Incidents, Injuries & Indignities

Some of the incidents and injuries sustained whilst in the care of health & social care professionals; further details follow below:

Fractured Neck	Slide Sheet. Incorrect use. Trauma and skin abrasion. Injuries aggravated.
Fractured Femur	Slide sheet. Failing to spot roll. Guidance ignored. Patient dangling from bed.
Fractured Hip	Shoulder dislocation. Caused by rolling body in bed. Aggravating shoulder injury.
Extensive bruising to vulnerable leg	Shoulder dislocation. Caused by inserting hoist sling incorrectly. Aggravating shoulder injury.
Dislocated shoulder	
Rolling out of bed and banging head on tiled floor	Inserting hoist strap roughly causing trauma & skin abrasion.
Rough Handling. Indignity. Trauma to vulnerable leg. Degradation	Rough handling of body and limbs. Trauma, sprains and bruising
Stand-aid equipment transfer. Multiple Incidents. Straps attached incorrectly	Bed cot sides lowered. Sliding off a bed raised 4 ft above the ground.
Hoist equipment transfer. Near miss of fall. Landed incorrectly.	Missing armchair. Landing on floor. Trauma, sprains and bruising
Rolling patient. Inserting hoist sling incorrectly. Putting pressure on dislocated arm	Missing commode chair. Landing on floor. Trauma, sprains and bruising
Rolling patient. Washing incorrectly. Unnecessary pressure on dislocated arm	Abrasive washing of inflamed skin and sensitive areas
Multiple falls in hospital	Patient served lunch and left lying flat in bed
Fall whilst using commode	Patient confined to bed and debilitated unnecessarily requiring rehabilitation
Hoist equipment. Insecure attachment. Sling straps broke during use	Failure to provide postoperative care
Stand-aid equipment. Insecure attachment. Sling straps broke during use	Patient suffers indignity

Incident	Details	How was this Incident avoidable?
<u>At home:</u> **Fractured Neck** *Significant Incident resulting in Severe Harm*	Social Care visited patient at home to complete a needs assessment. Focus of the visit was to identify barriers to safety whilst making adaptations and adjustments around the home. This includes provision of equipment. Social Care was alerted to a history of rolling out of divan in the night. To remove this hazard a profiling bed and/or cot sides were requested. This request was denied. After visit, patient tumbled out of bed again and fractured neck.	• If the needs assessment had been comprehensive; If Social Care had actively listened to warnings; If Social Care had provided the equipment requested; **This injury could have been avoided.** • Incident reported. No evidence of incident report
<u>In Hospital:</u> **Fractured Femur** **Fractured Hip** *Significant Incident resulting in Severe Harm*	Patient being accompanied by carers to toilet. Whilst motioning to sit down, chair not stabilised. Chair moved and patient fell to tiled floor. Patient sustained femur fracture in 3 places, broken hip and lump and bruising to forehead. Patient moved from floor before paramedics arrived. Nurse claimed that bone snapping heard. Multiple versions of incident offered. Surgery required. Metal plate and pins placed in leg. Due to staff resource pressures, temp carers recruited for a single shift from staff bank. Both carers unfamiliar with patient. No evidence of moving and handling assessment report in medical file. No evidence of report being shared with temp carers prior to manhandling.	• If moving and handling assessment report had been completed; if carers had read report in advance of handling patient; If carers had been familiar with patient; If carers had been properly trained and supervised; if carers had not been left unsupervised in a ward of elderly adults; **This injury could have been avoided.** • No evidence of incident report

Incident	Details	How was this Incident avoidable?
In Hospital: **Extensive bruising to vulnerable leg healing** *Serious Incident*	Patient being mobilised by nurses using stand-aid. During strapping and lifting patient, patient banged leg against stand-aid; whilst equipment in motion. Due to pain, patient asked nurses to stop but nurses ignored and continued with motion. Severe bruising to vulnerable leg still healing following recent operation. No evidence of medical examination. Nurses consulted but denied awareness of incident.	• If nurses had operated equipment safely; if nurses had remained vigilant to vulnerable leg; if nurses had responded to alert from patient; **This injury could have been avoided.** • Incident reported. No evidence of action taken or incident report completed
In Hospital: **Shoulder Dislocation** *Significant Incident resulting in Severe Harm*	Patient being mobilised by nurses. Stand-aid in use. Nurses claim patient slipped on a stand aid with sling and safety straps. Patient shoulder dislocated. Patient required operation to re-insert shoulder joint. Patient usually walked with use of gutter frame. Due to shoulder injury, arm in sling. Patient subsequently unable to use gutter frame for support and therefore unable to walk unaided. Patient now needs to transfer using hoist equipment. Mobility lost as a result of this injury. Permanent injury.	• If nurses had been trained to operate equipment safely; if nurses had remained vigilant; if moving and handling assessment report had been completed; if nurses had read this in advance of handling patient; if nurses had been familiar with patient history; **This injury could have been avoided.** • No evidence of incident report

Incident	Details	How was this Incident avoidable?
<u>In Hospital:</u> **Rolling out of bed and banging head on tiled floor** *Serious Incident*	Nurses failed to follow request. Son advised nurses of history of rolling out of bed in the night. Nurses were asked to ensure cot sides remained up at night. Note made in medical records. Note made in bright highlighter on front of file. Message not shared. Night staff failed to observe. Cot sides not kept up. Patient rolled out of bed in the night and banged her head against a tiled floor. Neurologist called to examine and claimed patient not seriously injured. Son called.	• If nurses had shared son's alert; if nurses had read message on and in medical records; if cot sides had been left up as requested, **This incident could have been avoided.** • No evidence of incident report
<u>At Home:</u> **Rough Handling** **Indignity** *Serious Incident of* Abuse	Home carers attended. Carers appeared hostile. Rough handling by carers visiting to perform personal care. Leg banged while being rolled roughly in bed, resulting in trauma to vulnerable leg and shoulder. Pain to leg caused by banging. Patient naked on bed. Female carer washing nether region. Male carer standing adjacently, staring at patients nether region while female washing. Patient felt degraded. After carers left, patient emotionally traumatised by both incidents. Tearful. Situation witnessed. Violation of Human Rights	• If carers had not handled her roughly and treated her gently and respectfully; if carers had respected her dignity during care, whilst a male carer present; **This incident could have been avoided.** • Incident reported. No evidence of action taken or incident report completed. Same carers returned the following week.

Incident	Details	How was this Incident avoidable?
<u>In Hospital:</u> **Stand-aid transfer. Insecure strap attachment.** Risk to dislocated arm and of further harm *Multiple Serious Incidences*	Nurses mobilising. During a stand-aid transfer from chair to bed 4 nurses in attendance. Sling straps not attached to patient's body correctly. Nurses failed to ask patient to cross her arms. Patient continued to hold T-bar. Straps dangled around patients elbow. Nurse activated equipment. T-bar started to rise. Patient's arms also started to rise. Straps positioned outside arms. If motion had continued for a few seconds more, patient would have injured her dislocated arm and fallen. Son intervened and provided rescue by alerting nurses to imminent harm. Nurses then stopped stand-aid. This was a multiple occurrence. Patient's arm was dislocated using same equipment 2 weeks earlier. Nurses claim patient slipped during that incident.	• If nurses were properly trained in use of stand-aid; if nurses had ensured the straps were attached to the stand-aid correctly; if nurses had observed the patient closely and, removed her hands from the T bar and positioned her arms correctly; **This incident could have been avoided.** • No evidence of incident report
<u>In Hospital:</u> **Hoist transfer. Landed incorrectly.** Risk of fall from chair *Serious Incident*	Nurses mobilising. Patient transferred by hoist, from bed to chair. Nurses inserted sling abrasively. When landed on chair, patient landed to front edge of chair with gap around lumber area. Patient not landed properly and at risk of sliding off chair. Son present and alerted nurses who lifted and re-landed patient. Son pushed patient to land at back of chair.	• If nurses were properly in how to insert a sling; if nurses had inserted the sling properly to avoid discomfort and pressure; if nurses had landed patient at back of chair; **This incident could have been avoided.** • No evidence of incident report

Incident	Details	How was this Incident avoidable?
In Hospital: **Rolling patient from side to side - inserting hoist strap incorrectly - putting pressure on patients dislocated arm in a sling.** *Serious incident*	Nurses mobilising. Nurses rolled patient onto both shoulders – inserting hoist strap incorrectly - following operation to repair dislocated arm. Nurses inserting hoist strap beneath patient while rolling from side to side. Patient at serious risk of further injury. Son alerted OT and physio who provided guidance to nurses. OT and physio demonstrated how to insert strap properly down the back of the patients head and back. This enabled injured patient to remain static without rolling. Strap then pulled beneath patient causing minimal discomfort and mitigating risk to further injury.	• If nurses had been trained properly how to manage patients with injuries; if nurses had observed injury; if nurses had not rolled a patient with a shoulder injury from side to side; if nurses had inserted hoist strap incorrectly; **This incident could have been avoided.** • No evidence of incident report
In Hospital: **Rolling patient from side to side - to wash in bed - putting pressure on patients dislocated arm in a sling.** *Serious incident*	Nurses mobilising. Nurses rolled patient onto both shoulders – to wash in bed unnecessarily - following operation to repair dislocated arm. Patient's shoulder recently dislocated using equipment on ward. Patients arm in a sling while injury heals. Nurses continue to roll patient in bed from side to side to wash. This places pressure on patient's vulnerable shoulder which is still healing. Son alerted nurses and asked them not to roll or wash patient in bed. Son asked nurses to wash patient on commode, or enter shower to minimise further injury to dislocated arm.	• If nurses had been trained properly how to manage patients with injuries; if nurses had observed injury; if nurses had not rolled a patient with a shoulder from side to side, if nurses had washed patient on commode or in shower; **This incident could have been avoided.** • No evidence of incident report

Incident	Details	How was this Incident avoidable?
<u>In Hospital:</u> **Regular Falls** *Multiple Minor incidences*	Nurses called son at home. During hospital stay, son advised patient fell to floor during accompanied walk whilst using gutter frame. No apparent injury sustained. These falls incidents are regular occurrences when patient in hospital. Son has received multiple calls. No similar occurrences at patients home.	• Details unavailable. • No evidence of incident reports
<u>In Hospital:</u> **Fall whilst using commode** *Minor incident*	Nurses mobilising. During hospital stay, patient using commode by bedside. Patient landed on knees on floor. One knee vulnerable following operation to insert metal plate and pins. Son nearby. Son heard commotion and went to rescue patient from floor. Nurse claimed that due to vulnerability of knee, a doctor would be called to examine leg. No evidence of follow up. No clear explanation about what caused fall.	• Details unavailable. • No evidence of incident report

Incident	Details	How was this Incident avoidable?
At home: **Hoist equipment. Insecure attachment.** **Sling straps broke during use** *Serious Incident*	Home carers. During a hoist transfer by carers, the sling straps broke off. Sling loops had not been attached correctly. Fortunately the motion had just commenced and, while in the air, patient was still over the bed. Son entered room. Injury avoided through rescue. Sprain, bruising and trauma.	• If carers had been properly trained how to use a hoist and ensured the strap loops were attached to the hoist correctly; **This incident could have been avoided.** • Incident reported. No evidence of action taken or incident report completed
At home: **Stand-aid equipment. Insecure attachment.** **Sling straps broke during use** *Serious incident*	Home carers attended. During a stand-aid transfer by carers, the sling straps were not attached to her body correctly. As the bar started to rise, the straps slid upwards and out with her arms and body. If the motion continued, seconds later patient would have tumbled backwards. Son alerted carers. Injury avoided through rescue. Second carer attending was in training. Trauma.	• If carers had been properly trained and ensured the sling and straps were attached to the stand-aid correctly; **This incident could have been avoided.** • Incident reported. No evidence of action taken or incident report completed

Incident	Details	How was this Incident avoidable?
At home: **Slide Sheet** **Incorrect use. Injuries aggravated. Trauma and skin abrasion through incorrect use.** *Multiple Serious incidences*	Home carers. When carers using slide sheet to glide patient up the bed, carers unaware of how to use the sheet properly. Failing to pull sheet properly beneath head to protect shoulders and neck. Dragging sheet around bed. Carers struggled to slide the sheet beneath body properly, and struggled to position her properly to glide her up the bed safely. This resulted in repeated attempts causing trauma to patient. On many occasions, son called to rescue incident. Skin abrasion to sacrum area. Neck and shoulder discomfort, due to existing injuries. Headache. Trauma through the constant activity and repeated missed attempts. Near miss sliding off bed.	• If carers had been trained to use the slide sheet correctly; if carers had been fully aware of, and managed patients injuries; **These incidents could have been avoided.** • Incident reported. No evidence of action taken or incident report completed
At home: **Slide sheet** **Failure to spot roll. Guidance ignored.** *Multiple Serious incidences*	Home carers. Formal guidance in moving and handling plan, directs carers to use slide sheet to spot role when turning patient in bed. Guidance ignored. Objective is to keep patient in centre of bed. Carers continue to disregard formal guidance and roll patient manually, using their hands to push and pull patient over to edge of bed, unnecessarily. This creates a hazard to patient dangling off the edge of an air mattress on a bed elevated 4 feet above the floor. Risk of serious fall.	• If carers had been trained to use the slide sheet correctly; if carers had followed documented guidance; **These incidents could have been avoided.** • Incident reported. No evidence of action taken or incident report completed

Incident	Details	How was this Incident avoidable?
<u>At home:</u> **Shoulder dislocation.** **Rolling body in bed.** **Aggravating shoulder injury.** *Multiple Serious incidences*	Home carers. Ignored guidance not to roll her body from side to side in bed; to avoid rolling onto vulnerable side and putting pressure on dislocated shoulder. Guidance directed carers to roll only to the one side of body that wasn't injured. Most carers ignored guidance and continually rolled patient onto vulnerable shoulder. This action contributed towards a second shoulder dislocation. Either or both actions caused another injury (this incident and the one directly below).	• If carers had been trained properly how to manage patients with injuries; if carers had followed guidance in moving and handling plan, if carers had not rolled her body from side to side, thereby placing unnecessary pressure on patients vulnerable arm; **These incidents could have been avoided.** • Incident reported. No evidence of incident report
<u>At home:</u> **Shoulder dislocation.** **Inserting hoist sling incorrectly** **Aggravating shoulder injury.** *Multiple Serious incidences*	Home carers. Ignored guidance not to insert sling from side to side. To avoid placing pressure on vulnerable arm and discomfort to skin, when inserting hoist sling, instead of inserting from top to bottom as directed, carers disregarded guidance and took the easy option of pushing and rolling her manually and inserting the sling from side to side. This action contributed towards a second shoulder dislocation. Either or both actions caused another injury (this incident and the one directly above).	• If carers had been trained properly how to manage patients with injuries; if carers had followed guidance in moving and handling plan; if carers had not ignored documented guidance when inserting the sling, thereby placing unnecessary pressure on patients vulnerable arm; **These incidents could have been avoided.** • Incident reported. No evidence of incident report

Incident	Details	How was this Incident avoidable?
At home: **Inserting hoist strap roughly causing trauma & skin abrasion.** *Multiple Serious incidences*	Home carers. Mobilising patient around bed uncomfortably and unnecessarily. Rolling patient against guidance. Pulling the hoist sling callously and abrasively during insertion under body and between legs resulting in bruising, scrapes, and skin burns; particularly in the groin area; trauma.	• If carers had been trained properly how to manage patients with injuries; if carers had not disregarded documented guidance; if carers had handled her body and limbs gently, if carers had treated her skin properly and inserted sling as directed; **These incidents could have been avoided.** • Incident reported. No evidence of incident report
At home: **Rough handling of body and limbs.** **Sprain and bruising** *Multiple Serious incidences*	Home carers. When performing care and mobilising i.e. lifting arms, legs, rolling body etc. bruising; handling patient roughly resulting in visible fingers marks all over body; spraining to wrists, shoulder area and vulnerable knee. Sprain, marks and bruising caused by rough handling.	• If carers had been trained properly how to manage patients with injuries; if carers had not disregarded documented guidance; if carers had handled her body and limbs gently, if carers had treated her skin properly and inserted sling as directed; **These incidents could have been avoided.** • Incident reported. No evidence of incident report

Incident	Details	How was this Incident avoidable?
At home: **Bed cot sides lowered. Sliding off a bed raised 4 ft above the ground. Fall rescued:** *Multiple Serious incidences*	Home carers. Sons request for one cot side to remain up for patient's protection refused. Moving and handling plan permitted the lowering of both cot sides on bed while bed elevated high above floor. Carers refused to leave one of the cot sides in place for patient's protection when rolling patient in bed. Carers failed to follow guidance to use slide sheet to spot roll centrally – and rolled patient to edge of air mattress, using hands. There were a minimum of 4 incidents witnessed of patient being rescued from sliding off the edge of an air mattress raised to a height of more than 4 ft. On one occasion carers oblivious to fall in motion which son had to rescue.	• If carers had not resisted a request to leave one cot side up to protect patient from falling; if carers had followed guidelines by spot rolling patient to ensure patient remained in centre of the bed; this would have mitigated risk of fall from a height and; **These incidents could have been avoided.** • Incidents reported. No evidence of action taken or incident reports completed
At home: **Missing armchair and landing on the floor:** **Trauma, sprain and bruising** *Multiple Serious incidences*	Home carers. While motioning to sit, carers failed to follow standard operating guidelines by ensuring the back of patient's legs were aligned with the chair prior to seating patient. On each occasion, when patient attempted to sit down, patient slid off the edge of the armchair and landed on the floor. Son often called to rescue. Instances of sprain and bruising. Trauma to patient.	• If carers had exercised due diligence, and followed standard operating guidelines; **These incidents could have been avoided.** • Incident reported. No evidence of action taken or incident report completed

Incident	Details	How was this Incident avoidable?
<u>At home:</u> **Missing the commode chair and landing on the floor:** Sprain and bruising *Multiple Serious incidences*	Home carers. While motioning to sit, carers omitted to lock the wheels to keep the chair in place. This caused the chair to roll back while patient was sitting. In other instances, carers failed to hold and stabilise the back of the chair as patient was sitting. On one occasion a carer was texting into her mobile instead of monitoring patient's mobility. Each time, the chair rolled back and patient landed on the floor.	• If carers had exercised due diligence, and followed standard operating guidelines; **These incidents could have been avoided.** Incident reported. No evidence of action taken or incident report completed
<u>At home:</u> **Abrasive washing of inflamed skin** Discomfort and trauma Multiple Incidences	Home carers. Whilst attending to personal care, carers rubbed inflamed skin, anal region and haemorrhoids abrasively. Carers rubbed these sensitive areas with a face cloth instead of gently dabbing vulnerable areas with a wet compress. This caused extreme discomfort for patient who cried out. Carers ignored these appeals, simply telling patient that she was ok.	• If carers had been appropriately trained in how to manage vulnerable skin and exercised due diligence; **These incidents could have been avoided.** Incident reported. No evidence of action taken or incident report completed

Incident	Details	How was this Incident avoidable?
In Hospital **Following admission, patient debilitated and confined to bed** Human rights violated Multiple Incidences	Patient admitted to hospital for short course of antibiotics to be administered intravenously. At point of admission, patient was capable of standing and walking with support of gutter frame. After point of admission patient was left to languish and unnecessarily confined to bed. Patient not taken out of bed to mobilise or sit. This had a detrimental impact on patient's mobility. One of the consequences of this immobility was muscle weakness and reduced mobility. It was necessary for patient to be transferred for rehabilitation to attempt to recover mobility.	• If nurses had exercised due diligence and observed policy guidelines; by mobilising patient from day one; **These incidences could have been avoided.** No Incident reported.
In Hospital **Patient served lunch and left lying flat in bed** Hazard *Near Miss*	Patient was served lunch in bed. Nurse failed to elevate patients head and left patient lying prostrate. Nurse left trolley close to patients head. Patient tried to feed herself unsuccessfully. Most of the lunch landed on patient's chest. Risk of burn to patient and choking. Son arrived and managed situation.	• If nurses had exercised due diligence; **This incident could have been avoided.** Incident reported. No evidence of incident report completed

Incident	Details	How was this Incident avoidable?
In Hospital **Failure to provide essential postoperative care** *Serious neglect*	Elderly patient entered theatre for operation on leg fracture caused in another hospital. Patient, who was diabetic, had received no food or fluids since midnight the previous evening. At approximately 2100 hours, patient re-entered ward. Son requested fluids to give patient postoperative nourishment and fluid. This was refused. Son took the necessary action to meet this essential need.	• If nurses had exercised due diligence and observed policy guidelines; and offered a disabled, post-surgery patient specialist postoperative care; if nurses had responded positively to son's request for fluids; **This incident could have been avoided.** • Incident reported. No evidence of incident report completed
In Hospital **Indignity** *Serious neglect*	Son arrived during visiting time to discover patient sitting in public area with breasts exposed. Patient had not been dressed correctly. Members of the public present. Patient had delirium and was unaware. Staff oblivious to major indignity.	• If nurses had exercised due diligence and observed policy guidelines; **This incident could have been avoided.** • Incident reported. No evidence of incident report completed