

Clinical negligence claims in  
Emergency Departments in England

Report 3 of 3:

# Hospital acquired pressure ulcers and falls





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# Foreword

For the past 10 years, Emergency Medicine (EM) as a specialty has occupied either first or second position each year in terms of the highest number of new claim notifications to NHS Resolution<sup>1</sup>. Each claim represents an episode of harm with associated financial cost to the NHS together with an immeasurable impact on patients, their families and the healthcare staff involved. The demand on emergency medicine is high and continues to grow year on year<sup>2,3</sup>. These claims are a valuable source of learning within the wider NHS<sup>4</sup>.

Thankfully, while the figures for EM are high in the context of claims, they are very low in relation to overall activity in the Emergency Department (ED), with a claim occurring for only one in every 17,000 episodes of ED care.

Emergency Departments in England are very safe but clearly face unique challenges. They are the NHS’s ‘always open’ service and must meet the health needs of a population that is both growing and ageing<sup>5</sup>. The needs of this patient population are increasingly complex<sup>5</sup>. Patients presenting to ED will often have comorbidities in addition to the problem they are attending for.

Despite this large and increasing demand on Emergency Departments the number of claims have risen broadly in line with the rising number of attendances to ED (17% rise in attendances, 23% rise in EM claims between 2010/11 and 2019/20, Figure 1). While this should be treated with caution due to the lagged nature of claims and the influence of the legal market (with claims overall peaking in 2013 due to legal reforms), the trend observed does not give reason to suggest a deteriorating picture in regards to either patient safety or claims risk in this area.

Every claim is an opportunity for learning, whether successful or not, and provides a unique lens through which to view the causes of harm; therefore it is important to consider claims both locally and nationally as a resource for improvement.

This report aims to provide clinical staff working in EDs with national learning from what NHS Resolution sees in claims across EM in England.

Given the full spectrum of care provided and the diverse patient group in EM it is not surprising that a range of themes emerged from this review. These are presented to the right in Table 1. However, there was a smaller group of consistent themes that occurred frequently and were associated with high levels of harm, namely: failings in the investigations process leading to missed or delayed diagnosis; and recognising and responding to both deteriorating and re-attending patients. Across these themes there was also an overarching issue with the provision of timely and appropriate senior review.

This report would not have been possible without input from the members of our Clinical Advisory Groups, none more so than Dr Cliff Mann OBE, GIRFT Clinical Lead for Emergency Medicine. Dr Mann sadly died in February 2021 and as an advocate for the speciality of Emergency Medicine and a leader in the NHS he will be sorely missed.

**Helen Vernon**  
Chief Executive, NHS Resolution

Table 1. Key conclusions across three reports from Emergency Medicine series following a thematic review of NHS Resolution claims.

| No. | Conclusion                                                                                                      | Theme occurs in                                                                                                                              |
|-----|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| 1   | Diagnostic errors including missing signs of deterioration, particularly for spinal and cerebral injury.        | <ul style="list-style-type: none"><li>• high value and fatality related</li></ul>                                                            |
| 2   | Failures in the investigation process leading to missed or delayed diagnosis.                                   | <ul style="list-style-type: none"><li>• high value and fatality related</li></ul>                                                            |
| 3   | Failure to recognise the significance of re-attendance to ED.                                                   | <ul style="list-style-type: none"><li>• high value and fatality related</li></ul>                                                            |
| 4   | Delay in accessing senior and specialty reviews, leading to missed therapeutic options.                         | <ul style="list-style-type: none"><li>• high value and fatality related</li><li>• missed fractures</li></ul>                                 |
| 5   | Communication issues impacting the escalation and handover of care and cross specialty team working.            | <ul style="list-style-type: none"><li>• high value and fatality related</li><li>• falls/pressure ulcers</li><li>• missed fractures</li></ul> |
| 6   | Absence of standardised risk assessments.                                                                       | <ul style="list-style-type: none"><li>• falls/pressure ulcers</li></ul>                                                                      |
| 7   | Failure to deliver proactive nursing interventions in ED, leading to harm.                                      | <ul style="list-style-type: none"><li>• falls/pressure ulcers</li></ul>                                                                      |
| 8   | Inconsistent use of incident reporting and investigations as tools for learning from harm to make care safer.   | <ul style="list-style-type: none"><li>• falls/pressure ulcers</li></ul>                                                                      |
| 9   | Diagnostic error, specifically where early incorrect diagnosis prevented further investigation.                 | <ul style="list-style-type: none"><li>• missed fractures</li></ul>                                                                           |
| 10  | Obtaining images to support diagnosis, including requesting, reporting, interpretation and follow up of images. | <ul style="list-style-type: none"><li>• missed fractures</li></ul>                                                                           |

The Royal College of Emergency Medicine (RCEM) welcomes these reports as learning opportunities to reduce the tragedy of preventable harm to individuals and their families as well as the staff involved. No clinician goes to work meaning to make a medical error. As specialty leaders and standard setters, we must use the stories and themes identified in these reports to focus our guidance and teaching and sharpen our advocacy for a better system of care modelled to deliver patient needs.

As well as making sure common errors are widely known about, we need to break down barriers in clinical pathways that can lead to difficult communication and delays. Emergency Departments are under pressure and fulfil every definition of an environment where there is a risk of making a mistake. It is of enormous credit to Emergency Department staff that for the most part they are so safe but as frontline clinicians we want the best care for everyone and know at times we fail.

The Emergency Department sees a greater range of clinical presentations than any other area of the hospital and the patients who present are unselected and most often unannounced. The work is high intensity both by patient volume and also often by severity and complexity. Job demands are high and frequently resources are lacking – despite Covid rules, Emergency Departments are still viewed as having elastic walls and end up holding patients until a hospital bed can be found often many hours later. Crowding is associated with patient harm and dilutes the staff resources to care for new patients. The risk of overwhelming the cognitive resources of the senior staff and demotivating all staff because they feel they cannot deliver the quality care they want to is real.

Reports like these have a responsibility to recognise the gap between what should be the standard of care and the operational pressures a service is working under in the real world. The responsibility for ensuring an adequately qualified staffed Emergency Department with the equipment needed and access to relevant inpatient specialties lies with those who plan healthcare services, but every clinician must look through a report like this. We must all think how we can eliminate patient harm by improving our knowledge and skills, teach others, advocate for better diagnostic pathways and safety net systems.

We must also get better at communicating risk and uncertainty realities to patients, so they feel involved and confident to return for review if things do not seem to be following the expected plan. We need to make sure we are following guidance that already exists, so we balance the hope of picking up atypical, rare but devastating diagnoses and the harms of over-investigation. RCEM is committed to doing everything it can to improve patient safety and reduce the use of resources needed to manage patient harm.

**Dr Katherine Henderson**  
Royal College of Emergency Medicine President

For many patients the Emergency Department is the front door they pass through on a journey through health and care services. When things go wrong there, the impact can follow them on every step of that journey, and affect short-term and long-term outcomes. This set of reports is a valuable source of learning for health and care services, and for nursing, beyond the front door, as the themes identified here resonate more widely.

Every nurse and health care professional will have been involved in an instance when things have gone wrong for their patients; a mistake, an omission, a missed opportunity to intervene. In the majority of cases this will not go on to become a claim, but it is essential to learn from those that do.

Risk is inherent in all settings in which health care is delivered, and the need for robust, documented risk assessment is emphasised, not only to prevent harm coming to patients, but also to support staff in their practice. As this series of reports recognises, current risk assessments are all too often burdensome and time consuming, with duplicated information in a range of paper and electronic tools. A contemporary digital risk assessment as recommended in this series of reports requires true collaboration and co-creation to ensure that it reflects practice at all stages of the patient journey.

When harm does occur, the need for effective incident reporting is highlighted as essential for learning, but so too are failings in current processes, and the impact on those involved – patients, families and healthcare staff. This series of reports reference work being done in NHS England to make this process more effective, and recommends the inclusion of significant information currently lacking on the context in which incidents happen, including staffing levels, skill mix and patient acuity.

The third report in this series focuses on pressure ulcers and falls, which are recognised as nurse-sensitive indicators of quality care, and highlights a lack of proactive nursing interventions. While none of these reports explicitly examine staffing levels, they highlight other publications which have done so. The link between poor patient outcomes and the number of admissions managed by each registered nurse in the Emergency Department is in line with the strong evidence base which links nurse/patient ratios within in-patient settings.

The Royal College of Nursing (RCN) has published Nursing Workforce Standards<sup>6</sup> which apply across all settings, and are designed to support a safe and effective nursing workforce wherever care is delivered. Implementation of these standards within the emergency care setting would support the recommendation of this report for dedicated nursing time to deliver high quality nursing interventions.

**Rachel Hollis**  
Chair of RCN's Professional Nursing Committee

# Executive Summary

NHS Resolution is an arm’s length body of the Department of Health and Social Care. Our purpose is to provide expertise to the NHS to resolve claims fairly, share learning for improvement and preserve resources for patient care. Annually NHS Resolution is notified of circa 11,000 clinical negligence claims with an estimated value of £4.5 billion.

## RATIONALE

In 2020/21, clinical negligence claims associated with the Emergency Department (ED) accounted for 11% of the total number of claims notified to NHS Resolution and 5% of the total estimated value of all claims notified. In total the value of notified claims equated to £321.98 million including both estimated damages and the legal costs. The reported value of these claims is third next to obstetrics and paediatrics<sup>7</sup>.

The impact of harm to these patients together with the volume and value of these claims have driven this deep dive into Emergency Department claims to identify common issues. Many who attend ED also have other health issues that may affect diagnosis and management and Emergency Departments provide open access to the public. These departments are often the only part of a hospital that many will see. They play an important part in caring both for those with acute illness and those with injury. Public expectation is high and increasing. Furthermore, this is a specialty that has seen a significant growth in demand with further demand anticipated in view of an increasingly ageing population and in the context where EDs are seen as a primary source of help.

We acknowledge the multi-faceted nature of emergency care; that ED claims include incidences of harm across a range of specialities and that claims are not restricted to care provided by Emergency Medicine teams. We also recognise that current coding systems do not always capture this detail. However, all claims allocated represent an incident of harm to a patient regardless of attribution and therefore these key messages apply to all emergency care settings and all emergency care teams rather than the Emergency Departments in isolation.

## AIMS

EDs have a number of unique challenges and the Getting It Right First Time (GIRFT) report from NHS England and NHS Improvement<sup>3</sup> has provided an excellent analysis of the operational issues. This series of thematic analyses complements that report by exploring the clinical issues that contribute to compensation claims. By providing practical recommendations for clinical care, we aim to improve patient safety, which will help prevent harm and ultimately reduce the number and cost of ED claims.

## METHOD

We undertook a thematic analysis of Emergency Department claims. A total of 220 claims were included in the analysis.

## RESULTS

For this report (number 3 of the ED series – Hospital acquired pressure ulcers and falls) the numbers are as follows:

40 closed, successful (compensation paid) claims were evaluated to form this report – 15 claims relate to pressure injury and 25 to falls, with an incident date between 1 April 2014 and 31 March 2018.

The total cost of the 40 claims was £1,207,350. Clinical themes for pressure injury and falls included failure to complete or accurately assess the risk of harm and implement an appropriate bundle of essential care. Documentation and communication were contributing factors in most of the incidents, compounded by variation in the standard of incident reporting and investigation. The majority of these claims relate to systems and processes which influence delivery of effective nursing care and how organisations learn when things go wrong.



**SUMMARY OF NATIONAL RECOMMENDATIONS:**

1. **Risk assessments:** national key principles should be collaboratively created to support the development of contemporary digital risk assessments. An electronic screening page should be designed to inform all risk assessments for harm, to ease the burden of duplicating information, to reflect modern nursing practices and to reduce variation between trusts.
2. **Proactive nursing care:** ED nurse staffing must be organised so that there is dedicated nursing time available on every shift to deliver regular and frequent high quality nursing interventions for all patients.
3. **Communication:** appropriate Electronic Patient Record (EPR) compatible handover forms supported by a proven methodology such as SBAR (situation, background, assessment, recommendation) should be created to facilitate effective communication and documentation on transfer of patients or handover of care. The Nursing and Midwifery Council should consider a proactive campaign of what good documentation looks like, to drive compliance with section 10 of The Code.
4. **Reporting and investigating incidents:** as a conduit to compliance with the awaited Patient Safety Incident Management System (PSIMS) and national roll out of the Patient Safety Incident Response Framework (PSIRF) some mandatory information should be included within incident and investigation reports, such as staffing, skill mix and acuity, to provide critical context to the environment and highlight shortfalls in appropriate safe staffing.



## Introduction

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Since 2017/18, Emergency Medicine as a clinical specialty has been one of the specialities associated with the largest number of clinical negligence claims made to NHS Resolution, accounting for 11% of the total claims notified in 2020/21<sup>7</sup>. The estimated cost of these claims was valued at £321.91 million, including damages and legal costs<sup>7</sup>. This accounted for 5% of total NHS claim legal costs; the second highest number of any specialty and third in value only to obstetrics and paediatrics. Emergency care in England is generally very safe and the overall claim rate in proportion to Emergency Department (ED) episodes is very low: < 0.005% (~1400 claims for 23.8m, in major EDs the figure is closer to 16 million ED episodes per year or less than one claim for every 17,000 attendances).

There are a number of unique challenges in Emergency Medicine, including the requirement to provide care for undifferentiated acute and urgent aspects of illness and injury for patients of all age groups with a full spectrum of physical and psychological disorders. In addition, patients presenting at the ED are often characterised by multiple morbidities and polypharmacy with complex clinical presentations that require sophisticated diagnostic input and multidisciplinary care<sup>9</sup> connecting with almost every other inpatient speciality. Furthermore, the demand on ED and acute medical services is increasing<sup>10</sup>.

This report complements NHS England and NHS Improvement's GIRFT EM report<sup>8</sup>. Their report highlights the operational challenges EDs face to deliver optimum care and treatment, including: demand, activity, safe staffing and appropriate estate resource<sup>8</sup>. These issues contribute to the variation in outcomes identified by the GIRFT EM report (2021).

## Summary of the key findings from the GIRFT EM report<sup>8</sup>

The GIRFT team visited a range of Emergency Departments (EDs) between 2017 and 2020, and observed a high level of variation – both unwarranted and warranted. Some of the variation they found was due to geographic, social and demographic factors. Some was also due to historical and funding issues. However, much was believed to be a result of system and operational processes, and a failure to meet the local demand for emergency care. Unfortunately, the EDs with the largest burden of deprivation and disease often had the poorest facilities and the fewest staff<sup>8</sup>.

The GIRFT for Emergency Medicine report (2021) focuses on giving providers accurate information to identify how best to meet the demand for emergency care from the catchment population. The GIRFT team developed some new metrics to interpret the data and some different ways of representing it. One such metric, the aggregated patient delay (APD), has already been adopted by NHS England and NHS Improvement's Model Hospital portal and some other metrics are also entering common usage. The Summary ED Indicator Table (SEDIT) that was developed is now available online and updated monthly, thus providing a readily available source of current and comparative information for all EDs.

Additionally, the Covid-19 situation has further stress-tested emergency care provision, throwing a national spotlight on many of the issues found in the course of GIRFT team visits to EDs over the past three years and making the case for change more urgent than ever before.

The key messages of relevance to ED claims were<sup>8</sup>:

- There is enormous unwarranted variation in Emergency Departments throughout England.
- There is variation in the four main GIRFT-EM domains of demand, capacity, flow and outcomes. Most of the variation in demand is due to geographical and demographic factors and is very difficult to change but variation in capacity is usually amenable to improvement.
- Flow and outcomes are dependent to some extent on the demand and capacity profile of an ED but the GIRFT-EM quadrants offer a graphical way of representing a considerable amount of ED data showing that there are many more factors at play.
- The GIRFT-EM SEDITs (Summary ED Information Tables) give a good oversight of the comparative metrics for every single ED in England and can be used to guide investment and improvement.

## Background

### NHS RESOLUTION AND CLAIMS COSTS

NHS Resolution aims to resolve and learn from clinical negligence claims, so that trusts and the wider NHS can learn from these incidents sooner to implement change and therefore mitigate future risk of harm and claims.

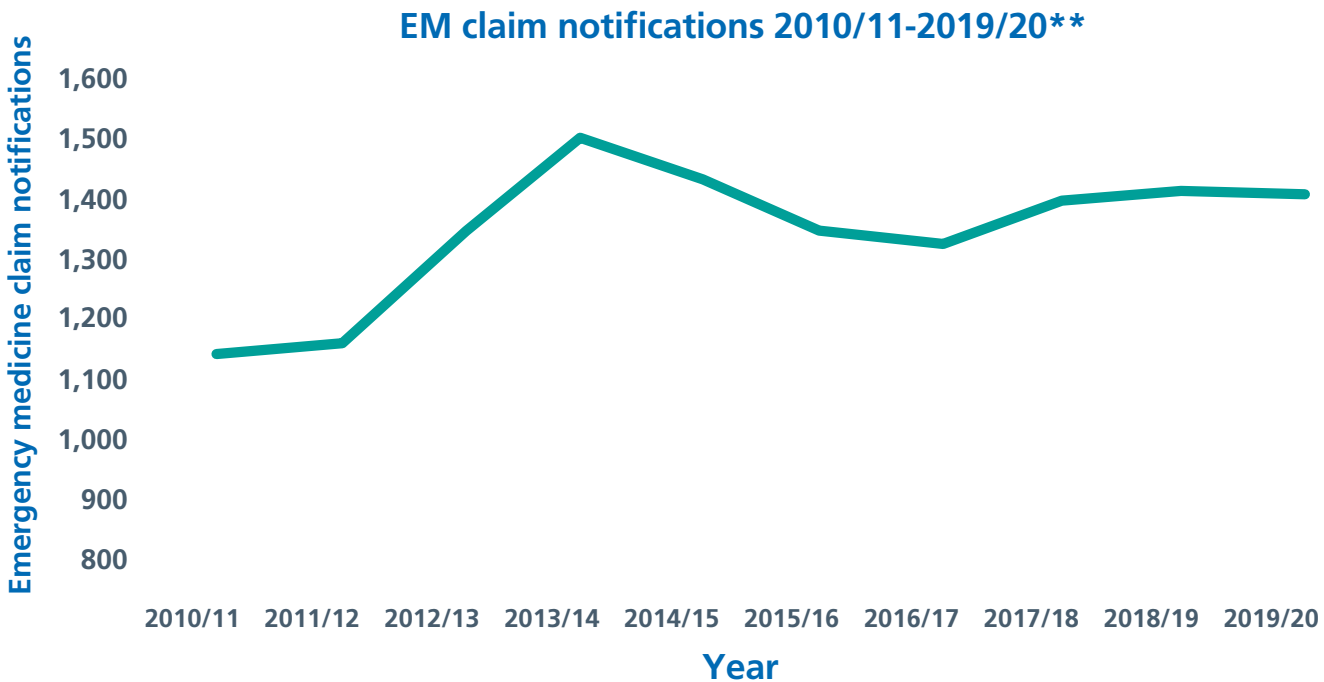
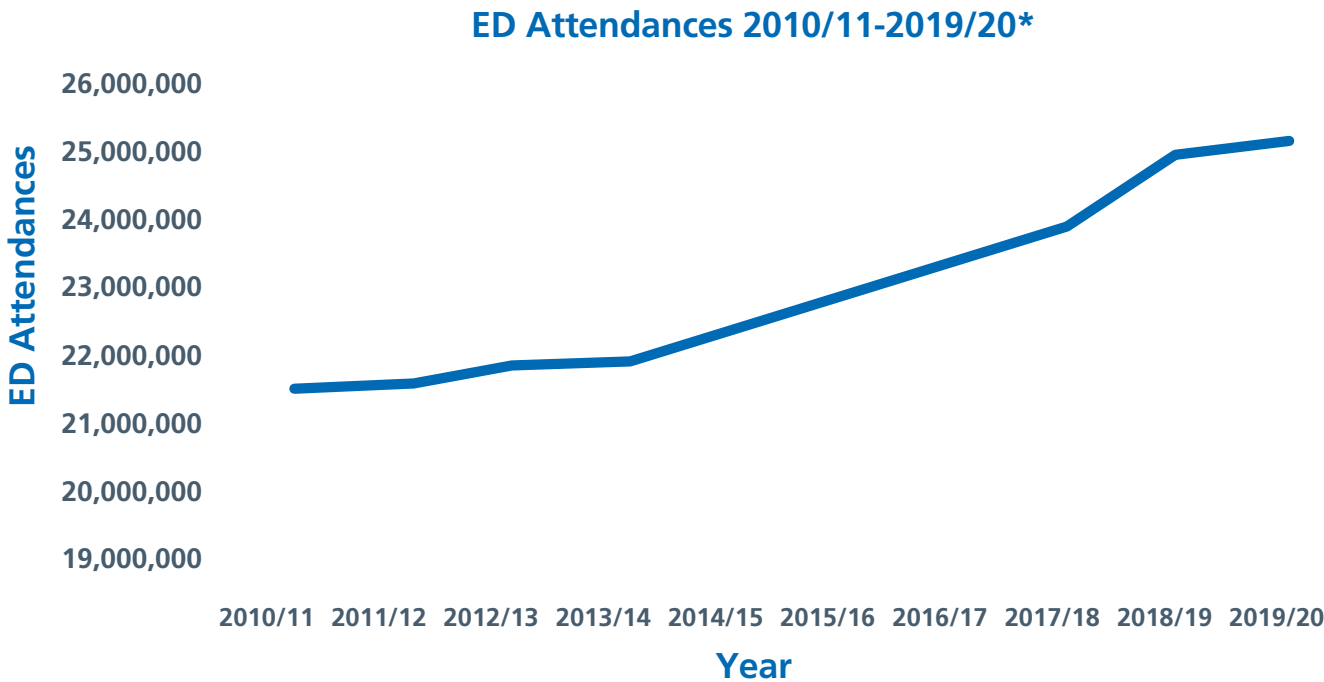
In 2020/21, NHS Resolution received 10,816<sup>a</sup> clinical negligence claim notifications<sup>7</sup>. Emergency Medicine accounted for 1,151<sup>7</sup> notifications, which is similar to the previous year's claims notifications at 1,401<sup>11</sup>. As NHS clinical activity has continued to rise this represents a fall in claims proportionate to clinical episodes.

It is important to note that initiatives to improve safety over previous years in other specialties, in particular orthopaedics, have had some positive impact by reducing claims in those areas. This makes EM now appear high whereas the reality is that, despite increasing patient numbers visiting EDs, the number of new notifications is fairly consistent (see Figure 1).



<sup>a</sup>Excludes data from general practice indemnity schemes.

Figure 1: ED attendances and EM claim notifications 2010/11 to 2019/20



\* ED attendances (MSitAE data published by NHS England and NHS Improvement<sup>12</sup>)  
\*\*EM claim notifications (volume of claims notified to NHS Resolution<sup>11</sup>)

Figure 2: The total number of clinical negligence claims received in 2020/21, broken down by specialty from a total of 10,816

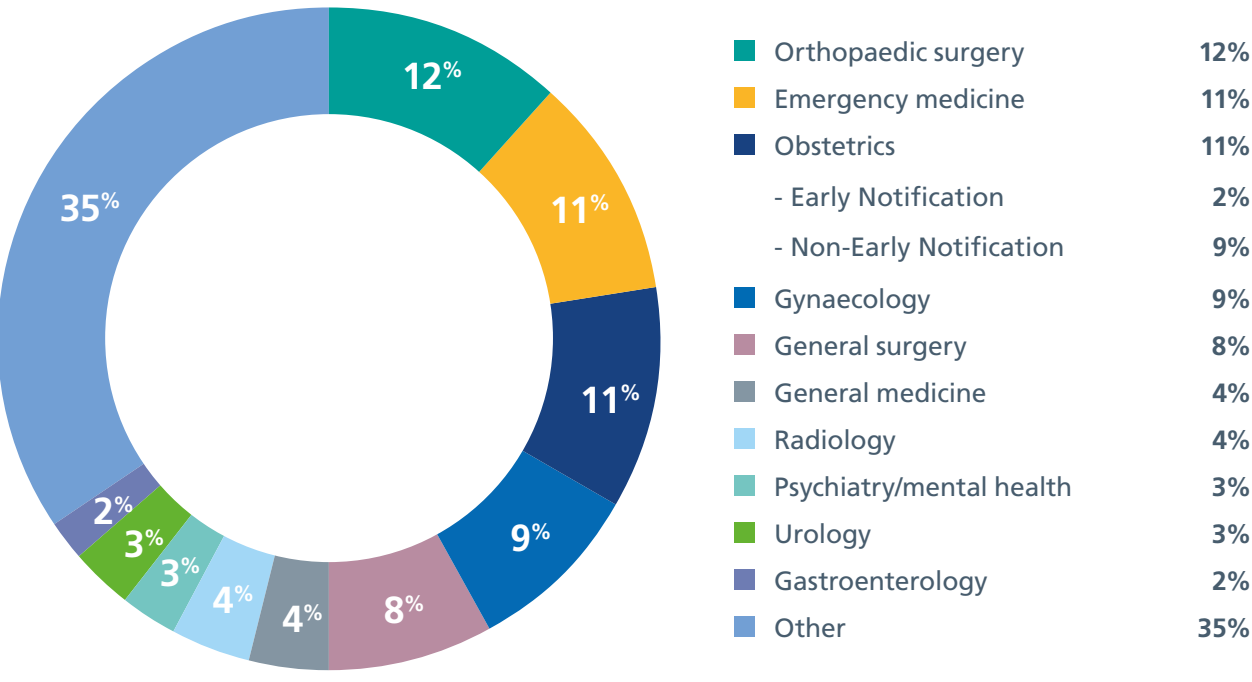
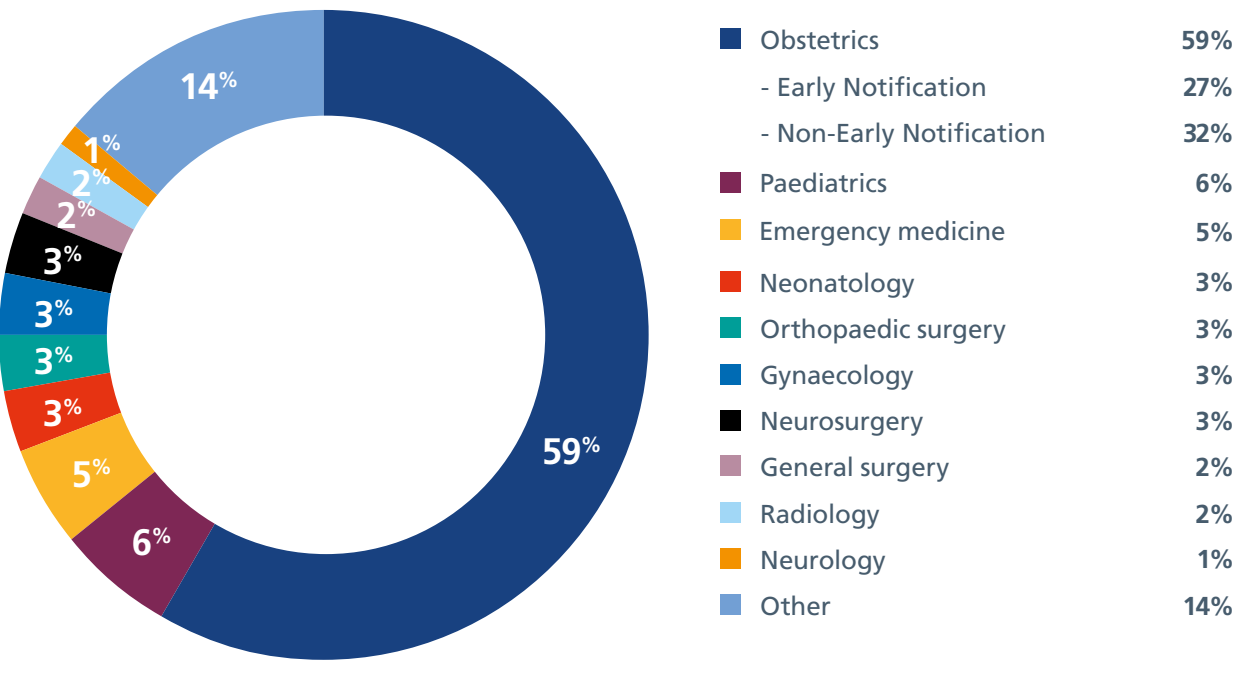


Figure 3: The total potential value of clinical negligence claims received in 2020/21, broken down by specialty from a total of £7,113.8 million



Source: NHS Resolution Annual report and accounts 2020/21 (both Figure 2 and 3)  
These figures exclude data from our general practice indemnity schemes (both Figure 2 and 3)

Investigating claims related to Emergency Medicine within the ED provides an important vehicle to identify learning to share with EM services and the wider NHS. Moreover, the investigation aims to identify areas and priorities for research in ED system level organisation and care provision.

Once a claim is lodged NHS Resolution will investigate by obtaining witness statements and expert advice to establish firstly whether there has been a breach of the duty of care owed by the NHS trust to the patient and secondly whether that breach has caused an injury which means that the claimant is entitled to compensation. Forty-four per cent of claims resolve without compensation being paid.

Compensation is assessed and negotiated according to established legal principles. NHS Resolution aims at all times to keep cases out of formal litigation which can be distressing for patients and clinical staff. Seventy-five per cent of claims resolve without formal proceedings and only 0.4% go to trial.



## Human cost

Over and above the financial cost of claims, each successful claim represents a patient journey or experience where the NHS has failed to meet expectations or standards and patients have come to preventable harm or suffering. Patient outcomes and experiences are also highlighted as a major concern of the GIRFT-EM (2021) report<sup>8</sup>. Each claim is a human story and is inadequately captured in the collection and interpretation of data alone.

Although the effects of clinical negligence are primarily felt by patients and their families, the impact on staff involved can also be significant and long-lasting<sup>2</sup>. Clinical staff strive to provide the best possible care and the discovery that an error or omission, often made as part of a wider systemic failure, has caused a patient harm can have far-reaching consequences for frontline teams and individual staff members<sup>2,3,4</sup>. This can include short term effects on practice and changes to area of practice and/or career, as well as contributing to some clinicians leaving the profession completely<sup>4</sup>. The current difficulties with recruitment and retention of health professionals, particularly in acute specialties, underline the need to provide a supportive and compassionate environment for clinicians when they are involved in a clinical negligence case<sup>2</sup>.

Nevertheless, there is a need for clinical accountability and a parallel 'system level' requirement to address weaknesses in policies and processes, practices, training and education, while striking a balance between accountability and a just and fair culture of learning<sup>2</sup>. This allows the greatest opportunity across the wider NHS to learn when things go wrong, and to mitigate future risk.

Claims relating to hospital acquired pressure ulcers (HAPU) in the Emergency Department

Introduction

Pressure ulcers are defined as “localised damage to the skin and/ or underlying tissue, usually over a bony prominence (or related to a medical or other device), resulting from sustained pressure (including pressure associated with shear<sup>b</sup>). The damage can be present as intact skin or an open ulcer and may be painful” <sup>5,13,14</sup>.

The National Institute for Health and Care Excellence (NICE) and the European Pressure Ulcer Advisory Panel (EPUAP) have created robust lists of risk factors, which can be found within their guidance on their respective websites. To summarise them, people most at risk are those who:

- are older;
- have limited mobility;
- have medical devices attached to them;
- are cognitively impaired;
- are obese;
- are incontinent;
- have a poor diet and/or are dehydrated;
- have medical conditions that affect blood supply, such as diabetes and peripheral arterial disease;
- have previous or current pressure ulcers; and
- are non-compliant with advice and use of pressure relieving aids<sup>5,13,14</sup>.

However, the list is not limited to the above cohort of people.

Inpatients in acute hospital settings are particularly vulnerable to developing hospital acquired pressure ulcers (HAPUs) because they usually fall into one or more of these groups. Pressure ulcers are a key indicator of quality nursing care and patient experience<sup>15</sup>. The reality is that if appropriate knowledge is provided and preventative best practice is followed consistently the vast majority of HAPUs could be avoided<sup>5,13</sup>.

The National Pressure Injury Advisory Panel (2018)<sup>13</sup>, in collaboration with the European Pressure Ulcer Advisory Panel<sup>14</sup>, classify pressure injury into six categories supported by guidelines introduced by NHS Improvement in 2018<sup>16</sup>.

The six stages are:

- **Stage 1:** Non-blanchable erythema of intact skin
- **Stage 2:** Partial-thickness skin loss with exposed dermis
- **Stage 3:** Full-thickness skin loss
- **Stage 4:** Full-thickness skin and tissue loss
- **Unstageable:** Obscured full-thickness skin and tissue loss
- **Deep tissue injury:** Persistent non-blanchable deep red, maroon or purple discoloration<sup>13,14</sup>.

<sup>b</sup> Mechanical force acting on the skin in a parallel direction to the surface of the body causing damage to tissue that is not visible at skin level, as opposed to friction injury where mechanical force is exerted across the skin.

Methodology

NHS Resolution has analysed a total of 220 ED claims; of these, 19 involved patients with a HAPU. We included closed claims, of adult patients, that settled with damages awarded (i.e. completed cases where compensation had been paid) with an incident date between 1 April 2014 and 31 March 2018 (four years). Four claims were excluded because the success of the claim was due to other failings in care not associated with the HAPU or negligence in ED care.

The nursing care of 15 claims has been analysed using information gleaned from NHS Resolution’s Claims Management System (CMS) and from our panel of solicitor firms representing NHS organisations. Documents were scrutinised to identify common omissions of care that contributed to the development of HAPUs. The nature of HAPUs is such that shortcomings in isolated episodes of care rarely lead to a successful claim and therefore care beyond ED was also examined. However, the root cause of all these claims was substandard nursing care in ED.

Where ‘unknown’ is stated in this chapter it relates to information not known because we were unable to find the information in our databases or it was not recorded by clinicians in the health records or other documents.



## Limitations

The small number of claims examined in this report is recognised as a limitation to the validity of the analysis and as such only the high-level themes have been explored. However, this report has prompted further analysis into HAPUs across other specialties within secondary care, and 137 successful claims have been reviewed. Findings of the wider analysis suggest the same themes are echoed within this report.



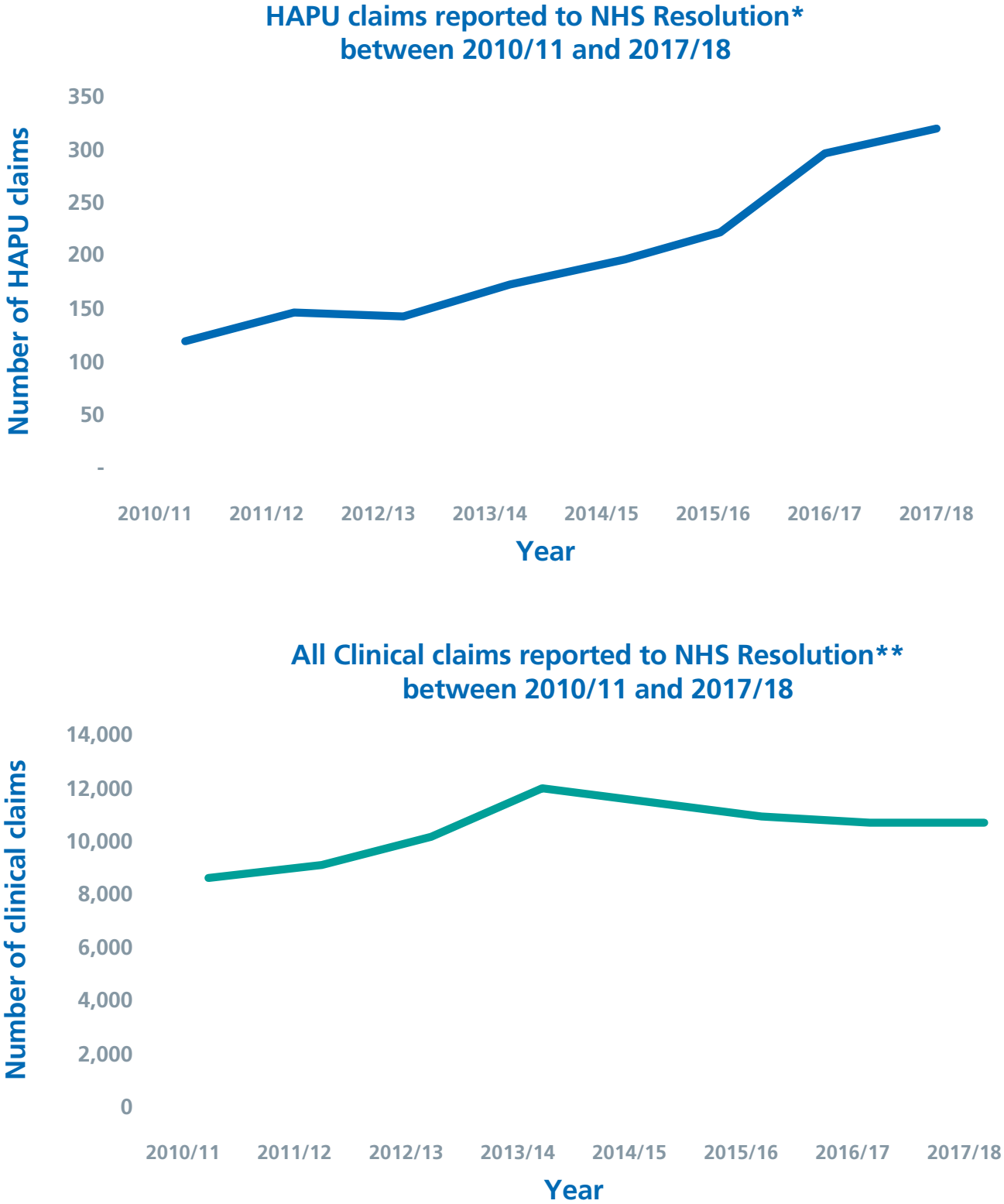
## Overarching data and financial impact

Despite progress since 2012, pressure ulcers remain a significant healthcare problem with over 1,300 new ulcers reported each month<sup>12</sup> affecting 200,000 people annually in the UK<sup>17</sup>.

From 2010/11 to 2017/18, NHS Resolution were notified of 1,781 claims relating to HAPUs in NHS trusts across all specialties. Of these claims, 91% were closed with the payment of compensation, a much higher proportion than the overall figure for all clinical claims: in 2020/21 only 66% of claims closed with the payment of compensation. The financial cost of these HAPU claims was £126.5 million. In addition to patient safety incidents, a range of factors can influence claims volumes and values.

Figure 4 shows the volume of HAPU claims in comparison to all clinical claims. While HAPU claims volumes have increased, there is no indication that it is an outlier in terms of patient safety or claims risk.

Figure 4: HAPU claims and all clinical claims reported to NHS Resolution 2010/11 to 2019/20



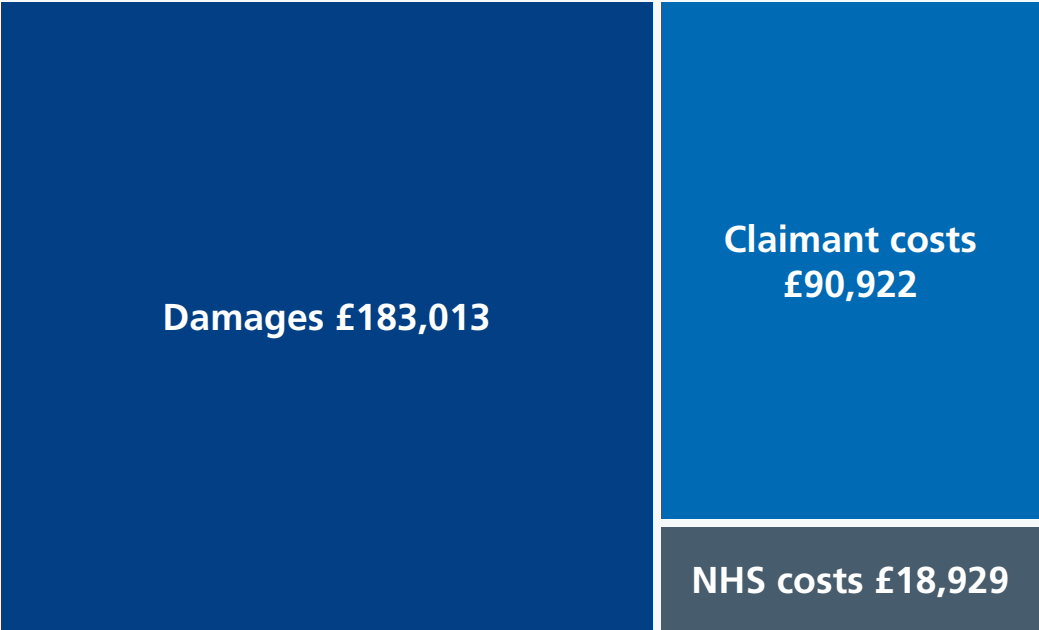
\*NHS Resolution Data

\*\*NHS Resolution, Annual Report Statistics<sup>18</sup>

NHS Resolution have paid £292,864.82 to settle the 15 HAPU related claims in Emergency Departments across England. The caveat to these figures is that there remains a number of ongoing claims yet to be settled and there is an unquantified number of potential claims not yet notified to NHS Resolution where patients/ families still have time to make a claim under the legal limitation period<sup>19</sup>. Figure 5 shows the breakdown of these claims, in terms of damages awarded and legal costs.

Compensation awards for pressure injury are generally not very high in relation to pain, suffering and loss of amenity. This is because the long-term physical, emotional and financial impact is mostly time limited and the patient does not generally have long-term and complex care requirements as a direct result of the clinical negligence.

Figure 5: Amount paid by NHS Resolution to settle HAPU claims in ED



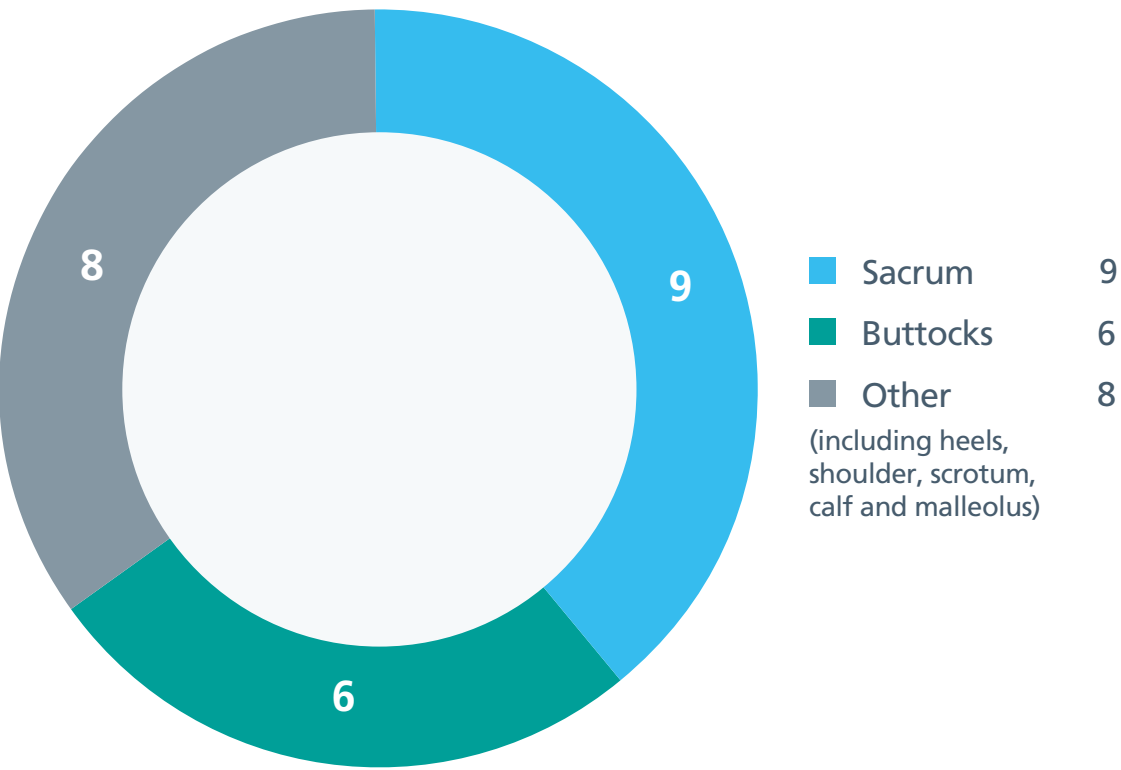
The average amount of damages paid was £12,200 – with actual compensation payments ranging from £4,000 to £30,000.

# Detailed analysis

## ANATOMICAL SITE OF ALL PRESSURE ULCERS

Five of the 15 patients had more than one pressure ulcer site. Figure 6 illustrates the sites of all the pressure ulcers. There was a causal link to prolonged time in ED and the lack of ability to change position on restrictive ED trolleys. Gamston (2019)<sup>20</sup> supports this finding.

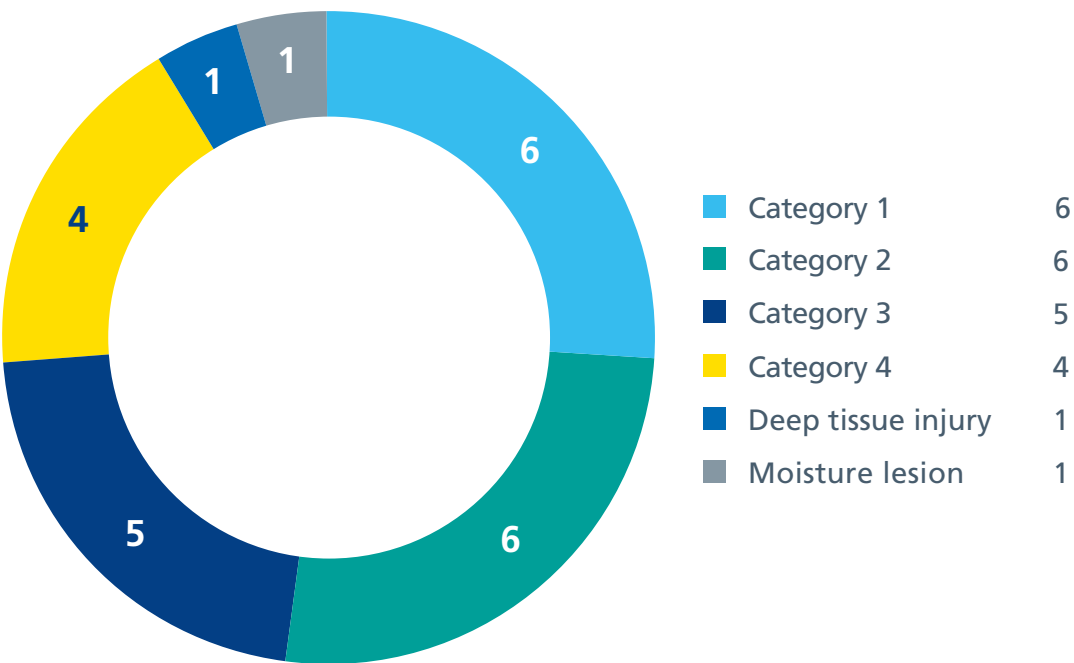
Figure 6: Anatomical sites of all pressure ulcers



## CATEGORY OF ALL PRESSURE ULCERS

The stage of pressure ulcer documented in this report refers to the correct categorisation of the HAPU at its worst by a Tissue Viability Nurse (TVN). It is noted the pressure timeline can be long and referral to a TVN may be delayed, sometimes after discharge. Inappropriate management during this period, and beyond ED contributed to the severity of the pressure damage in all the category three and four HAPUs.

Figure 7: Category of all pressure ulcers



## PATIENT JOURNEY

Twelve patients were admitted from their own home and three from residential care homes. Fourteen arrived in ED via ambulance, one via own transport. All the patients had been nursed in majors or the resuscitation area. Therefore, there is a perceived greater need for essential nursing care, and nurses to provide it, in these specific areas of Emergency Departments. All the patients were admitted for further care. Six patients died between two and thirteen months of them attending ED, two as a direct result of an infected HAPU and subsequent sepsis.

## AGE AND GENDER

Thirteen patients were aged 65 years or above. Increasing age is a recognised risk factor for HAPU, although the definition of older patients and quantification of age-based risk varies. Eleven of the patients were female – this is consistent with a higher risk score for women on the Waterlow assessment tool<sup>21</sup>. The Braden risk assessment tool<sup>22</sup> does not account for gender or age and therefore could be considered limited, in terms of accurate risk measurement.

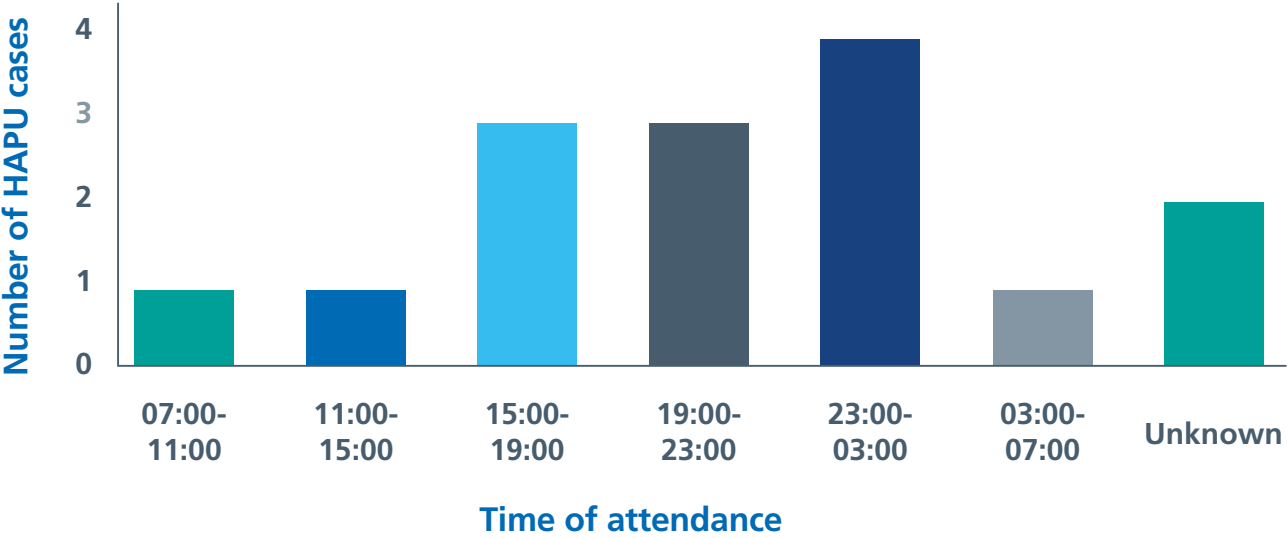
## COMORBIDITIES

Every patient had one or more medical comorbidity: there were a total of 47 separate predisposing medical problems of these patients. The most significant was cardiovascular disease and its association with suboptimal perfusion of tissue<sup>23</sup>. The second most common comorbidity was dementia; it is worth noting there is a recognised link between impaired cognition and risk of developing pressure damage<sup>24</sup>. In general, evidence supports the increased risk status for people with underlying medical issues<sup>23,24</sup>. Frailty, diabetes and known to be bed bound were some of the other past medical problems noted in our cohort of patients.

## TIMING OF ATTENDANCE

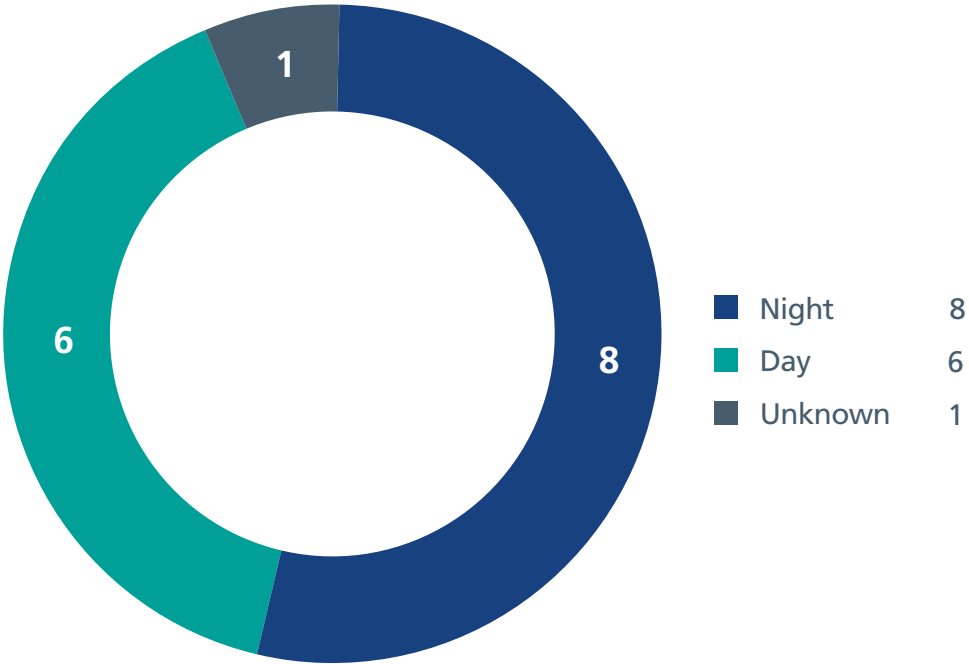
There was no statistical significance in the month or day of the week patients attended ED. Over two thirds of the patients attended between 15:00 and 03:00 hours. Twelve patients attended outside of the typical working day hours, i.e. 09:00 to 17:00 hours. Figure 8 illustrates four hourly time brackets of attendance.

Figure 8: HAPU cases, time of attendance to ED



There was no significant difference in attendance between 'day' and 'night' shifts. Figure 9 shows attendance time in relation to nursing shifts; we have used the time scale of 08:00 to 20:00 hours. We accept many EDs now staff their departments with 'long' shifts, typically 12 hours in duration.

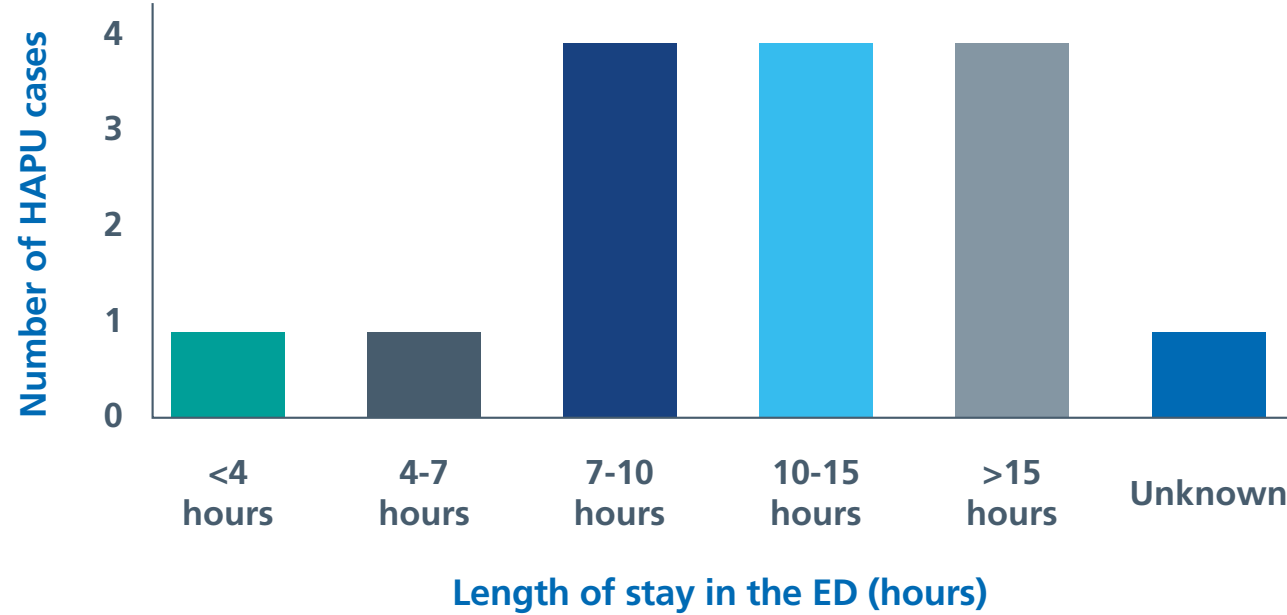
Figure 9: HAPU cases' attendance time in relation to nursing shifts



**LENGTH OF STAY IN ED**

Thirteen of the 15 patients spent more than four hours in ED. This demonstrates a potential risk factor for developing pressure damage. Figure 10 illustrates a breakdown of the length of stay for all patients.

Figure 10: HAPU cases' length of stay in ED



RISK ASSESSMENTS

The success of HAPU claims often hinges on failure to undertake appropriate and accurate risk assessments. Only four patients were risk assessed in the ED – one was completed on discharge. Of these four patients, only one risk assessment was fully completed and deemed accurate. Therefore, the majority of these patients (n=9) were not clinically assessed for acquiring pressure damage while they were under the care of the ED.

One trust’s ED clinical record states: “ask the patient if they have any pressure ulcers. If Yes or at risk of pressure damage – complete skin inspection”. Good practice would be to inspect the pressure areas and not rely on verbal information from unwell, potentially confused people or those unaware they have any skin damage.

In one case, a non-registered healthcare professional deemed a risk assessment was not necessary because the patient verbally confirmed they had no sores. However, this patient was known to have dementia and a mental capacity assessment had not formally been conducted.

The Waterlow score<sup>21</sup> is the most widely used risk assessment tool in NHS trusts for pressure injury in adults. Most organisations have internal policies for the completion of numerous risk assessments. Often such standards require they must be completed within 6–8 hours of admission. However, there is much confusion regarding the definition of an ‘admission’ and at what point the clock starts. Therefore, consideration to undertake a risk assessment should be extended to patients who spend more than four hours in ED regardless of potential admission.

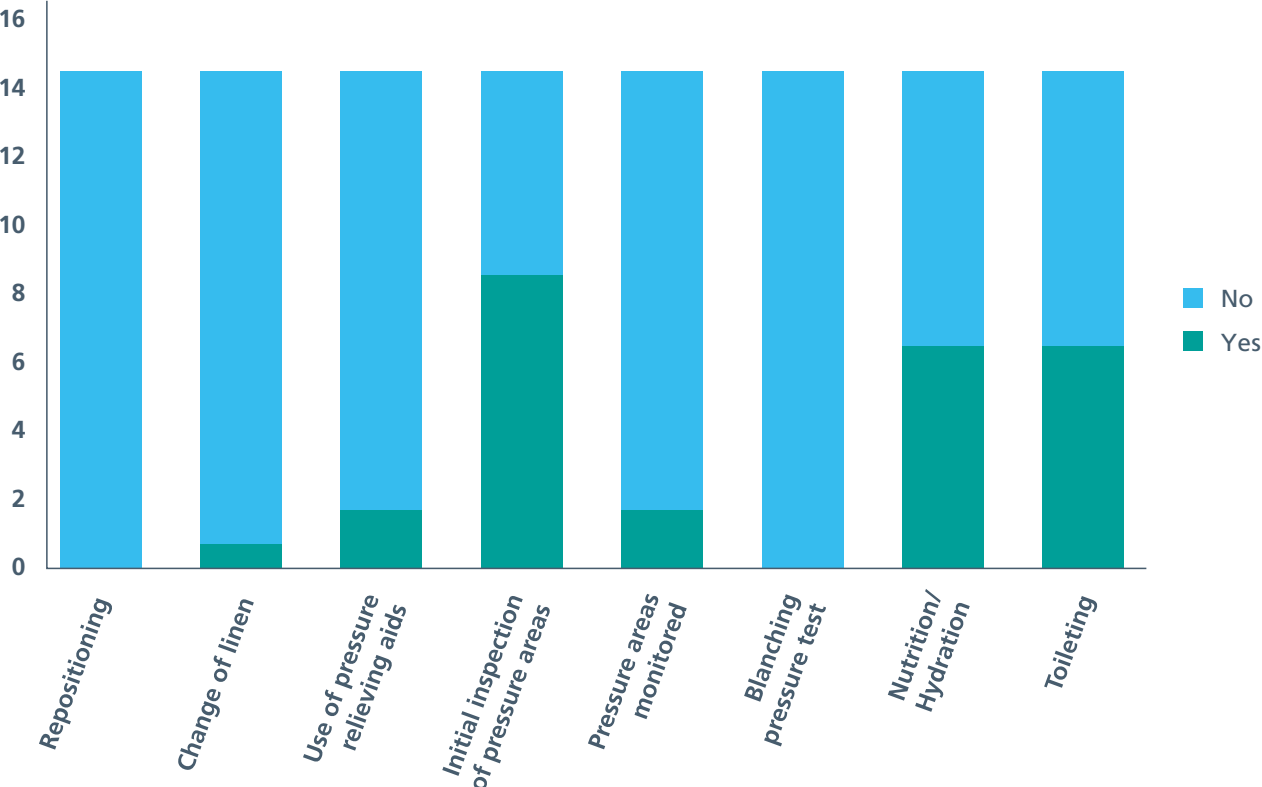
NURSING CARE

The World Health Organization suggest the purpose of risk assessments is to determine the level of risk and inform nursing care plans to prevent harm<sup>25</sup>. It is therefore reasonable to assume that if risk assessments are not completed nurses cannot plan and implement the requisite standard of care to individual patients in ED or indeed other clinical areas.

While creating a formal care plan would be impractical in an ED setting, it could be considered a reasonable compromise to implement frequent and regular ‘nursing care rounds’ to ensure all patients in majors and resuscitation areas receive high quality nursing care to prevent harm and unnecessary suffering.

There was lack of evidence in all the claims we examined to support delivery of good standards of nursing care to prevent skin damage, which included regular repositioning, use of pressure relieving aids and regular monitoring of pressure areas. Figure 11 illustrates specific nursing care provided/not provided to these patients. None of them received proactive nursing care to prevent the development of pressure injury. What is notable about this graph is that our analysis confirmed there was no nursing documentation to support any patient being repositioned while in ED. This does not meet Nursing and Midwifery Council standards in The Code<sup>26</sup>. This level of care does not meet the standards set out in national and international guidance<sup>5,13,14,27</sup>. There is no definitive rationale for this standard of nursing care because it was not documented in the clinical notes. From a legal perspective, nurses may be considered negligent in their care if they fail to identify patients at risk and/or fail to implement appropriate care to prevent such harm.

Figure 11: Specific nursing care provided/not provided to HAPU cases in ED



One patient had their pressure areas inspected on admission, and monitored while in the department, but did not have a blanching pressure test. Despite the pressure ulcer being identified in ED it was not reported on the trust incident reporting system before the patient left the department. Eight of the 15 patients had an initial inspection of their pressure areas – seven did not have them re-inspected, and none of them had a blanching pressure test performed. Half were documented to have their nutrition/hydration and elimination needs met.

Substandard nursing care continued into other clinical areas in every case. This level of care directly contributed to the deterioration of the HAPU and to the success of the claims. This highlights the requirement for trust-wide prevention strategies to ensure quality nursing care is consistently provided.

NURSING DOCUMENTATION

The standard of nursing documentation varied, across all 15 claims, from a brief triage summary to robust nursing entries. One trust had an intentional rounding checklist as part of the nursing care records to be undertaken by HCAs every two hours, but it was not consistently completed. Most trusts had a dedicated section within the ED clinical notes for nurses to calculate risk for pressure injury and yet they were not always completed. Not all entries were dated and timed and therefore it was unclear when specific events occurred: this is not in line with section 10 of The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates<sup>26</sup>. There were no Electronic Patient Records (EPR) used in any of these cases. It is worth noting that the time lag between clinical incidents and closure/settlement of clinical negligence claims can be a number of years. We are aware many trusts have introduced EPR within their EDs since April 2018, which will positively impact the issue of date and time stamped entries.

SERIOUS INCIDENT INVESTIGATION

There was disparity in the level of information within the four Serious Incident (SI) investigations undertaken. One organisation undertook a very concise level one investigation; it had no Duty of Candour, Root Cause, Contributing Factors or Actions/Recommendations, and therefore was not fit for purpose in mitigating future risk. Only one report had a robust action plan that would mitigate future risk providing it was completed. The remaining three were of good standard with respect to documenting the chronology of events and contributing factors.

One report provided details of nurse staffing, but no information regarding the acuity of the patients and therefore did not provide full context of the environment. It is worth pointing out that Serious Incident investigations and their reports can be pivotal in influencing change, improving safety and subsequently reducing clinical negligence claims. Therefore, organisations should include vital information such as staffing, skill mix and acuity within all their incident reports, which will ensure accurate data capture of clinical areas and whether they are considered safe, particularly in respect of appropriate staffing. Due to the lack of such information this report does not draw any conclusions in relation to clinical incidents and nurse staffing levels.

COMPLAINTS

Three claims were preceded by a complaint and all responses had a thorough explanation of care provided and answered the questions raised. One response had no apology within it and another suggested they were sorry the complainant wrote to the trust. One complaint response identified the failing in care; the other two did not. It is not clear if the complaint responses motivated the claim or if the patient’s lawyers suggested that a complaint be lodged prior to the commencement of a formal claim.

EMERGING THEMES AND RECOMMENDATIONS

The contributory factors and emerging themes arising from these claims are discussed in detail together with a range of proposed recommendations in Chapter 4.

Illustrative case story

A care home resident with a background of frailty attended ED at around midnight following a fall. He was seen by the triage nurse within three minutes of arriving by ambulance and categorised as level three – to be seen within 60 minutes. A doctor assessed him six hours later and found no significant injuries and the doctor decided to admit him for intermediate care. There were no beds available and he waited in ED, predominantly on a corridor, for a total of 16 hours 45 minutes.

An accurate Waterlow risk assessment was completed and found him to be at high risk of developing a pressure injury. The man was placed on a bi-flex mattress on the ED trolley; however, his pressure areas were never inspected. He was given drinks and food, but regular toileting was not provided and he was eventually incontinent of urine. Despite the trust practising four-hourly ‘comfort rounds’ there were significant gaps in the nursing documentation which did not support high quality nursing care in ED. Notable practice: implementation of a pressure relieving mattress in the ED and completion of an accurate and timely risk assessment.

The gentleman went on to acquire four separate stage two and three pressure ulcers to his sacrum, buttocks and both heels, causing unnecessary pain and suffering.

On the balance of probabilities there was failure in care to:

- undertake a skin assessment of a high risk patient and document it accordingly on a body map;
- perform regular nutrition reviews during the time in ED;
- perform two-hourly care and comfort rounds in ED; and
- adequately reposition him on the trolley.

Two allegations were successfully refuted, these included:

- failure to undertake an accurate Waterlow risk assessment in ED; and
- failure to ensure he was nursed on an appropriate mattress.

In summary, this case was successful and damages awarded because not all elements of care were provided despite appropriate identification of risk and utilising pressure-relieving aids. Therefore, this man did not receive the level of care expected of a reasonably competent practitioner.

*Note: this case is an amalgamation of claims and characteristic of a pressure ulcer incident only.*

Falls related claims in the Emergency Department

Introduction

“A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard”<sup>25</sup>. Falls are the second leading cause of accidental or unintentional death worldwide<sup>25,28</sup>, accounting for over 684,000 deaths per year. Seventy-five per cent of fatalities occur in older people – typically aged 70 and above<sup>28</sup>.

The cause of falling is multifactorial and can include any number of the following, but the list is not exhaustive:

- having a history of falls;
- muscle weakness;
- poor balance;
- visual impairment;
- polypharmacy or the use of alcohol/illicit drugs;
- environmental hazards; and
- underlying medical conditions, such as dementia<sup>25,28</sup>.

The impact of a fall varies from no injury to life-threatening fractures or brain damage and sometimes death.



**METHODOLOGY**  
Of the 220 Emergency Department claims analysed in NHS Resolution’s series of ED reports, 35 involved patients falling in or around EDs while accessing emergency treatment for something often entirely different. We included closed, settled with damages paid claims, of adult falls with an incident date between 1 April 2014 and 31 March 2018 and analysed 25 claims.

We excluded ten claims because the falls occurred in other clinical areas between 10 hours and three days after transfer out of ED. However, five patients fell in another clinical area and were included in the analysis because the patients fell between 25 minutes and six hours of transfer. A causal link was established because the risk of falling was not assessed in ED and effectively communicated to colleagues in other clinical areas and therefore preventative measures could not be implemented.

**OVERARCHING DATA AND FINANCIAL IMPACT**  
Inpatient falls within NHS trusts are a significant problem and are the most commonly reported patient safety incident<sup>29</sup>. In 2015/16 the number of reported inpatient slips, trips and falls incidents accounted for almost 245,000 incidents in England<sup>30</sup>. The majority – 83% – occurred in acute trusts, 14% in mental health care facilities and 3% in community organisations<sup>30</sup>.

Anyone can fall, but people over the age of 65 are particularly at risk and those over age 70 more likely to be fatally injured<sup>25,28,31</sup>. In 2015/16 they accounted for 77% of all inpatient falls<sup>30</sup>. Statistically, they are more likely to fall in hospital because they have a longer length of stay, have cognitive issues or are physically less mobile than younger people<sup>30</sup>.

From 2013/14 to 2018/19, NHS Resolution were notified of 2,250 falls-related claims across all specialties – 998 remain open, 523 were unsuccessful (no compensation paid) and 739 are closed with damages paid, resulting in NHS Resolution paying a total of £26.3m in damages and legal fees.

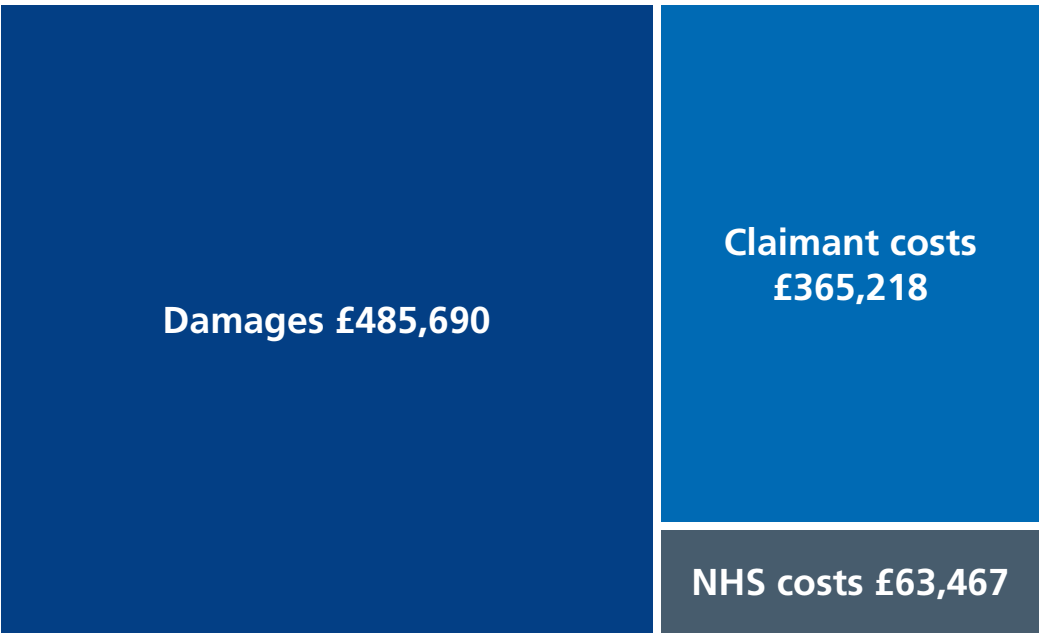
There is a clear need for healthcare providers to address this problem through robust preventative initiatives. National and international guidance suggests prevention strategies should emphasise education, training, creating safer environments, prioritising fall-related research and establishing effective policies to reduce risk<sup>25,28,30</sup>.

International meta-analysis has shown significant links with omitting essential care and higher incidence of harm, such as falls and pressure ulcers in acute healthcare settings<sup>32,33</sup>. One systematic review of 21 English published studies between 2006 and 2017 concluded there were positive outcomes with the introduction of care rounds<sup>33</sup>. Therefore, it is reasonable to suggest such an intervention should be actively promoted locally, regionally and nationally.

With an incident date in the financial years of 2014/15 to 2017/18, NHS Resolution paid £914,375 to settle the 25 falls claims in ED. This is broken down by damages and legal costs in Figure 12.

The mean average amount of damages paid was £19,428 – with actual compensation payments ranging from £2,000 to £125,000.

Figure 12: The cost of falls related claims in ED with incident dates between 2014/15 to 2017/18



# Detailed analysis

PATIENT JOURNEY

The vast majority of patients were admitted from home (n=23), one from a community hospital and one from a residential care home. Twenty patients arrived by ambulance. Most patients were cared for in majors – Figure 13 shows the ED area they were admitted to and the clinical area where they fell. Figure 14 shows what happened to these patients after their episode in ED.

Figure 13: ED area of admittance and location of fall

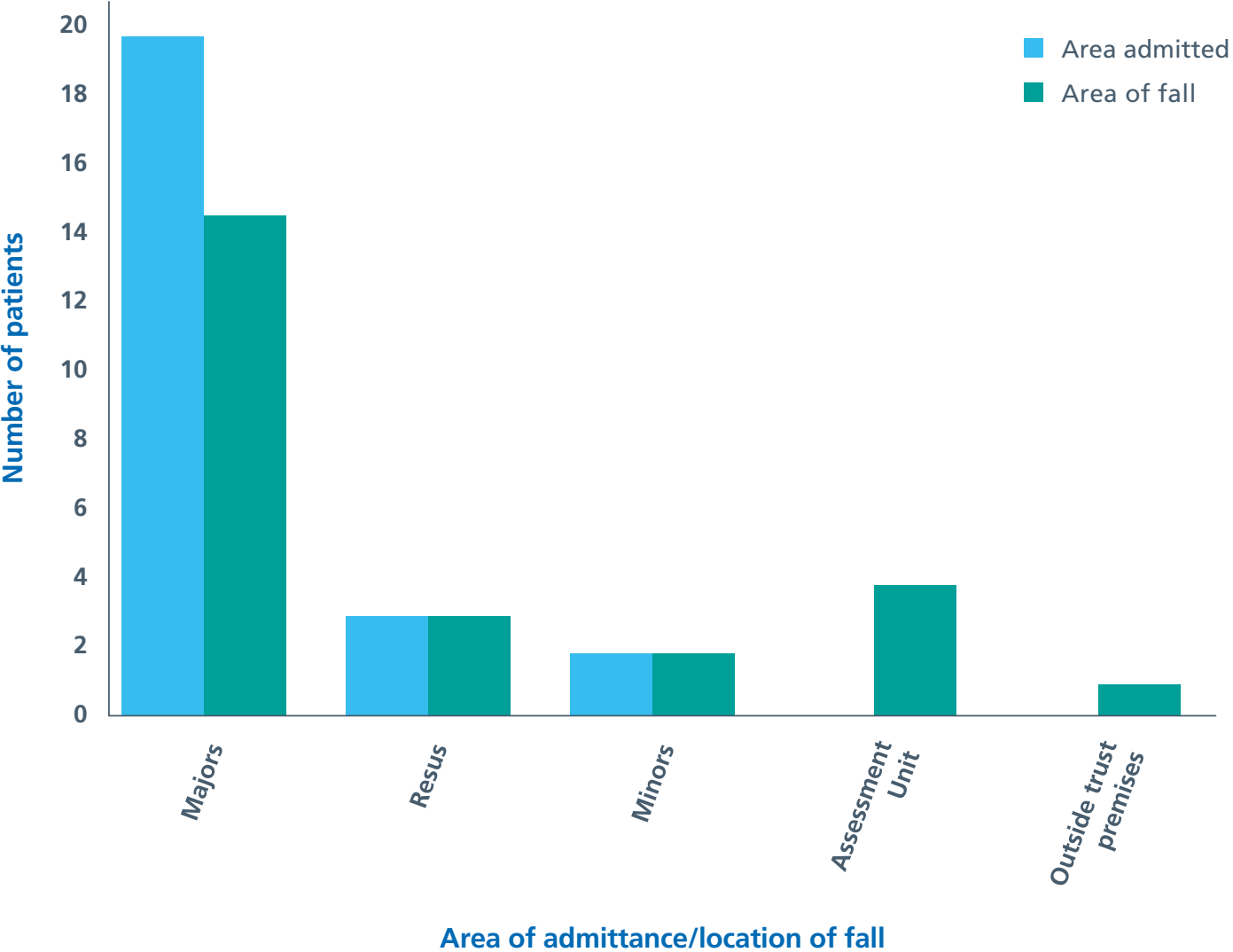
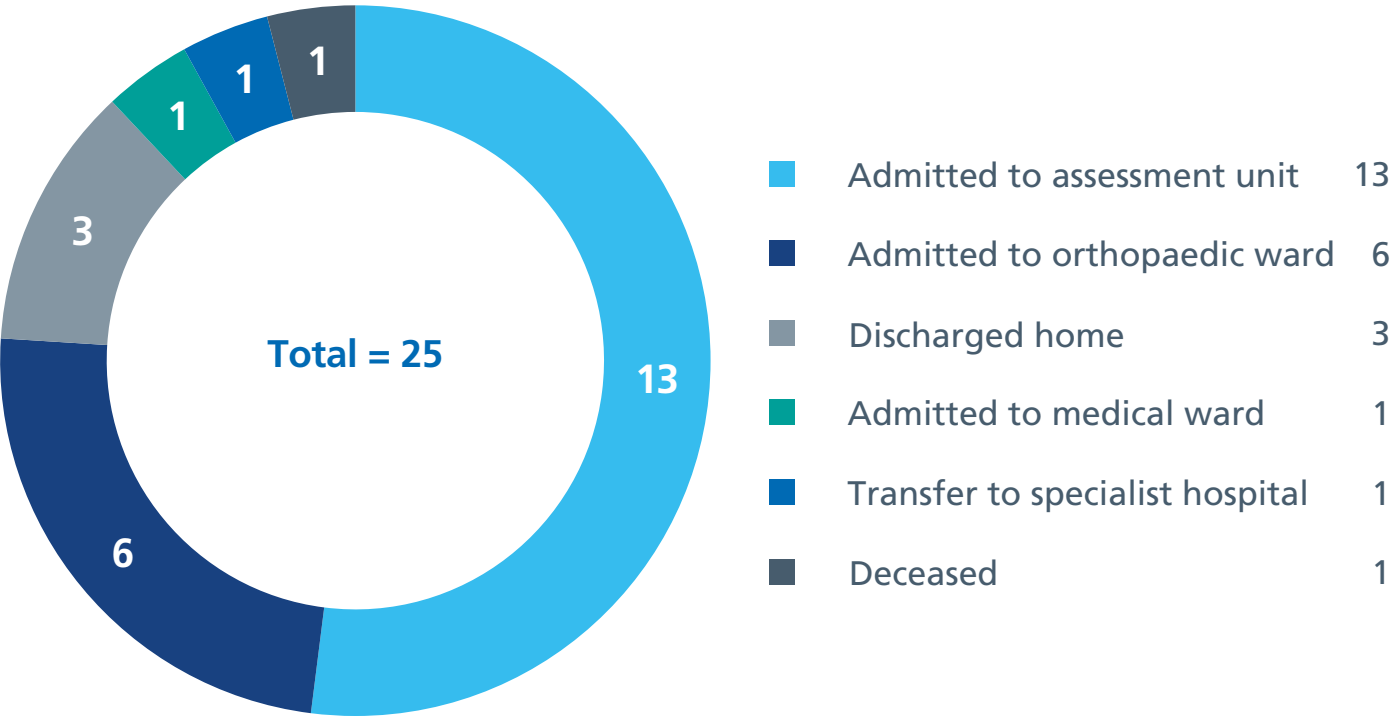


Figure 14: Where fall patients went after their stay in ED



AGE AND GENDER

There were more people over the age of 65 (n=15) in comparison to those aged 50–65 and below 50 years, and ages ranged from 28 to 94 years. This supports evidence that older people are more at risk of falling<sup>25,28,29,30,31</sup>, but does not explain why falls assessments are not carried out on older people. Ten patients were below the age of 65, suggesting anyone is at risk of falling<sup>25,28</sup>. NICE recommends people between the ages of 50 and 64 with health conditions should be assessed for falls risk<sup>31</sup>. More women (n=15) than men (n=10) fell while in the ED.

COMORBIDITIES

Four patients had no known underlying medical problems; the remaining 21 had one or more medical comorbidity. There were a total of 73 different medical comorbidities, the most common being cardiovascular disease, followed by disorders affecting cognition, the skeleton, gastroenterology and endocrinology. Notably seven patients had a history of falls. These statistics add weight to the theory that people with underlying health issues are more at risk of sustaining harm in hospitals<sup>23,24</sup>.

**TIMING OF ATTENDANCE AND FALL**

There were more falls statistically during autumn and winter (n=20) than spring and summer (n=5), which is supported by Johansen et al (2016)<sup>32</sup>. Given Emergency Departments are continuously busy all year round we could not determine any specific rationale for this trend, from our data, given 24 patients fell within the ED. There was no statistical difference in the day of the week patients attended ED; Saturday had the least number of falls with just two.

The time of day was scrutinised – more people attended ED during nursing ‘day shifts’, typically 08:00–20:00 hours (Figure 15); however, more falls occurred in the early evening or night (between 19:00 and 07:00 hours) in ED.

Figure 15: Fall patients admittance to ED by nursing shift

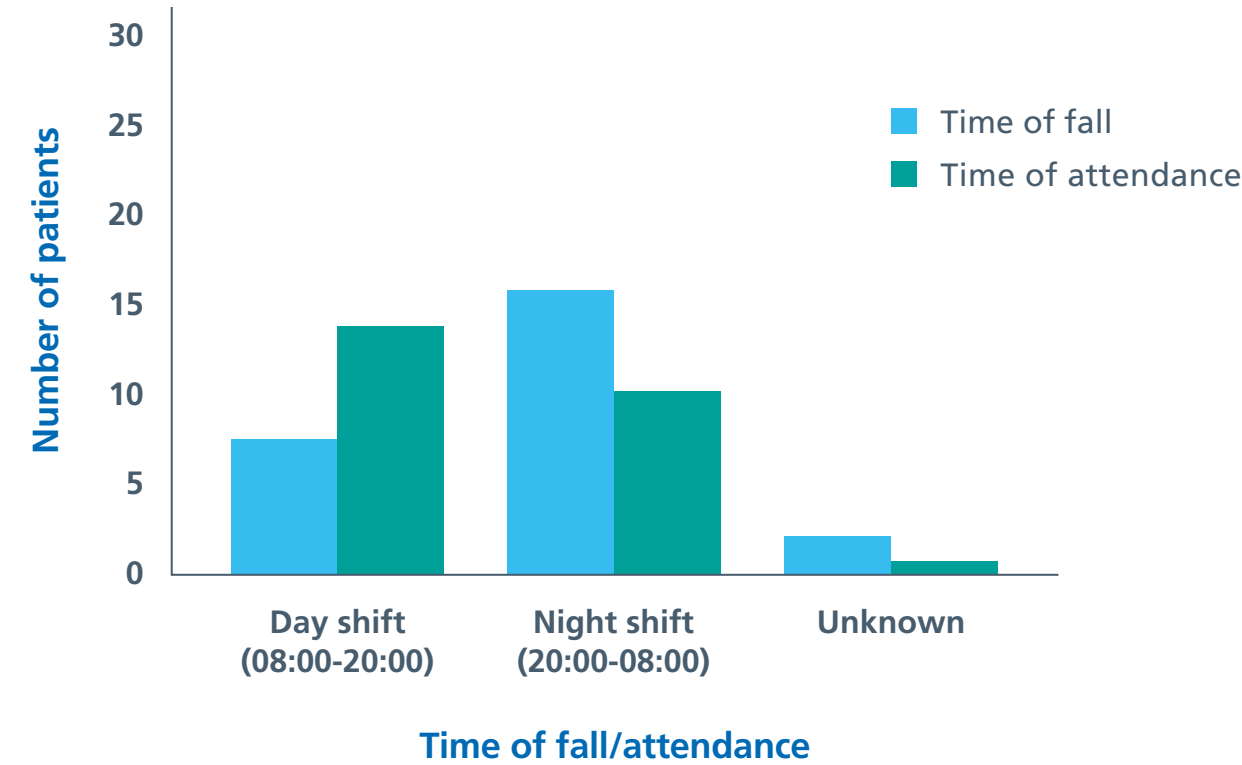


Figure 16: Fall patients admittance to ED by time

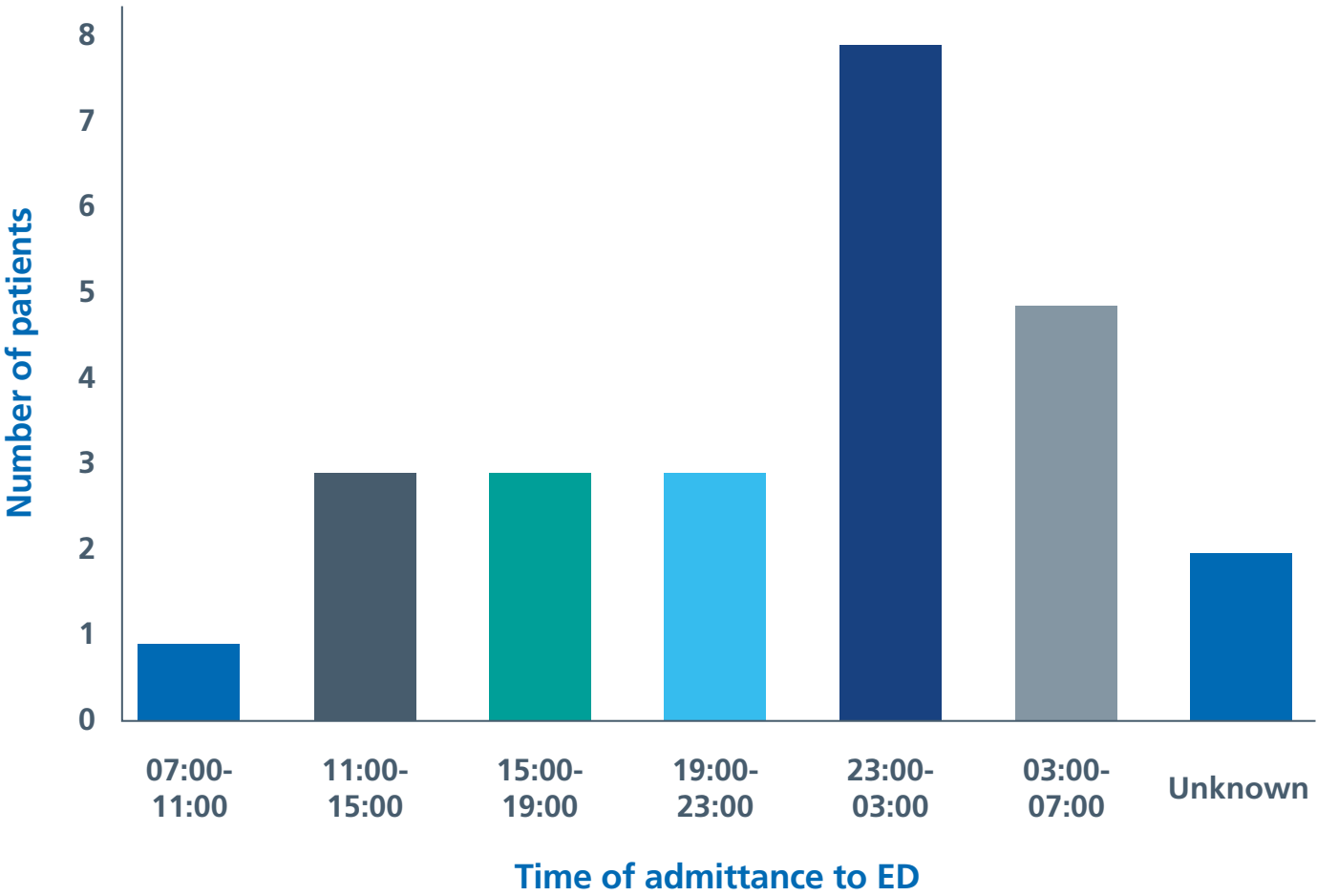
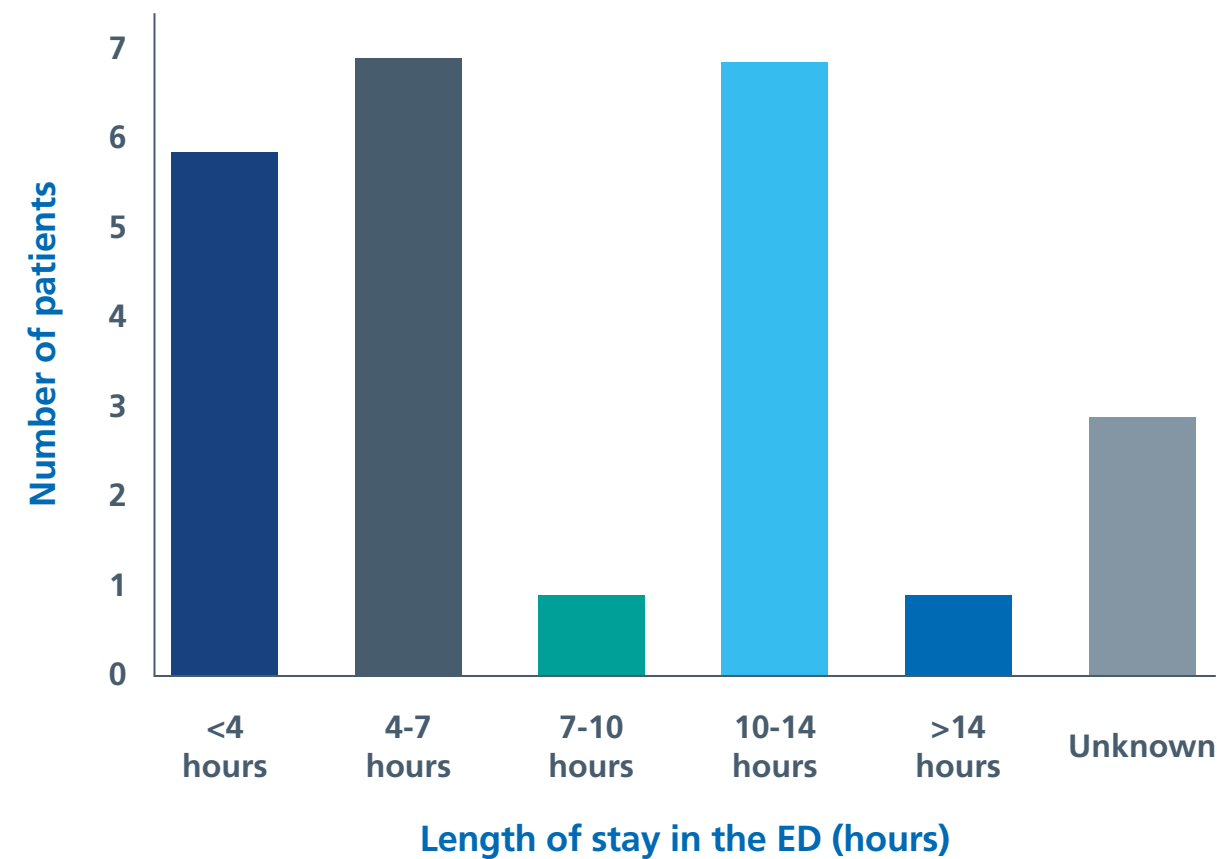


Figure 17: Length of time spent by fall patients in ED



LENGTH OF STAY IN ED

Three cases did not have the time of departure from ED documented – we classified these as unknown. The average time spent in ED was 7 hours 40 minutes: this ranged from 1 hour 41 minutes to 15 hours. Six patients met the national four-hour target. Figure 17 shows the breakdown of the length of time the patients spent in ED.

INJURIES SUSTAINED FROM FALL

For clinical negligence claims to be successful there must be a degree of harm suffered by the person. Some patients had multiple injuries as a direct result of falling and we identified 34 separate injuries of the 25 patients. The most common type of injury was a fractured bone and accounted for 19; others included lacerations, soft tissue damage and intracranial haemorrhage. One person died as a direct result of the fall in ED.

RISK ASSESSMENTS

Most patients (n=20) did not have a risk assessment completed despite the average time in ED being over seven hours. When risk assessments were undertaken (n=5), two were complete, i.e. every question was answered, but none were accurate. This means their level of risk was erroneous and effective nursing care could therefore not be planned or implemented. One assessment was completed when the patient was being discharged/transferred.

NURSING CARE

We found no evidence in the analysis of the clinical care in these cases to support ‘intentional rounding tools’ or ‘comfort rounds’ having been routinely and regularly undertaken in any ED. This is despite a number of departments having specific local policy and documents, within ED records, to enable this intervention. Seven falls occurred while the patient attempted to go to the toilet alone, which supports the conclusion that assistance with elimination needs is a vital nursing intervention in the prevention of falls in hospital. There was no evidence in 75% of the claims we reviewed to support the conclusion that these patients had their nutrition and hydration needs met.

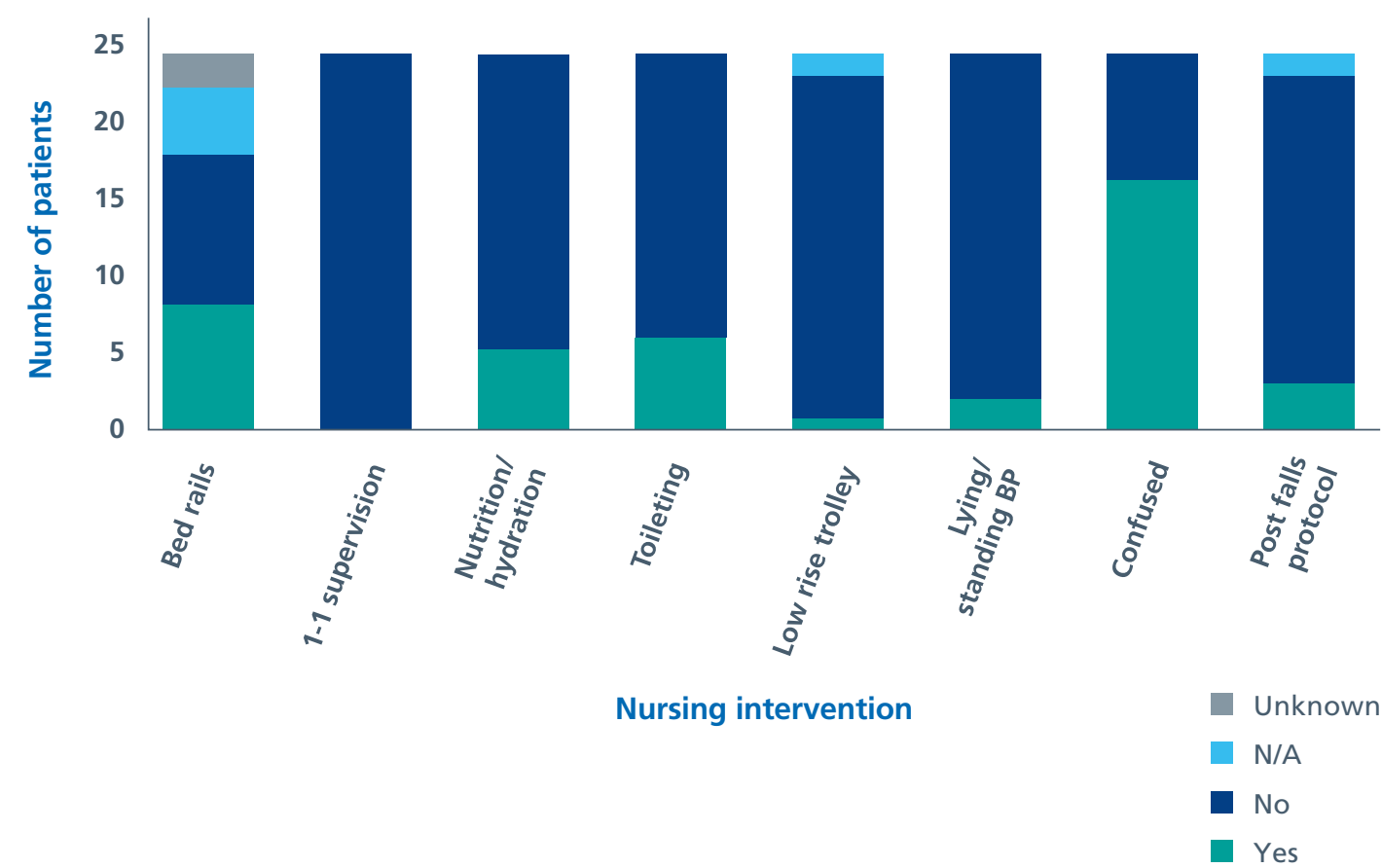
No patients received dedicated 1:1 supervision while in ED despite many patients having impaired cognition. We defined impaired cognition as symptoms affecting their ability to maintain their own safety, such as confusion, dizziness, falls, overdose and seizure. Seventeen patients had a history of dementia or were known to be confused at the time of attending ED (as documented in the clinical records) and only one had a formal mini mental capacity assessment undertaken. None of them had a lying and standing blood pressure taken.

Ten patients did not have the bedrails in the up position while on an ED trolley, nine did and for some it wasn’t applicable because they were not on a trolley at the time of the fall (n=4). In two cases we could not find this information and therefore it is unknown. There was no evidence in our documents to suggest bedrail assessments were undertaken to support or refute the use of bedrails. We could not determine from our documents if EDs widely utilise low rise trolleys; only one patient was known to have been cared for on a low rise trolley.

There was a lack of evidence that patients received all the elements of care usually found on an ‘intentional rounding tool’. This supports the theory that this simple intervention is effective in delivering quality nursing care and yielding positive outcomes for patients<sup>33,34</sup>, therefore potentially improving patient safety, decreasing patient incidents/harm and reducing the financial burden of litigation. Figure 18 illustrates the nursing interventions provided /not provided in ED.

“Intentional rounding (IR) is the structured process whereby nurses in hospitals carry out regular checks, usually hourly, with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.”<sup>39</sup>

Figure 18: Nursing interventions provided/not provided in ED



OTHER HEALTH PROFESSIONALS

Five of the cases involved other healthcare professionals, such as doctors and radiographers. One failed to raise the bedrails after obtaining blood samples and the patient fell from the trolley. Similarly, another failed to raise the bedrails after performing an investigatory procedure. One asked the patient to get off the trolley and walk alongside it, then left the patient to get a piece of equipment to assist clinical examination. Finally, one patient was medically discharged without having appropriate imaging, overnight observation or instructions following a head injury, resulting in a fall off NHS premises.

LOCAL INCIDENT REPORTING

The majority of falls (n=23) were reported via local incident reporting systems, 16 reported in ED, six on assessment units and one on a specialty ward. There was variation in the standard of information – one incident report did not record the date, time and location of the fall, escalation process or details of post-fall management. The earliest incident reported was 29 minutes and the latest two weeks. One senior ED nurse stayed two hours after the shift ended to ensure the incident was reported and included all salient information. Only one incident report documented the number of nursing staff on duty and how many were agency staff, but it did not include skill mix. No incident reports detailed the department activity, acuity or medical staffing levels.

SERIOUS INCIDENT INVESTIGATION AND REPORTS

Not all claims had a serious incident investigation undertaken – 17 of the 25 falls did have some level of investigation to understand what had happened. One report was not available in CMS and therefore not scrutinised. Two investigations were level one concise investigations; of these, one patient suffered severe harm and should have had a more extensive investigation at the time to include a robust action plan to mitigate risk, in line with the Serious Incident Framework<sup>35</sup>. Of the eight claims that had no investigation, six patients suffered a low level of harm and two moderate harm and so the absence of investigation can be considered acceptable, in that the harm did not meet the threshold for SI investigation<sup>35</sup>.

There was disparity across all 16 reports analysed with respect to identifying the correct root cause of the incident. Three reports cited failure to assess risk, six reports found there was failure to effectively observe/supervise patients, one found failure of the bedrails and another ineffective inter-departmental communication. Two reports had no dedicated section for identifying the cause of the fall. One report stated three root causes: failure to print the ambulance handover sheet; relatives were in the waiting room; and the patient was confused behind cubicle curtains, all of which did not address the real cause – lack of appropriate observation of a confused person.

Thirteen reports complied with Duty of Candour regulation<sup>36</sup> – all these incidents occurred following the introduction of Duty of Candour regulations in November 2014. Twelve reports had action plans although only nine of these would have potentially reduced reoccurrence of similar incidents. Nine reports documented plans for shared learning – none were trust wide. One report documented that it was not applicable to take any steps to reduce future risk.

Nine cases documented staffing levels in either the local incident report or SI report.

Only four cases recorded patient numbers (majors or resuscitation only) and none documented specific acuity or total number of patients in the whole ED. Therefore, we are unable to draw any conclusions regarding ED activity and nursing numbers impacting on harm sustained in EDs across England.

COMPLAINTS

Nine claims involved a written complaint – overall the standard of the trust responses was satisfactory. The quality of the duty of candour process varied across all responses (for those incidents occurring after November 2014): some articulated meaningful apologies very well and others did not – the apology that the complainant ‘feels’ there was substandard care featured in some of the complaint responses we examined.

While it is important to remain factual, some of the language could have been more compassionate. We considered three of the responses could potentially be interpreted as overly defensive.

Three claimants were initially dissatisfied with the original reply to their complaint and challenged the complaint response – they all received supplementary correspondence. The second response from one trust significantly improved its language and offered a genuine apology, which was not evident in the first letter – had the trust been more compassionate initially it could have avoided additional correspondence or even the claim. It is not clear if the remaining six complainants were satisfied with the trust replies, but they all led to successful claims.

Five complaint responses admitted failings in care; six answered the questions honestly and explained trust procedure and rationale for care. Six responses explained the lessons learnt and there was evidence of some dissemination of learning within ED only. This demonstrates a commitment to learn from mistakes, mitigate future risk and promote positive cultures. However, the vast majority of the learning was transferrable to other specialties and wider sharing could yield broader benefits in the patient safety space.

# Illustrative case story

An eighty-year-old man arrived in ED mid-afternoon via ambulance following a fall at home. He had a history of dementia, deafness and numerous falls at home. He was triaged immediately, categorised as level three – for medical assessment within 60 minutes. A junior doctor clinically assessed him within 45 minutes and diagnosed a Urinary Tract Infection with a plan to exclude any injuries from the fall at home and admit for consultant review the following morning. The doctor noted the cognitive impairment.

The man was transferred to an assessment unit (part of the ED) to await a bed on the specialty ward. At some point, he had an episode of loose stools and was moved to a single side room, which was not in an observable position. At around 01:00 hours, 10 hours after presenting in ED, while attempting to go to the toilet he fell (unwitnessed), sustaining a fractured neck of femur. At the time of the fall, he was alone. Sadly, three months later the man died.

The serious investigation report identified the root cause as staff underestimating the extent of his dementia and wrongly assuming he could maintain his own safety. Nurses did not complete a falls risk assessment in ED or following the fall. The SI report stated the patient was in ED, therefore the falls bundle was not completed – the assumption being that the trust did not have a policy of completing risk assessments in ED at the time. Despite the level of harm the SI investigation was concise; it did not provide a robust chronology of events, notable contributing factors or an action plan to mitigate future risk. However, it did record the staffing levels at the time – the assessment unit had its establishment of five nurses – three registered and two support staff, although three of the five were agency/temporary nurses.

NHS Resolution instructed two expert witnesses – an orthopaedic surgeon and a nurse. They both concluded there was a breach of duty in failing to complete a falls risk assessment in ED and although they could not definitively say doing one would have prevented the fall, on the balance of probability it would have reduced the risk of inappropriate observation.

The trust accepted liability for the fall, subsequent pain and requisite surgery. The family were awarded damages.

*Note: this case is an amalgamation of claims and representative of a falls incident.*

## Discussion, emerging themes and recommendations

# Introduction

This chapter discusses the emerging themes from the two types of harm, namely HAPU and falls, and explores a number of recommendations with the aim of making improvements to patient safety, reducing harm and positively impacting the number of clinical negligence claims reported to NHS Resolution.

The themes emerging from the two categories of claim include:

- 1. Risk assessments
- 2. Proactive nursing care and closer observation
- 3. Communication
- 4. Reporting and investigation of incidents.

## Theme 1: Risk assessments

This thematic review has highlighted the shortfalls in current risk assessment tools for pressure damage and falls risk. The Waterlow assessment tool<sup>21</sup>, predominantly used in NHS organisations for assessing patients at risk of developing pressure injury, has its challenges. It was developed in 1985, reviewed in 2005 and has not been updated despite the changing landscape of healthcare – notably, people are generally living longer with complex medical comorbidities<sup>23</sup>. The Waterlow risk assessment is a score-based tool which, when added together, provides three categories for risk – a score of 10+ is “at risk”; 15+ is “high risk”; and a score of 20+ is “very high risk”. There is no category for patients scoring less than 10 and it is reasonable for health practitioners to assume patients with this score are therefore not at risk, which is not necessarily the case. However, some NHS organisations have adapted this tool to meet their own needs. Additionally, if a patient’s condition does not change (deteriorate) it is unlikely their risk assessment will be repeated within a week. Seventeen years on from the tool’s last review, it could be suggested some of the terminology is subjective and potentially confusing for assessors. This in turn is leading to incomplete or inaccurate risk assessments.

Similarly, the Braden scale<sup>22</sup> is also outdated, having been created in 1987 in America and not revised since. The Braden scale calculates low risk patients with a higher score than those at risk and for clinicians familiar with the Waterlow assessment this could potentially lead to confusion. The Braden risk assessment does not account for age, gender or underlying health problems.

While the Waterlow risk assessment tool does take these into consideration, it is evident that the phrasing regarding medical comorbidities is confusing and nurses often do not appreciate the link between multiple comorbidities, such as COPD, diabetes and heart failure being three separate organ or system failures.

The falls cases highlight the fact that there is no universal or nationally recognised risk assessment tool for falls, unlike for pressure ulcers (Waterlow). This presents potential for variation in standards of care nationally in relation to completion and implementation of such risk assessments. The provision of quality nursing care must be underpinned by robust and effective process. Given slips, trips and falls remain a significant problem within the NHS it is reasonable to suggest there is potential for improvement in this area to be driven nationally.

One potential solution to ensuring the completion and accuracy of all risk assessments is the use of digital solutions which can automate the initiation and population of risk assessments based on patients’ records. This would build on the work currently being undertaken at NHS England and NHS Improvement (NHSEI) to inform risk assessments for all harm, including venous thromboembolism, nutrition and hydration, bedrail and delirium assessments.

Such assessments must be unambiguous and endorsed by NHSEI through its improvement initiatives, to support reducing the incidence of falls and pressure ulcers across England.

The perceived benefit of such contemporary risk assessment tools can reduce harm, and prevent extended hospital stays, complaints and potentially claims. This has the potential to make a notable and positive financial impact across the wider NHS.

- Recommendation 1:**
- National**
1. This report supports the aims of the NHSX digital clinical safety strategy particularly in identifying “how digital technologies can be best applied to patient safety challenges”. In the context of risk assessments digital technologies support the automation of tasks, an established effective intervention to overcome human error.

2. New interventions should not be implemented without appropriate education and training. Therefore, it is recommended that a robust training programme is established.

**Theme 2: Proactive nursing care and closer observation**

The clinical care reviewed in all 40 claims highlighted the lack of proactive nursing interventions and an absence of close observation of high-risk patients, particularly those at risk of falling. While this report did not explicitly examine staffing levels, a number of other publications have done so: the GIRFT Emergency Medicine report highlights the large national variation in ED nurse staffing and the fact that outcomes are negatively affected in EDs where the number of admissions per registered nurse is high<sup>8</sup>.

The importance of addressing patients’ daily activities is key to their recovery and avoidance of unnecessary harm<sup>33,34</sup>. The findings from this analysis suggest that essential nursing care interventions are not wholly being provided for patients in ED and indeed other clinical areas.

Our information tells us there is a need for closer observation of patients at risk of falling. Providing closer observation on a 1:1 basis is one answer; however, we accept this can often be impractical in an ED setting, given the throughput of patients. Although it is not impossible to achieve with dedicated resources, such as Nursing Care Guardians.

Identification and recognition of patients at risk of falls or developing pressure injury is particularly challenging in EDs. Patients are frequently moved around to accommodate their own and other patients’ clinical needs. The challenge is to visually identify people at risk rather than rely on entries in health records or on whiteboards, which are often not easily accessible or visible. There should be a visual prompt for nursing staff to provide frequent and regular nursing interventions, which consistently follow the patient. The challenge is to determine the most effective method.

- Recommendation 2**
- National**
1. ED nurse staffing must be organised so that there is dedicated nursing time available on every shift to deliver regular and frequent high quality nursing interventions for all patients. One potential solution to achieve this is with the role of Nursing Care Guardians. These dedicated roles would solely undertake nursing care rounds and deliver essential nursing interventions.
- Local**
1. NHS trusts should review their processes for procuring and providing 1:1 supervision to achieve safe observation of patients at high risk of falling.

2. Trusts should review their procedures for where vulnerable patients should be nursed in ED, in relation to observable trolleys when 1:1 supervision cannot be achieved.

3. EDs that do not have their own pressure relieving aids should seek to purchase some as part of their departmental resource or have a low threshold to acquire them from a trust ‘equipment pool’.

Theme 3: Communication

Communication between clinical areas was a significant factor in all the HAPU cases and six falls cases. There was no evidence in the documents we reviewed to support patients’ risk was effectively communicated, verbally or written, to colleagues in other clinical areas or between shifts. Therefore, nurses taking over care did not receive adequate information to implement the appropriate level of care. It is worth remembering that ED is the beginning of the patient’s journey and considered to be the foundation for quality care, thus effective communication should be embedded at the outset and delivered throughout the patient’s journey. This is critical to patient satisfaction, to avoidance of incidents and to good outcomes. Thus, organisations that provide excellent holistic care and document it in their EDs would yield enhanced patient journeys and satisfaction, fewer incidents, complaints and inherently fewer claims.

One potential solution to support communication between both clinicians and organisations would be a standardised tool for handover. This would ensure that relevant information is consistently shared and reduce the risk of error. In their 2018 report ‘Under Pressure: safely managing increased demand in Emergency Departments’<sup>37</sup> the CQC support the use of SBAR<sup>d</sup> format as a standard for sharing information.

Recommendation 3

National

- 1. The Nursing and Midwifery Council should consider a targeted awareness campaign on good record-keeping and effective communication to drive the Code’s standards and reduce non-compliance.

Local

- 1. Individual EDs should audit their own clinical health records for evidence of effective handover information. The findings of these audits should be presented to clinicians and leaders to drive improvement programmes for the delivery of salient clinical information.

Theme 4: Reporting and investigation of incidents

Local incident reporting

Seven of the 15 HAPU cases and two of the 25 falls did not have a local incident report completed. It is important for organisations to encourage the timely reporting of harm to their patients. Improving reporting will help trusts understand the level of incidence, care delivery issues and how they can make improvements to prevent reoccurrence. Despite two patients having their pressure ulcers identified in ED, only one had an incident report and this was completed outside ED. It is the responsibility of the clinician in the clinical area where incidents occur to report them.

There was inconsistency in the level of information provided and notably the absence of staffing levels and acuity in any of the reports we reviewed. There was a delay between three and 15 days for three HAPUs to be reported and this could explain the limited information within the reports.

Open reporting practices are key to fostering proactive and effective learning cultures<sup>2,3</sup>. This approach to risk management and quality care facilitates a no blame and just culture by driving continual transparency across all sections of healthcare provision.

Root cause analysis and serious incident investigations and reports

There was variation in the standard of SI investigations and reports that we reviewed. Five of the 15 patients with pressure ulcers and 17 of the 25 patients who fell had a root cause analysis investigation.

Accurate and objective information contained within SI reports is vital for organisations to understand what went wrong and to implement improvements to mitigate future risk. There was huge disparity in the standard of information in the SI reports we reviewed.

Similarly, the sharing of lessons was diverse. While some SI reports documented sharing within the ED, there were no trust-wide communications of HAPUs and falls. This was a disappointing finding, although not surprising. Organisations must proactively share learning and improvements with colleagues in other specialties. Given HAPUs and falls occur across all specialties in acute trusts, this would be a perfect example of best practice, transparency and fostering a positive learning culture.

Of the root cause analysis reports completed after the introduction of the Duty of Candour regulations, none involved the patient or their family during the process to provide their perspective. However, all the serious incident reports were forwarded to the patient or family.

It is important to note all these incidents occurred during the period that the Serious Incident Framework (2013 & 2015) was in place, as the national guidance for undertaking an investigation of a serious incident. As such the focus was around identifying the root cause and mitigating future risk through action plans<sup>35</sup>.

NHSEI are currently developing a new reporting system and framework for safety incidents – Patient Safety Incident Response Framework<sup>38</sup> – which will inform a national database. As a conduit to compliance, some mandatory information within all incident reports could be established as the gold standard, such as number of all staff on duty and skill mix, the establishment, the number and acuity of patients in the clinical area. This information provides crucial context to the environment where patient safety incidents occur and including it in incident reports can support identification of contributing factors and drive organisational improvements. The roll out of the new guidance is awaited, where the focus will be:

- a risk-based approach – incorporating Safety 2 methodology;
- fostering transparency and just culture; and
- improved oversight and governance<sup>38</sup>.

<sup>d</sup> SBAR is a framework for healthcare communication (situation, background, assessment, recommendation).

## Recommendation 4

### National

1. This report supports the NHSEI rollout of the 'Learn from patient safety events (LFPSE) service'. This system will allow for better information collection to support learning. It should support the capture of environmental and contextual factors for incidents including staffing levels, skill mix and patient acuity.

### Local

1. NHS organisations should encourage all disciplines and levels of staff, clinical and non-clinical, to report incidents including 'near miss' situations.
2. Local incident reports and SI investigations must include nursing and/or medical staffing levels, the budgeted establishment and acuity in the clinical area at the time of the incident.
3. Organisations must provide appropriate risk management and SI investigation training to all levels and disciplines of staff involved in this process. The reports should have executive sign off and adhere to the national principles of serious incident investigation and reporting.
4. Given the local variation of reporting criteria between healthcare providers and their commissioners, these organisations should ensure their standards are aligned to national guidance.
5. NHS organisations should work to promote trust-wide sharing of learning and improvements to demonstrate their transparency and commitment to improving safety.

## Conclusion

The evidence from our unique data tells us clinical negligence is proved, on the balance of probabilities, when clinicians fail to adhere to national guidelines for the delivery of care that a reasonable body of health professionals would have provided. Some elements of this breach of duty of care could be attributed to poor documentation or, more likely, that it simply wasn't done. In order to prevent harm and subsequent litigation the importance of providing holistic and complete care to all patients cannot be underestimated and should be actively promoted.

The 40 clinical negligence cases we have analysed in this report demonstrate the clinical need for the development of national contemporary risk assessment tools, specifically for pressure injury and falls. The development of such tools will positively influence how nurses accurately and regularly assess their patients for hospital acquired harm and therefore strengthen quality care.

While some systems and processes may not support effective nursing care, it is ultimately the responsibility of every nurse to provide high quality care. The NMC Code states that registered nurses and associate nurses are expected to work within the limits of their competence<sup>26</sup>. This includes documenting their actions while being mindful they are accountable for their own actions and omissions. Healthcare organisations also have a responsibility to support nurses in upholding the NMC standards and should do so through robust and effective policies, processes, appropriate resources and regular training. The impact of such support will be realised on a human and financial level while improving organisational reputation and securing service user trust and confidence.



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# Glossary

Available at: <https://resolution.nhs.uk/glossary>

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