEA protocol.

103. In relation to the timescale to complete the SEA, The Trust has acknowledged and apologised that it took much longer than 4 weeks, which was required by the Trust's policy. The Trust indicated in its apology that this was due to difficulty in scheduling meetings with the staff involved in the SEA. I also note

that the Trust had to reconvene the SEA panel for the purpose of investigating the failure to properly monitor the patient the night before her death, as this issue only came to light while the SEA report was initially being drafted. I acknowledge that the SEA process was delayed well beyond the Trust's target, however I note that the Trust has provided valid reasons for this delay and has apologised for the unacceptably long time that it took to complete the SEA.

104. I note that section 7.1 addresses the overlap between an SEA and the complaints process. This section states that *'the relevant HSC organization must be clear as to how the issues of complaint will be investigated*.' This policy states that it is '*important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to an SAI investigation. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner'.*

105. I note that on multiple occasions the patient's family queried what had happened when their mother's catheter came out, and whether she had suffered any injury as a result. Despite the SEA referencing this issue as one of the questions that the patient's family wanted to be answered, and although the catheter issue was addressed as part of the SEA follow up meeting, I note that there was no discussion of this issue within the SEA report itself, indicating that this issue was not assessed by the SEA panel.

106. The Third and Fifth Principles of Good Administration, 'Being Open and Accountable' and 'Putting Things Right' require a public service provider to '*acknowledge mistakes and apologise where appropriate'*, be *'open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete',* and to *'operate an effective complaints procedure'.* I find that the Trust's SEA inquiry failed to properly address the patient's family's concerns about their mother's catheter coming out at the time of her fall. I consider that this constitutes maladministration.

107. I note that although the complainant received an apology from the nurse on the ward on the day of the fall, no formal apology or explanation were ever offered

by the Trust for the failure to replace the catheter promptly after the fall. However, I note that the Trust have stated that they would be '*happy to provide a further apology to the complainant in writing'.* I agree that the Trust should issue such an apology.

108. In reviewing the Trust's SEA's conclusions and recommendations, I have considered whether the Trust's conclusions were reasonable, I have had regard to the IPA advice provided by the Nursing and Respiratory Consultant IPAs. I note that the complainant disagreed with the Trust's conclusion that the bedrails on her mother's bed were up at the time of the fall and that her mother crawled out though a gap at the bottom of the bed. As discussed in Issue 1, I have accepted the advice of the Nursing IPA that although *'there is no evidence within the medical and nursing documentation to demonstrate that bedrails were up when the patient had her unwitnessed fall, it is documented on the incident form.'* Based on the contemporaneous records, including the incident form, I am satisfied that the bedrails were in place. I am unable to conclude whether the patient climbed over the bedrails or through the gap at the bottom of the bed. I consider that based on the patient's injuries, it was reasonable for the Trust to conclude that she exited through the gap between the end of the bedrails and the bottom of the bed. However, as identified in Issue 1 above, the key consideration regarding the patient's fall was the Trust's failure to appreciate that she should have been nursed in a '*high-low bed set at the lowest level so that if she successfully got out of bed independently, she would be less likely to suffer any harm.'*

109. I have also reviewed the recommendations from the SEA inquiry. I note that while the SEA report concluded that bed rails were up and in place, the SEA did not make any recommendation on whether this was appropriate care for the patient. I also note that the SEA failed to discuss or recommend the use of a high-low bed set at the lowest height as part of its conclusions and recommendations. I have considered the Nursing IPA's analysis of the SEA investigation. In particular, I note the Nursing IPA noted that *'[w]ith regards to the SEA, the Trust appear to support the use of bedrails (page 5). The SEA should have identified that the patient had been attempting to climb out of bed*

the night before her fall and that the bedrails were no longer appropriate for her'. I note that this advice was shared with the Trust who declined to comment.

110. I have considered Section 8.0 of the Trust's policy regarding the SEA which states that *'[t]he key aim of this procedure is to improve services and reduce the risk of incident recurrence…'* I have also considered the guidance for completing the SEA form, which requires that this section *'describe the main and underlying reasons contributing to why the event happened…'*

111. Having reviewed the SEA report. I note that the IPA is correct that the report did not record that the patient had attempted to climb out of bed the night before her fall, as documented in the medical records. Having considered the IPA advice and the policies and procedures governing the SEA inquiry, I find the Trust ought to have noted this fact and discussed its significance as part of the SEA inquiry.

112. The First and Sixth Principles of Good Administration, 'getting it right' and 'seeking continuous improvement' require a public service provider to take '*reasonable decisions, based on all the available evidence'* and to ensure '*that the public body learns lessons from complaints and uses these to improve services and performance*.' As the SEA inquiry failed to properly consider the patient's attempts to climb out of bed the night before her fall, her multiple transfers, and the use of a high-low bed set in the lowest possible position, the Trust has failed to take the adequate and necessary steps to *'improve services and reduce the risk of incident occurrence.'* This failed to meet the requirements of the First and Sixth Principles of Good Administration. I consider that this constitutes maladministration.

113. I have also noted the SEA's conclusions and recommendations in relation to the Trust's admitted failure to properly monitor the patient' NEWS Score. I commend the review team for identifying this issue and the improvements put in place by the Trust to address the issues identified by the SEA. The Trust has advised that NEWS scores are now audited by Ward Sisters and by independent staff. All staff attended NEWS training and Certificates are now

available on the ward. The Trust also confirmed that falls and all audits are discussed at monthly ward meetings and the Ward has commenced 'End of Bed' handovers and the Ward Safety Brief is discussed at the beginning of each shift to alert all staff to any patients at risk of falls. I also note that the Nursing IPA concluded that '*the SEA did identify that the patient' NEWS Score was not repeated in a timely manner on the evening of 11 October 2014 (it was repeated after two and a half hours rather than one hour which is expected in line with local policy). However, this was not a ward-wide issue and thus the service improvements already identified [in the SEA] are reasonable'.* I accept the IPA's advice that the recommendations identified by the Trust regarding the staff failures are reasonable. These failures were not *'a ward-wide issue'* and I note that the Trust' SEA has acknowledged several failings on the part of the nursing staff who were monitoring the patient on the evening before her death and have taken disciplinary proceedings against those staff. Accordingly, I find that the SEA's recommendations regarding the failure to properly escalate the patient' NEWS score are reasonable.

114. I further note that the Trust's SEA identified that the patient's fall risk assessment and orientation was not properly completed and has implemented learning on these points. The Trust have provided me with evidence of this learning which was reviewed by the IPA. I note that the IPA concluded that '*the SEA's service improvements are reasonable (points 3, 4 and 5). However, the Trust should ensure that falls care plans are completed and updated by ward staff. This can be achieved through senior nurse auditing of documentation'.* I accept the advice of the IPA that the recommendations provided for in the Trust's SEA report are reasonable and note that the Trust have confirmed that ward sisters and independent staff audit the NEWS scores. I further note the Respiratory Consultant IPA's comments regarding the DNACPR order and note that this issue was discussed at the Trust's meeting with the patient's family on 21 October 2015. Accordingly, I find that the SEA's recommended service improvements to falls risk assessments and care plans are reasonable.

Comments Received Regarding the Draft Report.

115. The Investigating Officer met with the complainant to discuss the draft report. She expressed her gratitude to NIPSO for the investigation. She expressed her appreciation for the findings that bed rails should not have been used and the steps that could have been taken to prevent the fall. She was also satisfied about the findings in relation to the catheter. She explained that she was still upset that the Trust had not informed her about her mother falling earlier and had not determined how the fall had occurred, but acknowledged the Trust had apologised for this.

116. Although she acknowledged the IPA advice was clear, the complainant expressed that she will never stop believing the fall caused her mother's death. She understood the IPA findings, but she thinks her mother was in shock after that and that's what caused her to die.

117. The Trust accepted the findings in the report.

CONCLUSION

118. The complainant submitted a complaint to me about the actions of the Trust in relation to the care and treatment provided to her mother. She complained about the Trust's failure to take appropriate steps to prevent her mother from falling out of bed on the morning of 11 October 2014 and also believed that her mother's death was linked to her fall out of bed the day before. She also queried the conclusions and recommendations of the SEA.

119. I have investigated the complaint and have found a failure in care and treatment in relation to the following:

(vi) Failure to consider the patient's individual risk factors, including her recent attempt to climb out of bed, confusion, and multiple recent transfers;

(vii) Failure to nurse the patient in high-low bed, set on the lowest setting, with bed rails down; and

(viii) Failure to replace the patient's catheter within a reasonable timeframe after her fall out of bed on the morning of 11 October 2014.

120. I am satisfied that the failures in care and treatment that I have identified caused the patient to experience the injustice of pain, anxiety and distress.

121. I have also investigated the Trust's SEA investigation and have found maladministration in relation to the following matters:

(ix) Failure to properly establish whether the issue of complaint regarding the patient's catheter would be considered as part of the SEA investigation, or as part of the regular complaints handling process; and

(x) Failure to properly consider the patient's attempts to climb out of bed the night before her fall, her transfers, and the use of a high-low bed set in the lowest possible position;

122. I am satisfied that the maladministration I have identified caused the complainant to experience the injustice of distress, frustration, uncertainty, and the time and trouble of pursuing her complaint.

Recommendations

123. I recommend that the Trust:

(i) Issues the complainant with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified, and should be issued within **one month** of the date of my final report.

124. I welcome the fact that as a result of the SEA inquiry, the Trust has already implemented steps to ensure that patients are appropriately reassessed, including '*a facility within new nursing documentation booklet to enable staff to re-evaluate the 'fall assessment'*. As part of its FallSafe project, the Trust have also implemented learning requiring reassessment of patients to risk of falls. In relation to the FallSafe project, the nursing IPA commented that *'the SEA's recommendations are reasonable… However the Trust should ensure that falls care plans are completed and updated by Ward staff. This can be achieved through senior nurse auditing of documentation.'* The Trust have confirmed that

monthly falls audits are completed on the ward and have also confirmed that NEWS scores are audited both by Ward Sisters and independent staff. All staff attend NEWS training, and the nursing staff responsible for failing to escalate the patient's deterioration the night before her death have been appropriately disciplined. I am satisfied by the measures adopted by the Trust to address the issues identified in the SEA.

Paul McFadden
Acting Ombudsman **10 March 2020**

APPENDIX ONE

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.