Scottish Parliament Region: Glasgow

Case 200500778: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospitals; Care of the Elderly/clinical treatment

Overview

The complaint concerned whether it was appropriate for a patient (Mr C) to be left sitting in a chair unattended in view of his medical condition and as a result he sustained a fall. The complainant was also concerned that it was the patient who advised her that a fall had occurred, rather than nursing or medical staff.

Specific complaints and conclusions

The complaints which have been investigated are:

(a) that Mr C should not have been sitting out of bed *(upheld);*

(b) that there was inadequate communication with Mr C's family regarding the fall *(upheld);*

(c) whether Mr C should have been put back to bed following the fall *(upheld);* and

(d) whether the nursing assessment, care planning and documentation was inadequate *(upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) remind staff of their responsibilities to assess patients who have fallen, for potential injuries, before moving them to an appropriate and safe place;

(ii) audit the use and effectiveness of the Cannard Risk Assessment Form and Falls Care Plan; and

(iii) review the nursing documentation within the Generic Integrated Care Pathway (ICP) for the Older Person, to ensure that nursing assessments and care plans are visible and reflect the requirements of the NMC Code of Professional Conduct.

Main Investigation Report

Introduction

1. On 14 June 2005 the Ombudsman received a complaint from a woman (Mrs C) about the circumstances which led to her late husband (Mr C) falling from a chair, while in Ward 57 of the Southern General Hospital, Glasgow (SGH) on 16 October 2004.

2. The complaints from Mrs C which I have investigated are:

(a) Mr C should not have been sitting out of bed on 16 October 2004; and

(b) there was inadequate communication with Mr C's family regarding the fall.

When commenting on the complaint, the adviser raised the following additional issues:

(c) whether Mr C should have been put back to bed following the fall; and

(d) whether the nursing assessment, care planning and documentation was inadequate.

Medical Background to the Complaint

3. Mr C, a 74 year old gentleman, was referred by his GP to the Accident and Emergency Department at SGH with a chest infection on 13 October 2004. He had been suffering with a cough for which the GP had prescribed antibiotics without improvement. He had become confused and was reported to have visual hallucinations. Mr C was reported to have been mobilising without aids; during the previous 48 hours his mobility had reduced; he was struggling with activities of daily living; had needed help to transfer; and was also reported to have fallen at home. His medical records show that he had had a couple of falls and his balance was impaired in 2004. Mr C was known to suffer from Parkinson's disease, Bronchial Cancer and Bronchiectasis. He was receiving medication for his Parkinson's disease but prior to admission the records show he had not been complying fully with his medication regime recently.

4. On admission, he was found to be frail and confused with obvious weight loss. He was pyrexial and paracetamol was administered to reduce his temperature. He was diagnosed with a chest infection and a chest x-ray was requested. Mr C was transferred from Accident and Emergency to Ward S20. On

admission, his vital signs were within normal limits and his pyrexia had subsided. A nursing profile was carried out, including an assessment of his activities of daily living, and a care plan completed. The profile, whilst brief, identified that Mr C was at risk of falls; cot sides were required; he was confused; had a poor appetite; required assistance with his personal hygiene; and was at risk of developing pressure ulcers.

5. On 14 October 2004 Mr C was seen by medical staff. He was dehydrated and had been vomiting. He was commenced on intravenous fluids and antibiotics. He was also seen by the Speech and Language Therapist for a swallowing assessment and a Physiotherapist for chest physiotherapy. His temperature was raised at 13:30. Later that day (21:00), Mr C was transferred to Ward 57, an assessment ward, and an ICP (Integrated Care Pathway) for the Older Person commenced. The ICP included an initial assessment undertaken by a nurse and, as Mr C had had previous falls, a falls risk assessment was ticked to indicate that this had been completed. The nurse undertaking the assessment identified Mr C as being at low risk of falling and completed a falls care plan.

6. On 15 October 2004, the nursing records in the form of a daily checklist indicated that Mr C was satisfied with the care received on the early shift and that all the activities of daily living had been met, with the exception of breathing and pain which had been marked as not applicable. Mr C was reported to be using urinals in bed and was quite lucid. Intravenous fluids and antibiotics continued. He was assessed by the Physiotherapist, who recorded that Mr C was 'feeling awful' and weaker. As Mr C was unable to manage his own secretions, the Physiotherapist (with Mr C's agreement) attempted to remove these by suction. The Speech and Language Therapist reviewed Mr C's swallowing ability and advised diet and fluids to be given with care.

7. On 16 October 2004 at 14:30 Mr C was found lying on his back on the floor. His vital signs were normal but he complained of pain in his left hip. He was assisted back into his chair and medical assistance sought. The on-call doctor (Doctor 1) saw Mr C at 15:10, at which time he was sitting in his chair. The records show that Mr C informed Doctor 1 that he had got up by himself to go to the toilet and tripped. He had landed on his left side and had been unable to bear weight following the fall, due to pain. During this time, Doctor 1 spoke to Mr C's son and

Mrs C (who had arrived at the normal ward visiting time) and they discussed his fall in the ward and that an x-ray would be taken to exclude a fracture. The records show that Mr C was then put back to bed to facilitate examination by Doctor 1, who found Mr C's left leg to be externally rotated with reduced range of movement due to pain. At 17:10 Mr C returned from x-ray and an intertrochanteric fractured neck of the left femur was identified. Doctor 1 discussed treatment with the Orthopaedic Specialist Registrar and it was agreed to transfer Mr C to Ward 2 (orthopaedic) later that evening. Doctor 1 contacted Mrs C to explain the diagnosis and future plans.

8. Mr C was transferred to Ward 2 and on 3 November 2004, to the Hip Fracture Unit. Sadly, his condition deteriorated and he died on 13 December 2004.

9. Mrs C complained to Greater Glasgow and Clyde NHS Board (the Board) on 21 October 2004. A response was issued on 19 November 2004 which did not resolve the complaint and Mrs C was offered a meeting with senior nursing staff on 27 April 2005. Mrs C attended the meeting and received a further written response from the Board on 17 May 2005 but some issues remained unresolved and she complained to the Ombudsman on 9 June 2005.

Investigation

10. The investigation of this complaint has involved reading all the documentation supplied by Mrs C; Mr C's clinical records and the complaints file. Two professional nursing advisers (the advisers) were appointed to advise me on the clinical issues of the complaint. Interviews were conducted with Mrs C, a senior nurse and a ward sister. It was not possible to interview the sister for Ward 57. I set out my findings of fact and my conclusions for each of the heads of Mrs C's complaint. Where appropriate, the Ombudsman's recommendations are set out at the end of the sections dealing with individual heads of complaint. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. A glossary of medical terms used appears at Annex 2. Mrs C and the Board have had the opportunity to comment on the draft investigation report.

(a) Mr C should not have been sitting out of bed

11. Mrs C said that her husband had been admitted to hospital because of chest

problems and confusion. Prior to the admission, her husband had been able to sit in a chair which had been supplied by a specialist firm through the Social Work Department. He needed to be watched constantly and had to be propped up to keep him leaning over to one side. She did not think he would have been capable of using a call buzzer to attract assistance.

12. The Board commented that it was thought Mr C had tried to walk unaided with his Intravenous Infusion (Drip) Stand. No staff had witnessed the fall and a patient within the same bedded area had pressed the nurse call system to summon help. It was not possible to offer one-to-one nursing observation or supervision and it is not hospital policy to restrain patients in a chair.

13. The adviser commented that Mr C suffered from Parkinson's disease and had Bronchial Cancer and Bronchiectasis. On 16 October 2004 he had been in hospital for two full days, was receiving treatment and had been assessed by the multidisciplinary team. Loss of balance and falling can be common features in Parkinson's disease, caused by many factors including physical problems, effects of medication and hazards. While not all patients with Parkinson's disease will experience falls, those who do fall are more likely to suffer further falls. Although there is no way that falls can be totally prevented, there are some precautions that can be taken to reduce the risk of falls occurring, including appropriate observation, access to a nurse call bell and ensuring a safe environment free from hazards. Keeping a patient in bed for longer than is necessary can lead to further problems, for example, development of pressure ulcers and problems with breathing.

14. On transfer to Ward 57 a nurse assessed Mr C to be at low risk of falling and a pre-printed falls care plan consisting of a number of tick boxes was completed. The care plan indicated that prevention and general safety precautions had been discussed with Mr C and his family, the Physiotherapist had been informed and the use of cot sides had been considered. The nurse concerned also ticked the relevant boxes to indicate that Mr C had been oriented to his surroundings and the area was hazard free and finally that Mr C's care had been discussed with the family.

15. In Mr C's case, given that he had a chest infection and suffered from Parkinson's disease, it may have been reasonable for nursing staff to have sat

Mr C in a chair for short periods provided his condition was stable, he was orientated to his surroundings and an appropriate falls risk assessment had been undertaken. The adviser could find no entry in the nursing records or daily evaluation of care to indicate any reason why Mr C should or should not have been sat out of bed (paragraphs 27 to 35 of this report address the issue of nursing documentation).

(a) Conclusion

16. Mrs C believes that her husband was not fit enough to have been left in a chair at the side of his bed. The Board have said that it is not possible to offer one-to-one supervision and it is not hospital policy to restrain patients in a chair. The advice from the adviser, which I accept, is that, given Mr C suffered from Parkinson's disease and a chest condition, it may have been reasonable to sit him in a chair for short periods, provided an appropriate falls risk assessment had been completed and precautions were taken. The nursing documentation failed to provide adequate evidence that would support the decision that Mr C was fit to sit in a chair or alternatively that he was not fit to sit in a chair. On balance, I uphold this aspect of the complaint.

(b) There was inadequate communication with Mr C's family regarding the fall

17. Mrs C said that when she arrived on the ward with her son she noticed her husband was sitting in a chair by the side of his bed. She thought he must have been feeling a bit better but the first thing he said was that he had had a fall. Mrs C's son immediately approached the nurses' station and this resulted in Doctor 1 going to see Mr C and saying that she had heard he had had a fall. Doctor 1 then examined Mr C. Mrs C believed Doctor 1 only knew about the fall when she was approached by her son.

18. The Board commented that Mr C had fallen prior to Mrs C visiting and that a nurse had informed Doctor 1, who was already in the ward at the time. Doctor 1 was reviewing Mr C's casenotes when Mrs C's son approached the nurses' station. Doctor 1 could not recall the exact conversation with Mrs C's son but she recalled that it was a nurse who informed her about Mr C's fall and that it was her intention to examine him once she had read his casenotes. The Board accepted that Mrs C should have been informed of Mr C's fall on arrival at the ward and that had been

the intention of nursing staff. The Board also accepted that the lack of communication led Mrs C to assume that no action was being taken. Nursing staff in the ward had been reminded of the importance of communicating with family members and difficulties caused when this is lacking.

19. The adviser commented that the records show that Mr C was found lying on his back on the floor in the bay at 14:30. Nursing staff assisted Mr C back into his chair and sought medical assistance. At interview we were informed by the senior nurse (who had conducted the investigation into the incident and interviewed the staff concerned) that she believed Mr C had tripped over the drip stand whilst attempting to go to the toilet, although this is not recorded on the incident report or in the care records. We were informed that Doctor 1 was already on the ward at the time of the incident and agreed to see Mr C. As it was visiting time, Mrs C and her son entered the ward to visit Mr C and, before staff could inform them of the incident, Mr C told them that he had fallen. Mr C's son immediately went to seek out further information about the incident and spoke with Doctor 1 at the nurses' station.

20. The adviser continued that the records show that Doctor 1 reviewed Mr C at 15:10 firstly whilst he was in the chair. A patient with a fractured femur would show some shortening and rotation of the affected limb, therefore, in order to exclude a fracture, it would be necessary to put Mr C into bed. Mr C was then put into bed so that his leg could be examined more fully. The records also show that Doctor 1 discussed Mr C's fall with his son and Mrs C and advised that an x-ray had been ordered to exclude a fracture. At 17:10 Mr C returned to the ward from x-ray and an intertrochanteric fractured neck of the left femur was identified. Doctor 1 telephoned Mrs C at 17:30 to explain the diagnosis and future plans. The adviser commented that it is unfortunate that nursing staff did not intercept Mrs C and her son to inform them of the incident before Mr C did so. However, it was reasonable that nursing staff informed medical staff without delay in accordance with the Department of Medicine for the Elderly guidelines. In the adviser's opinion, she could find no reason to doubt that nursing staff would have delayed contacting Mrs C to inform her of the incident had it not been so near visiting time.

(b) Conclusions

21. Mrs C believed that it was her son who first alerted Doctor 1 to Mr C's fall while

she was at the nurses' station and that Doctor 1 approached Mr C and said that she had heard he had had a fall. The Board have said staff found Mr C on the floor prior to visiting and put him back in the chair and immediately informed Doctor 1 who was on the ward at the time. Doctor 1 was reading Mr C's casenotes at the nurses' station when she was approached by Mr C's son who also informed her about Mr C's fall. The adviser has commented that the records support the view that it was nursing staff who informed Doctor 1 of the fall and this would be deemed to be appropriate action. Where matters went wrong, however, were when nursing staff were unable to inform Mrs C about the fall on arrival at the ward and she heard the news from Mr C. I can also understand that Doctor 1's comments when she had asked Mr C that she had heard he had had a fall, could be interpreted that she heard about the fall through Mr C's son or from a nurse. The Board have accepted that there was a lack of communication and staff have been reminded about their responsibilities in this area. I have no reason to doubt that nursing staff acted appropriately to ensure that Mr C was examined by a member of the medical staff but that the failure in communication caused Mrs C some concern. Accordingly, I uphold this aspect of this complaint.

(c) Whether Mr C should have been put back to bed following the fall

22. The adviser commented that, following the fall, Mr C's vital signs were normal but he was complaining of pain in his left hip. He was assisted back into his chair and medical assistance sought, an accident form completed and a brief entry of the incident made on the daily check list form. The adviser was unable to find information or documentary evidence that the staff had examined him to exclude any injury at the time of his fall, prior to sitting him back in his chair. The records show that Mr C was complaining of pain at the time and this should have alerted the nurse to a potential injury. At interview, we were informed by the senior nurse and the ward sister that in the event of a patient falling it is normal practice to check that the patient is safe from immediate harm, assess the patient for injury and pain, call for assistance from another member of staff and then make a judgement on whether the patient can be moved to a chair or bed.

23. The adviser said that she believed it was unreasonable for Mr C to be placed in a chair following his fall. Transferring Mr C from the floor to a chair and then into his bed later to be examined would have only added to his discomfort and pain. The adviser recommended that the Board reminds staff of their responsibilities to

assess patients who have fallen, for injury, before moving them to an appropriate and safe place.

(c) Conclusions

24. The Board have said that the normal practice would be for staff to check the patient was safe from immediate harm, assess the patient for injury and pain, call for assistance and make a judgement on whether the patient can be moved to a chair or bed. The adviser has said that, following the fall, Mr C was assisted back into his chair by nursing staff and medical assistance was sought. However, the records do not indicate that Mr C was examined to exclude any injury at the time of the fall, prior to sitting him back in his chair. The adviser felt that as Mr C was complaining of pain this should have alerted the nurse to a potential injury. She also felt that it was unreasonable for Mr C to have been placed back in the chair following the fall as it would have added to his discomfort when transferring him from the chair to the bed for the examination by Doctor 1.

(c) Recommendations

25. In view of the advice which has been received, the Ombudsman recommends that the Board reminds staff of their responsibilities to assess patients who have fallen, for injury, before moving them to an appropriate and safe place.

(d) Whether the nursing assessment, care planning and documentation was inadequate

26. The adviser commented that Mr C was admitted initially to Ward S20. A nursing profile was carried out, including an assessment of his activities of daily living and a care plan completed. The profile, whilst brief, identified that Mr C was at risk of falls; cot sides were required; he was confused; had a poor appetite; required assistance with his personal hygiene; and was at risk of developing pressure ulcers. A care plan, equally brief, was completed and identified nursing interventions to meet these needs and the record reveals some evaluation. Although a formal falls risk assessment was not completed on Ward S20, the admitting nurse had identified that Mr C was at risk of falls and required cot sides. The adviser believed that the nursing assessment undertaken on Ward S20 was reasonable, considering it is a short stay admission ward.

27. The adviser continued that Mr C was transferred to Ward 57 at 21:00 on

14 October 2004. He was seen by a member of the medical staff who recorded the reason for admission as falls, confusion, reduced mobility, dehydration and vomiting. The admitting nurse initiated the ICP for the Older Person and completed an initial assessment. The nursing assessment, albeit brief, reveals that he was confused and disorientated, required assistance with his personal hygiene, was constipated, had a poor appetite and was at high risk of developing pressure ulcers. Despite Mr C being admitted with a chest infection, the adviser was a little surprised that the nurse assessing Mr C recorded that he had no problems with his breathing. Mr C was assessed at risk of falling and the relevant boxes on the ICP were ticked to confirm that a Cannard Risk Assessment Scoring Form and a Falls Care Plan had been completed. Mr C was assessed as being at low risk of falls. It is unfortunate that the 'completed' Cannard Risk Assessment Scoring Form is absent from the records, as the adviser is unable to identify and comment on the criteria on which the nurse based her assessment.

28. At interview, the senior nurse informed us that she had interviewed the nurse concerned who could not recall completing the form but had stated that, if she had ticked and signed that the Cannard Risk Assessment Scoring Form had been completed, then it must have been completed. The senior nurse said that the falls care plan could not have been completed unless the Cannard Risk Assessment Scoring Form had been completed. The senior nurse acknowledged that Mr C would have been at risk of falling and that she would also have assessed him as being at low risk. The adviser said both medical and physiotherapy records show that Mr C's mobility had reduced significantly; he suffered from Parkinson's disease and had not been taking his medication recently; he required help to transfer; he was confused and had been hallucinating; he had also sustained a previous fall at home. These factors should have alerted the nurse that Mr C was at moderate to high risk of falling and a plan of care to reduce any risk agreed and implemented. In the adviser's opinion, the nurse's assessment appeared to contradict previous assessments and ignored Mr C's presenting medical condition. The adviser commented that assessment tools provide a framework for assessment and are no substitute for professional judgement. She felt that the assessment that Mr C was at low risk of falls was unreasonable.

29. The Falls Care Plan consists of a series of tick boxes to be completed for a patient who is either at low risk of falls or moderate to high risk. The nurse

completing the form assessed Mr C at low risk of falls and ticked some of the interventions to promote and maintain his safety and reduce the risk of further falls. However, these are not individualised and are open to interpretation. The adviser also expressed surprise that, given that Mr C had a history of Parkinson's disease, the nurse did not consider it necessary to liaise with the occupational therapist to establish if appropriate seating or footwear was necessary.

30. The adviser went on to comment that the Department of Medicine for the Elderly had put in place documentation to support an ICP for the Older Person and it was evident from the record that physiotherapists, medical staff and speech and language therapists used the document well. Unfortunately, she found it very difficult to locate evidence in the ICP of any nursing interventions required to meet Mr C's nursing needs and any evaluation whilst he was patient on Ward 57. At interview, we were informed that this was achieved by completion of a daily checklist and that activities of daily living were met by ticking the appropriate box. However, the adviser could find no evidence of how these activities of daily living had been met or individualised specifically to meet Mr C's nursing needs. For example, on the day of Mr C's fall, the record shows that his mobility had been met for the early shift but there was no entry regarding how this need had been met.

31. Both the senior nurse and the ward sister informed us at interview that nursing records are completed in accordance with the NMC guidelines. Health care records are a tool of communication within the health care team[1]. Nursing staff are professionally accountable and responsible for ensuring that health records are an accurate account of treatment, care planning and delivery of care. The advisers explained that the nursing record should enable nursing staff and other health care professionals to understand what nursing care the patient requires and the reasons why, so that they are able to deliver that care appropriately and safely.

32. Care plans should be developed, wherever possible, in consultation with the patient. In the absence of care plans, the care delivered may be open to interpretation by individual practitioners. In the adviser's opinion, the nursing focus had somehow been lost in the development of the ICP. In her view, the

[1] The NMC code of professional conduct: standards for conduct, performance and ethics 2004

evaluations of the ICP undertaken in March 2002 and again in October 2004 reflected staff's difficulty in identifying patient nursing needs. Both the senior nurse and the ward sister agreed that the daily checklist was open to interpretation. The adviser's understanding was that, as a result of the evaluations, further changes had been made to improve the documentation and a patient progress sheet had been added. The adviser welcomed these improvements.

33. In Mr C's case, the absence of a precise nursing assessment and care plan, along with a failure to undertake proper risk assessments, may have led staff to underestimate his risk of falling. The adviser concluded that the assessment that Mr C was at low risk of falling was inaccurate. In Mr C's case, the nursing documentation was poorly completed and in some places missing. During the investigation, the adviser was unable to locate any guidance on the scoring threshold on which nurses differentiate between a patient at low risk of falling, medium risk and high risk. The exception is a score of 13, which warrants consideration and referral for hip protectors. The adviser recommends that the Board should, if it has not already done so, audit the use and effectiveness of the Cannard Risk Assessment Form and Falls Care Plan. The adviser also recommends that the Division reviews the nursing documentation within the ICP for the Older Person, ensuring that nursing assessment and care plans are visible and reflect the requirements of the NMC Code of Conduct.

(d) Conclusions

34. The adviser has raised concerns about the completion of the nursing documentation. Mr C had been assessed as being at low risk of falling. The adviser felt that this assessment appeared to contradict Mr C's previous assessments and ignored his presenting medical condition. She would have assessed Mr C as being moderate to high risk of falling and has advised that a plan of care to reduce the risk should have been implemented. The Falls Care Plan consists of a series of tick boxes and covers patients who are either at low risk of falls or moderate to high risk and is open to interpretation. Likewise, the daily checklist, which was used in conjunction with the ICP for the Older Person, is open to interpretation and consisted of check boxes. My investigation has found that there was no indication of what nursing interventions were required or how the patient's needs were met. This may have led staff to underestimate Mr C's risk of falling.

(d) Recommendations

35. The Ombudsman recommends that the Board should audit the use and effectiveness of the Cannard Risk Assessment Form and Falls Care Plan. She also recommends that they review the nursing documentation within the Generic ICP for the Older Person, to ensure that nursing assessment and care plans are visible and reflect the requirements of the NMC Code of Conduct.

26 September 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The complainant's husband
SGH	The Southern General Hospital Glasgow
The Board	Greater Glasgow & Clyde NHS Board
The adviser	Clinical adviser appointed by the Ombudsman
Doctor 1	The on-call doctor who examined Mr C

Annex 2

Glossary of terms

Antibiotics	Medication to combat infections
Bronchial Cancer	Lung cancer
Brochiectasis	Widening of the airways
Cannard Risk Assessment Form	Falls risk assessment tool
Dehydrated	Lack of fluids
ICP	Generic Integrated Care Pathway: a multi-disciplinary outline of anticipated care to help a patient with specific conditions or a set of symptoms to move progressively to a positive outcome
Intertrochanteric fractured neck of the left femur	Fractured hip
Intravenous	Administration of liquid directly into a vein
NMC	Nursing and Midwifery Council: regulatory body for nurses and midwives
Paracetamol	A simple pain relief medication in tablet form
Parkinson's disease	Disease affecting the limbs with uncontrolled tremors or shaking
Pyrexial	High temperature