Radius Residential Care Ltd — Althorp

A Report by the

Aged Care Commissioner

(Case 19HDC01522)

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Executive summary

1. This report concerns the care provided to a man when he was a resident at Radius Residential Care Ltd — Althorp[1] (Radius Althorp) in 2019.

2. The man was admitted to Radius Althorp for psychogeriatric care. During his stay there were a number of reported incidents where another resident entered the man's room, leading to a number of aggressive altercations. The final incident occurred when allegedly the man was physically assaulted while he was unconscious and in the final stages of life. Concerns were also raised about the quality of the man's end-of-life care, the standard of documentation, communication with the man's family, and the staffing levels in the dementia unit at the time.

Findings

3. The Aged Care Commissioner considered that a failure to put in place effective measures to ensure the man's safety led to the incident, and that in conjunction with inadequate staffing levels in the unit, poor documentation relating to the man's clinical notes, charts and end-of-life plan, and poor communication with the man's family, this demonstrated a pattern of sub-optimal care by Radius Althorp. As such, the Aged Care Commissioner found Radius Althorp in breach of Right 4(1) and Right 4(4) of the Code.

Recommendations

4. The Aged Care Commissioner recommended that Radius Althorp conduct a random audit of end-of-life plans, progress notes and charts for ten residents over the past six months, provide an update to HDC on the corrective actions taken as a result of this complaint, and provide the family with an apology.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her father, Mr A, by Radius Residential Care Ltd — Althorp (Radius Althorp). The following issue was identified for investigation:

- *Whether Radius Residential Care Ltd — Althorp provided Mr A with an appropriate standard of care from Month1[2] to Month2 2019.*

6. This report is the opinion of Aged Care Commissioner Carolyn Cooper, and is made in accordance with the power delegated to her by the Commissioner.

[1] Radius Residential Care Ltd is the owner and operator of Radius Residential Care Ltd — Althorp.
[2] Relevant months are referred to as Months 1–3 to protect privacy.

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7. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Radius Althorp	Provider

8. Further information was received from:

RN C	Provider/Clinical Team Leader
HCA D	Provider/healthcare assistant
HCA E	Provider/healthcare assistant
HCA F	Provider/healthcare assistant
HCA G	Provider/healthcare assistant
RN H	Provider/registered nurse
RN I	Provider/registered nurse
RN J	Provider/Clinical Nurse Manager
Te Whatu Ora|Health New Zealand (formerly District Health Board (DHB))[3]	

9. Also mentioned in this report:

Ms K	Consumer's daughter
Dr L	Provider/general practitioner
Mr M	Other resident
Consumer's ex-wife	

10. In-house advice was obtained from Hilda Johnson-Bogaerts, Nursing Advisor, Aged Care (Appendix A).

Information gathered during investigation

Background

11. On 1 Month1, Mr A (aged in his seventies) was transferred to Radius Althorp from another facility. Mr A had a medical history of atrial fibrillation,[4] cognitive impairment, Alzheimer's disease and dementia, and a pancreatic mass (likely cancer). He passed away on 26 Month2 while he was a resident at Radius Althorp. Following Mr A's death, Police were involved initially, and the matter was referred to the Coroner.

12. This report concerns the care Mr A received at Radius Althorp between Month1 and Month2, in particular incidents involving another resident that concerned Mr A's safety, the

[3] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand.
[4] A condition that causes an irregular and often rapid heartbeat.

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quality of Mr A's end-of-life care, the standard of documentation, and the staffing levels in the dementia unit at Radius Althorp during this time.

Radius Althorp

13. Radius Althorp is part of the Radius Residential Care Group. At the time of these events, Radius Althorp cared for up to 117 residents across four service levels — dementia, hospital, psychogeriatric, and some rest-home care. There are four separate units for the dementia service, and each unit has 15 beds. Three of the units provide D6-level care, and one of the units provides D3-level care.[5]

Admission to Radius Althorp

14. Mr A was admitted to Radius Althorp on 1 Month1. He arrived with his family and was placed in a D6 room. The progress notes from the admission record:

> "Admitted [male in his seventies], Medical history: Alzheimer's Dementia, Pancreatic cancer, Heart problems. Transferred from [another facility].
> No known allergies.
> OBS taken and recorded.
> Diet: [Mr A] was on regular diet. Wife informed about recent choking episode requested soft diet.
> Mobility: 1–2x assistance with cares. Mobile.
> Has own teeth. No glasses and no hearing aids
> Medication: takes whole meds with water
> Communicates well to staff."

15. The progress notes on 1 Month1 also record that a sensor mat was not available for Mr A, but that the night-shift registered nurse would be informed about the need for a sensor mat. The progress notes do not mention whether a sensor mat became available subsequently.

2 Month1 — incident one

16. On 2 Month1 at around 5.30pm, Mr A was bitten on the arm by another resident, Mr M. Mr M had been a former occupant of Mr A's room, but at the time of these events resided in another room at Radius Althorp. He had been diagnosed with severe dementia and had a history of territorial behaviour and physical aggression due to his cognitive impairment. Mr M had been assessed by the Mental Health Services for Older People (MHSOP) inpatient unit. MHSOP had provided Radius Althorp with specific recommendations as to how to communicate with Mr M, which included placing signs in the ward to direct Mr M back to his room.

17. Mr A had punched Mr M as he had come into his room. The incident was documented in Mr A's progress notes as follows:

[5] D6-level care refers to psychogeriatric specialist hospital care. D3-level care refers to rest-home-level care.

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"[17.30] — [Mr A] bitten on the arm by resident [Mr M]. Area was red and raised, cleansed and placed an ice pack. Skin still intact as he was wearing long sleeves at the time. [Mr A] admitted that he punched [Mr M] because [Mr M] said he was in his room. Daughter informed of incident, she verbalised that it was upsetting what had happened. Reassured her that we will keep both residents apart. Daughter spoke to [Mr A] over the phone."

18. The incident was also documented in Mr A's behaviour identification and interventions chart, and it was noted that staff intervened by "approach[ing] them calmly and [separating] them. Redirected to the dining room and attended on the affected area that was bitten by resident [Mr M]; offered dinner afterwards."

19. Ms K, Mr A's daughter, told Police that she received a telephone call from a female employee at Radius Althorp and was told that Mr A had been bitten by another resident. Ms K told Police that she believed that Radius Althorp would implement barriers to stop this occurring again.

20. RN C, a clinical team leader at Radius Althorp, told HDC that she escalated the incident to the attending psychogeriatrician at Radius Althorp. RN C's concern was the increase in physical aggression that Mr M was demonstrating to other residents in the home.

21. Radius Althorp informed MHSOP of the incident, and on 8 Month1 Mr M was admitted to the MHSOP inpatient ward at the public hospital owing to concerns about the side effects of his medication.[6]

interRAI assessment

22. An interRAI assessment[7] for Mr A was completed on 17 Month1. It was recorded that an enduring power of attorney (EPOA) was in place, but that this had not been activated. The assessment summary identified that physical activities should be promoted (staff were to encourage Mr A to join physical activities); that Mr A needed assistance with daily living activities; and that Mr A preferred to stay in his room and could become aggressive if his personal space was invaded. Mr A was assessed as being at a high risk of undernutrition and urinary incontinence. The progress notes and behaviour charts did not incorporate the assessment summary set out in the interRAI assessment.

23. It was not recorded who had been appointed as the EPOA for Mr A. Ms B and Ms K were the family members whom Radius Althorp contacted in relation to Mr A's care during his time at Radius Althorp.

18 Month1 — incident two

24. On the evening of 18 Month1, an unnamed resident (not Mr M) entered Mr A's room. Mr A's behaviour and identification chart records that Mr A responded by hitting the resident with a stick.

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[4] The serious incident report uses the term "sedation".

[7] Long-term care facility assessment.

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25. Staff intervened by removing the resident from the room. The incident was not documented in Mr A's progress notes, and there is no record of whether Mr A's family were informed.

24 Month1 — incident three

26. On 23 Month1, Mr M was discharged from the MHSOP inpatient ward and returned to Radius Althorp.

27. On 24 Month1, Mr M went into Mr A's room again, and Mr A tried to punch him. Mr A's behaviour and identification chart recorded: "[T]ried to punch [Mr M] [who] went in his room saying it was his." However, other than staff "redirecting" the other resident, the incident was not recorded in the progress notes, and there is no record of the action taken. It is not documented whether the incident was reported to management at Radius Althorp, or whether Mr A's family were informed.

14 Month2

28. On 14 Month2, Mr A's progress notes record that Ms B had raised her concerns with the staff at Radius Althorp. The notes state:

> "Visited by daughter [Ms B] today. She voiced concern about other residents going inside [Mr A's] room … Reassured her that staff is able to ensure to redirect these residents from [the wing]. She also acknowledged that swapping rooms may be not the best idea as [Mr A] may not like a shared toilet …"

29. In relation to residents entering Mr A's room, it was recorded in his progress notes that the "[registered nurse was] to evaluate [the] effectiveness of the plan", but there is no further documentation in relation to this, or evidence that this was actioned.

Deterioration in health

30. On 16 Month2, Ms B told staff that Mr A turned "greyish" and told her that he felt as if he was dying. Mr A was reviewed that day by the attending general practitioner (GP), Dr L, who noted that Mr A looked "frail" but appeared to be comfortable. Dr L recorded in the progress notes that the cause of the episode was unclear, but it was possible that Mr A was entering the last days of his life.

31. A further entry on 16 Month2 records: "EPOA/daughter informed about GP visit, acknowledged and happy to be informed."

32. Mr A's health began to deteriorate on the morning of 22 Month2, and he was placed on 30-minute checks. The progress notes record that he was "unwell" and had "rapid heavy breathing", but there is no mention that an end-of-life care plan was activated. Ms B was informed of her father's condition. The care activity chart contains gaps in the 30-minute checks in the morning and in the afternoon, but it is unclear whether the family were present on these occasions.[8]

[8] From 22 Month2, as set out in the care activity chart, Mr A was to have 30-minute checks unless family were present.

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33. Ms B contacted Radius Althorp in the evening of 22 Month2 asking to be informed of any emergencies at any time of the day.

34. Mr A's ex-wife told Police that she was told by staff that they would keep the corridor door shut to stop Mr M from going into Mr A's room during the night.

35. Over the following days, the care activity chart records that from 12am until 6am each day, Mr A was checked only hourly (despite remaining on 30-minute checks), and there were subsequent gaps (missed checks) during the day.[9]

23 Month2 — incident four

36. At 6am on 23 Month2, it is recorded in the care activity chart that Mr A left his room "as [Mr M] had gone to [Mr A's] room". Radius Althorp confirmed to HDC that Mr M entered Mr A's room on 23 Month2, and that Mr M raised his fist at Mr A. There is no record of this incident in the progress notes or the behaviour identification and interventions chart. Two separate incidents were noted in the behaviour and intervention chart in which Mr A had blocked his door on two occasions on 23 Month2 using "at least 4 chairs to keep [Mr M] from entering his room". It is not documented whether the family were informed of these incidents.

37. Dr L reviewed Mr A at 4.05pm on 23 Month2 and noted: "[A]dvanced illness, likely approaching last days of life. Has anticipatory prescribing in place." The progress notes indicate that the family were "informed", but there are no further details of what was discussed with them or whether this included an end-of-life plan.

38. At 8.30am on 24 Month2, Mr A was recorded to be crying in his room and stating that he had "[two] days left", and it is unclear whether Mr A's family were informed. The progress notes record general observations of Mr A's condition, but there is no reference to an end-of-life plan or whether the advanced care directive was put in place.

39. Mr A was checked every hour during the night. From 7.30am until 12.30pm, checks were completed every 30 minutes, but these were not maintained, and there are gaps of two hours.

25 Month2 — incident five

40. Mr M entered Mr A's room again on the afternoon of 25 Month2. This incident was not recorded in Mr A's progress notes or his behaviour identification and intervention chart. Radius Althorp advised HDC that the incident was recorded in Mr M's behaviour and intervention chart, and that Mr M was verbally aggressive to Mr A and wanted to remove him from the room. Mr M became agitated and started to spit at staff who were redirecting him from Mr A's room.

41. Ms K told Police that at around 3pm, while she and her sister were visiting Mr A, Mr M tried to push his way into Mr A's room. She described Mr M as agitated and yelling, "[Get] him out of my f-ing bed." Ms K stated:

[9] It is recorded in the care activity chart that Mr A's family were present at the 12pm check.

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"I was pushing the bedside emergency button, on a lead beside Dad's bed. [Ms B] was also trying to push through the door past [Mr M] and yelling for staff to come [to] us.

The [buzzer] didn't appear to work, as nobody came for what seemed an age, and [Mr M] managed to force his way past [Ms B] and I as we tried holding the door closed. He was yelling that he was going to spit in our faces.

[Ms B] and I blocked [Mr M's] path over to Dad once he had accessed the room and a Nurse arrived just in time and managed to coerce [Mr M] over to her and away from Dad."

42. Ms K said that she was told that as a result of the incident, a bell mat would be installed and staff would shut corridor doors to keep Mr M out. She asked for her father to be moved, but was advised by staff that there were "no free beds in either a separate ward or the medical ward".

43. Ms B told Police that she and Ms K stayed over on the night of Friday 24 Month2 to Saturday 25 Month2, as they were concerned about their father's safety, and the incident on the afternoon of 25 Month2 had left her "very upset". She said that she was assured by staff that the doors would be closed, and a small bell mat was installed in Mr A's room, but she still had concerns that Mr M would be able to get into the room.

44. Mr A's progress notes record: "[B]ellmat in place inside [Mr A's] doorstep to alert staff in case one of the residents will enter his room." RN I told Police that after the incident, the fire doors were shut between the two wings. It is also recorded that Mr A was on 30-minute checks, but the records show that Mr A was checked hourly and then every 30 minutes in the afternoon and evening. General observations of Mr A's deteriorating condition were noted, but not that an end-of-life care plan was in place.

26 Month2 — incident six

45. A healthcare assistant, HCA E, told HDC that at 6.45am Mr M came to the nurses station as he was hungry. She gave him porridge and went to complete her safety tasks. While she was in another resident's room, she heard the fire door close and knew that this was Mr M, and saw him enter Mr A's room. HCA E stated:

"I went to the room and [Mr M] was standing next to the bed facing [Mr A]. [Mr A] was in bed unconscious … I pulled [Mr M's] top, and reminded him that this was not his room. He was angry to [Mr A] telling him to wake up as this was his bed …

I tried to move him away by pulling the sleeve on his shirt and upper arm guidance. I told him that this was not his room. [Mr M] turned to me and punched me on the arm twice yelling at me 'hey'. He turned back to [Mr A] grabbing his top and shook him telling him to get up from the bed. I knew the situation was out of my control so I went to the lounge and pressed the emergency bell.[10] I went immediately back to [Mr A's] room

[10] HCA E told Police that it took her approximately 40 seconds to reach the emergency bell and return to Mr A's room.

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> and [Mr M] was still standing in the same place and [Mr A] was on the floor on the opposite side of the bed. In this time, 3 other staff arrived …
>
> [HCA F] held [Mr M's] arms and moved him out of the room. [Mr M] was trying to hit all the staff. Me, [RN I] and [HCA G] moved [Mr A] back to his bed. [Mr M] came back into the room, tried to hit us again as we were defending [Mr A] in bed. I exited the room and went to the lounge to press the emergency bell again. [HCA D] arrived and [Mr M] was in his room."

46. After Mr M had been removed, HCA E noticed that Mr A had had a "bang" to the back of the head and that there was a small amount of blood on the back of his head, which was being attended to by RN I. Throughout the incident, Mr A did not wake up and had not responded to staff.

47. RN I told Police that she heard the emergency bell at 6.45am and made her way to Mr A's room, where she saw Mr A on the floor, and HCA E trying to remove Mr M from the room. RN I said that she assisted HCA E and HCA G to get Mr A into bed, and noticed a "small tear" on the back of his head, which had "mild bleeding".

48. RN I stated that Mr M returned to the room and tried to punch her, HCA E and HCA G, and also hit Mr A on the legs. RN I called HCA D, and HCA F also arrived, and Mr M was removed by HCA D.

49. RN I dressed the wound on Mr A's head and completed an incident form. She said that before finishing her shift, she notified the clinical team leader, RN C, of the incident. RN I stated that she was advised to inform the family in person, but this was handed over to the next shift.

50. RN H was informed of the incident at handover in the morning of 26 Month2, and later advised Ms B of the incident, as it had been decided at handover to inform the family of the incident in person rather than over the phone.

Subsequent events

51. Ms B told Police that she rang Radius Althorp at about 8am and was told that her father was still asleep and that he would be woken for breakfast, which she thought was "odd", as he was in the final stages of dying. She asked to be contacted if there were any other changes in his condition. Ms B was contacted at 11am and asked what time she would be coming in. She asked whether her father was all right and was told that he was "about the same", and that he had not woken up. Ms B confirmed to staff that she would be there at 2.30pm.

52. Ms B arrived at Radius Althorp at 1pm and went with a staff member to check on Mr A. She told Police:

> "We walked into the room and he was taking his last breath and he was white. I don't think he had been checked on in the last few hours because if he had they should have called us urgently. I got the feeling the nurse was as surprised as I was that it was his last breath. I called my sister and then my Mum. [The nurse] asked me if I wanted time

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with Dad and I did spend about 15 [minutes]. About 1:30pm I said they could clean and dress him. [The nurse] then asked to speak to me and told me that [Mr M] had been in [Dad's] room that morning and tried to get Dad out of bed and there was a cut to the back of [Dad's] head which she had dressed. My first reaction was 'What? Did he [manage] to get Dad out of bed' and she said 'No he just tried to'."

53. Ms K told Police that she arrived after Mr A had passed away at 1pm. She noticed a mark on Mr A's right arm, which looked like a "fresh scratch", but was not informed of the incident until later when she discussed this with her sister.

54. The care activity chart for 26 Month2 records that Mr A was checked every hour until 6.50am. He was not checked again until 8am. The next checks were at 10am, 12pm, and then 2pm, when it is recorded that Mr A had passed away. Radius Althorp accepted that Mr A should have been checked every 30 minutes on the morning of 26 Month2, and that this did not happen.

55. The progress notes on 26 Month2 contain entries at 6.07am, 6.31am and 2.30pm. The next entry at 3.17pm records Mr A's passing at 1pm. The notes contain no record of the incident with Mr M.

56. Later on 26 Month2, RN I advised the on-call manager that Mr A had passed away, and described the incident that had occurred in the morning. The Clinical Nurse Manager, RN J, was not aware of the incident until the morning of 27 Month2, when she saw an alert from HCA D on the message board. Subsequently, RN J met with Dr L and Police regarding the incident, and also discussed the incident with Ms B.

57. At 11.37am on 27 Month2, Dr L recorded in Mr A's progress notes that he had been notified that an alleged assault by Mr M on Mr A had taken place on the morning of 26 Month2. Due to the nature of the incident, Dr L contacted the Coroner and Police.

58. RN C told HDC that she was not on duty at the time of the incident, and was unaware of it until she returned to work on 28 Month2 and was informed by RN J.

59. On 28 Month2, RN J and the Facility Manager completed section 31 incident reports[11] in respect of notifications regarding health and safety concerns for residents and a death reported to the Coroner.[12]

[11] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires providers to notify the Director-General of Health about any health or safety risk to residents, when a Police investigation has been commenced in relation to any aspects of the provider's service, or when a death is reported to the Coroner of a patient who has received services from the provider or when the death occurred in any premises in which the services were provided.

[12] Radius Althorp staff who were involved with the incident on 26 Month2 were interviewed by Radius Althorp, and statements were provided to HDC.

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Further information

Autopsy report

60. A post mortem examination was completed on 29 Month2. The cause of death was recorded as pneumonia, with cardiovascular disease[13] and pancreatic cancer being significant conditions contributing to death. The autopsy report noted that an examination of the brain showed acute cerebral ischaemia,[14] and that the pneumonia may have been a sequela of being bed ridden from the advanced pancreatic cancer or following the assault. It was further noted that it was difficult to determine whether the cerebral ischaemia was secondary to the assault or other causes.

Radius Althorp

61. Radius Althorp told HDC that staff implemented the behaviour and risk care plan that was in place for Mr M, as well additional measures, which included increasing the observation of Mr M and Mr A, ensuring that staff were aware of Mr M's behaviour, keeping Mr M engaged in activities, developing techniques for dealing with Mr M, and planning to relocate Mr M to a different room. Radius Althorp accepted that the on-call nurse manager was not notified of the incidents on 25 and 26 Month2, and that this was contrary to Radius Althorp's policies and procedures (referred to in Appendix B), and that Dr L was not made aware of the incidents on 2, 24, 23, 25 and 26 Month2. Radius Althorp also accepted that it had not identified a level of care or plan in a timely manner in relation to Mr M's escalating behaviour. In addition, Radius Althorp accepted that the information contained in the advance directive[15] and end-of-life care plan for Mr A were not up to standard, and that care plans were also not up to standard.

Internal investigation

62. On 18 Month3, Radius Althorp completed an investigation into the care provided to Mr A. The report addressed concerns that there had been a failure to ensure the safety and respectful passing of Mr A, and that there had been a failure to respond appropriately to the escalating behaviour of Mr M and to use the identified method of communicating with him.

63. The key findings from the review included:

- Key care needs assessments were not carried out by registered nurses over six shifts to identify that Mr A was entering the end-of-life stage and to question the appropriateness of him remaining in D6-level care.
- An appropriate level of care and a subsequent plan were not identified in a timely manner when it was clear that Mr M was displaying territorial behaviour towards "his"

[13] A build-up of cholesterol plaque in the walls of the arteries causing obstruction of blood flow.
[14] A condition that occurs when there is not enough blood flow to the brain to meet metabolic demand.
[15] Radius Althorp confirmed that all residents have an advance directive that sets out the resident's wishes in respect of end-of-life care, which is completed on admission by a registered nurse with input from the resident and family. The care directive is then discussed with a medical practitioner within 48 hours of the resident's admission.

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bedroom. This placed Mr A in a potentially threatening situation that subsequently eventuated.

- Staffing levels in the dementia unit were inadequate.
- Communication with Mr A's family was often not transparent at the time leading up to Mr A's death and in the days after his death.
- A clear strategy for management of the behaviours that challenge the service was not evidenced.
- Poor quality, unfinished and insufficient documentation was identified in clinical notes for care plans, progress notes and charts.

Staffing roster — 20–26 Month2

64. The staffing roster for the week of 20–26 Month2 shows that one healthcare assistant night-shift position was unfilled on 23, 24, 25 and 26 Month2 with no replacement healthcare assistant identified. In its response to HDC on 6 May 2021, Radius Althorp told HDC that the position had been filled. In a response dated 16 July 2020, Radius Althorp told HDC that at the time of the incident at 6.45am on 26 Month2, staffing ratios for the night roster (11pm to 7.15am) were one registered nurse and four healthcare assistants to 58 dementia care beds. Radius Althorp accepted that the staffing levels were inadequate. In a further response on 6 May 2021, Radius Althorp told HDC that at the time of the incident there was one healthcare assistant rostered to care for 15 psychogeriatric residents, and one registered nurse to oversee 34 psychogeriatric residents. Radius Althorp stated that Mr A's room was located 10 metres from the lounge area, and that at the time of the incident, rostered healthcare assistants summoned support from the rostered registered nurse and other healthcare assistants in the lounge area.

Te Whatu Ora

65. A serious incident review in respect of Mr M was completed by Te Whatu Ora. The investigation concluded that there was no apparent communication between Radius Althorp and MHSOP regarding the escalating behaviour of Mr M prior to the incident, and that Radius Althorp had not consistently followed the care needs or communication tools previously identified by MHSOP for managing Mr M. In particular, Radius Althorp failed to place a sign on the ward redirecting Mr M to his room, as recommended by MHSOP. The review also noted that staffing ratios were inadequate in light of Mr M's need for close monitoring. Following the review, a number of recommendations were put in place that related to improving communication between MHSOP and Radius Althorp, the escalation process within Radius Althorp, and the early identification of risk factors.

HealthCERT

66. A surveillance audit was completed by HeathCERT[16] in February 2018 for the Ministry of Health. The audit noted that improvements were required around the timeframes for

[16] HealthCERT is responsible for ensuring that hospitals, rest homes, residential disability care facilities and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability (Safety) Act 2001.

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interRAI assessments. Standard 1.3.6 (Service Delivery/Intervention) was recorded as "PA moderate" — partially attained. It was noted that the care plans audited were "goal orientated but did not provide for all care needs", and that behaviour and turning charts were not completed consistently.

67. In relation to standard 1.3.3.3,[17] "PA low" was recorded with the report identifying that not all assessments and interRAI had been completed according to timeframes.

68. In response to the provisional opinion, Radius noted that this audit also recorded 15 "Fully Attained" standards relating to complaint management, communication, governance, adverse event reporting, service provider availability and evaluation.

69. An inspection report was also completed by HeathCERT. The report concluded that Radius Althorp did not comply with 15 of the Health and Disability Service Standards, and that the partially attained standards related to consumer rights, organisational management, HR management, service provider availability, service provision, restraint provision, and process and facility specifications. As a result of the findings, ongoing monitoring of Radius Althorp was to be undertaken by Te Whatu Ora, and written progress reports were to be submitted to HealthCERT relating to compliance with the identified service standards.

70. Te Whatu Ora appointed a consultant to address the corrective actions identified in the report and to complete an assessment of Radius Althorp and identify any breaches in relation to the agreement between Radius Althorp and Te Whatu Ora.[18]

71. Radius told HDC that it worked with the consultant, and the corrective actions were completed and sustained in March 2020. In the surveillance audit undertaken in July 2020, there were no partial attainments, and no corrective measures were identified.

Responses to provisional opinion

The family

72. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. She stated that the family will never forgive themselves for not doing more to keep Mr A safe. She said that the family were told by Radius Althorp staff that it was all under control when this was not the case, and Mr A died without dignity and without his family at his side owing to a lack of communication. Ms B said that she wished she had arrived earlier in the day, as she would have seen his condition and been aware of the incident earlier in the morning on 26 Month2.

Radius Althorp

73. Radius Althorp was provided with an opportunity to comment on the full provisional opinion.

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[17] Criterion 1.3.3.3: Each stage of service provision (assessment, planning, provision, evaluation, review and exit) is provided within time frames that safely meet the needs of the consumer.

[18] Te Whatu Ora and Radius Althorp are parties to an agreement ("the ARRC Agreement") for the provision of age-related care services.

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74. Radius told HDC that an end-of-life plan was activated on 23 Month2 and remained in place until Mr A passed away on 26 Month2. Radius stated that the relevant staff and Mr A's family were aware that Mr A was receiving end-of-life cares during this time. Radius accepts that Mr A was not always checked every 30 minutes between 23 and 26 Month2, and that this was contrary to Mr A's end-of-life care plan and accepted practice. Radius also accepts that its staff did not engage appropriately with Mr A's family between 23 and 26 Month2, and that this was contrary to its usual and accepted practice.

75. Radius told HDC that there was, and is, no ongoing issue in respect of the end-of-life care it provides to its residents at Radius Althorp. Radius explained that the issues relating to Mr A's end-of-life care were solely and directly attributable to staff shortages in the dementia unit at the time. Radius stated that it did everything it could at the time to fill the staff roster, but was not able to do so.

76. Following the incident, Radius increased its staffing levels in the dementia unit to ensure that it had appropriate staffing levels to meet immediate needs and acuity. Radius Althorp's process for end-of-life care, as well as staffing levels, were audited as part of the Surveillance Audit carried out on 30 July 2020, and relevantly, no "partial attainments" were assessed.

77. Radius told HDC that the Surveillance Audit completed in 2019 shows that Radius had sufficient policies and practices in place at the time and that it took all reasonable and appropriate measures to ensure that its staff understood and implemented these practices and policies appropriately. Radius does not accept that the shortcomings in Mr A's care were service delivery failures and that individual staff members were responsible for not following documented policies.

78. Radius told HDC that since this incident occurred, it has made a number of significant changes to its practices and processes such that it is confident that the risk of a similar event occurring in the future is low. Radius also stated that it reviews its processes and practices regularly, and provides its staff with up-to-date training, to ensure that it continues to meet industry standards and best practice guidelines. In support of this, Radius referred to its most recent audit results in 2020 and 2021, which taken together show that Radius is meeting industry standards in the provision of care for its residents.

Opinion: Radius Althorp — breach

Introduction

79. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), Radius Althorp had a responsibility to operate the care home in a manner that provided its residents with services of an appropriate standard.

80. Mr A transferred to Radius Althorp for psychogeriatric care in Month1. I have a number of concerns about the care provided to Mr A from 1 Month1 until 26 Month2 relating to his

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safety and the quality of his end-of-life care, and the standard of documentation and staffing levels at Radius Althorp. In my view, there were deficiencies in the care provided to Mr A by multiple staff at Radius Althorp. These were systemic issues for which Radius Althorp bears responsibility, as outlined below.

Incidents between Mr A and other residents

81. As noted above, there were at least five physical altercations and/or incidents between Mr M and Mr A that started shortly after Mr A was admitted to Radius Althorp — on 2 Month1, 24 Month1, 23 Month2, 25 Month2 and 26 Month2. In addition, there was a further incident on 18 Month1 involving Mr A and another resident.

82. For the first three incidents (on 2, 18 and 24 Month1), staff responded by removing the resident from Mr A's room, or redirecting the resident. Mr M was admitted to MHSOP in Month1 due to concerns about the side effects of his medication, and not as a consequence of his behaviour toward Mr A. Radius Althorp told HDC that after these incidents it put in place a number of measures, including increasing the observation of Mr M and Mr A, ensuring that all staff were aware of Mr M's behaviour, keeping Mr M distracted and engaged in activities, developing techniques for dealing with Mr M and redirecting him to his room, and making plans to relocate Mr M to a different room. Following the incident on 14 Month2, Mr A's ex-wife was told that the corridor door would be kept shut. After the fourth incident, on 23 Month2, Mr A's family were told again that the corridor door would be kept shut to prevent Mr M from going into Mr A's room during the night. After the fifth incident on 25 Month2, a bell mat was placed inside Mr A's doorstep to alert staff in the event that another resident entered his room. Although 30-minute checks were instituted from 22 Month2 (for Mr A's end-of-life care, rather than as a safety intervention), these checks were not performed consistently.

83. My in-house aged-care advisor, RN Hilda Johnson-Bogaerts, stated that managing challenging behaviour in residents with dementia requires a systematic and multidisciplinary approach, focusing on finding and treating the underlying problems and health issues. She said that where interventions are not effective, this should be escalated with input from the GP, and where the behaviour includes physical aggression/assault of another resident, this should be escalated to the clinical manager immediately and the resident referred for a medical review. Radius Althorp has accepted that it did not identify an appropriate level of care and subsequent plan in a timely manner when Mr M was displaying territorial behaviour.

84. RN Johnson-Bogaerts considers that the measures put in place by Radius Althorp were insufficient to prevent Mr M from entering the room and to keep Mr A safe from aggression. Overall, RN Johnson-Bogaerts concluded that there was a "significant" deviation from accepted practice.

85. I accept this advice. On 2 Month1, Radius Althorp was put on notice that Mr M was acting aggressively towards Mr A, as he was residing in Mr M's old room. Radius Althorp told HDC that the measures they put in place after knowing Mr M's behaviour and prior to 23 Month2 included increasing the observation of Mr M and Mr A, ensuring that all staff were aware of

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Mr M's behaviour, keeping Mr M distracted and engaged in activities, developing techniques for dealing with Mr M and redirecting him to his room when he became aggressive, and making plans to relocate Mr M to a different room. However, these measures were clearly ineffective in preventing further incidents between Mr M and Mr A as there were further incidents that same month. In addition, I consider that measures such as moving or redirecting Mr M on 2, 18 and 24 Month1 were reactive measures rather than proactive, and despite making plans to relocate Mr M, this was not done. Overall, I am concerned that ultimately the measures put in place by Radius Althorp were ineffective in preventing Mr M from entering Mr A's room and keeping Mr A safe from aggression. Despite the escalation in Mr M's behaviour, Radius Althorp management were not notified of the incidents that occurred after 2 Month1, and it appears that Radius Althorp's policies relating to serious events or incidents were not followed on these occasions. It is concerning that Mr A's family felt the need to stay overnight at Radius Althorp in order to protect their father.

86. Radius Althorp's Accident/Incident event reporting policy (Appendix B) sets out the process for reporting and investigating accidents and incidents, and any corrective action taken to prevent reoccurrences. The policy directs that events are reported promptly and brought to the attention of the Facility Manager, and that an incident form is completed as soon as possible, family and EPOA are notified as soon as possible and within 24 hours, the incident is documented in the progress notes, and a "communication with family form" is completed.

87. The Serious and Sentinel Events policy covers the reporting process for serious and sentinel events (including the serious assault of a resident). As with the policy relating to accident and incident reporting, serious events must be reported to the Facility/Clinical Manager and family. Open disclosure to family is required, as well as the completion of an incident form and recording of the event in progress notes and the communication with family form. The policy also sets out that an investigation is to be conducted to ascertain the causes of the incident.

88. Given the seriousness of the incidents between Mr A and Mr M, I would have expected Radius Althorp to have followed the procedures for serious events after the incidents on 2 Month1 and on 25 Month2. On 2 Month1, Mr M bit Mr A's arm and Mr A punched Mr M. In my view, this constitutes a "serious event"[19] under Radius Althorp's policy. The incident on 25 Month2 involved Mr M forcing his way into Mr A's room where both Ms B and Ms K had to try to stop Mr M from entering. Mr M was verbally aggressive and threatened to spit at them, and he spat at staff. In my view, this incident also constitutes a "serious event" under Radius Althorp's policy. Therefore, Radius Althorp was required to comply with its Serious and Sentinel Events policy in respect of the incidents on 2 Month1 and 25 Month2. Mr A's family were notified of the incident on 2 Month1, but there is no documentation outlining that the subsequent incidents were discussed with them, and there are no incident forms or communication with family forms on any of these occasions. It is also unclear whether the Facility Manager was involved, given the seriousness and escalation of the incidents

[19] Under Radius Althorp's Serious and Sentinel Events policy, a serious event includes an event with potential to result in a sentinel event, and a serious assault of a staff member, resident, contractor or visitor.

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between Mr M and Mr A, and whether entries in an incident and accident register were completed.

89. In addition, I note the findings from the serious incident review by Te Whatu Ora that the communication tool developed by MHSOP for Mr M (placing a sign in the ward redirecting Mr M to his room) was not followed by Radius Althorp, and that there was no apparent communication between Radius Althorp and MHSOP regarding the escalating behaviour of Mr M prior to the incident on 26 Month2. In my view, Radius Althorp did not provide services in a manner that minimised potential harm to, and optimised the quality of the life of, Mr A, and ultimately Radius Althorp failed in its duty of care to Mr A.

Quality of end-of-life care

90. Mr A's health started to deteriorate on 16 Month2, and it was anticipated that he was entering the last days of his life. The progress notes record that the family was kept "informed", but there is no detail of these conversations. Although Dr L documented on 16 and 23 Month2 that Mr A was entering the last days of his life, I note that the progress notes do not include observations of the changes that indicated this, or that an end-of-life care plan had been activated.

91. In response to the provisional opinion, Radius Althorp stated that an end-of-life plan was activated on 23 Month2 and remained in place until Mr A passed away on 26 Month2. Radius said that the relevant staff and Mr A's family were aware that Mr A was receiving end-of-life cares during this time. Radius accepts that Mr A was not always checked every 30 minutes between 23 and 26 Month2, and that this was contrary to Mr A's end-of-life care plan and accepted practice. Radius also accepts that its staff did not engage with Mr A's family appropriately between 23 and 26 Month2, and that this was contrary to its usual and accepted practice.

92. Radius told HDC that the issues relating to end-of-life care were solely and directly attributable to staff shortages in the unit at the time. However, I do not accept this statement. I consider that the poor communication with Mr A's family (as discussed below) and the inadequate end-of-life planning cannot be solely attributable to staff shortages at Radius, and that these deficiencies point to systemic issues at Radius.

93. From 22 Month2, 30-minute checks were put in place during the times family were not present, as part of the end-of-life plan. However, these checks were not followed consistently, and it is not clear from the documentation whether this was because family were present at the time. RN Johnson-Bogaerts noted that the progress notes, the complex healthcare procedure chart, and the medication charts show that Mr A received care consistent with end-of-life care, to keep him as comfortable as possible. However, she considered that the end-of-life care provided lacked a holistic and family-centred approach. She noted that there was no planning for end-of-life care, and no evidence of input from the EPOA. In addition, implementation of the 30-minute checks was poor, especially in the days leading up to Mr A's death and on the day he died. RN Johnson-Bogaerts considers that overall, in the circumstances, the end-of-life care provided to Mr A was "a moderate to significant deviation from accepted practice".

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94. Radius Althorp accepted that 30-minute checks were not completed on 26 Month2. Radius Althorp confirmed that Mr A had an advance directive but accepted that the information in these documents was not up to standard.

95. I accept RN Johnson-Bogaerts' advice. The clinical notes do not refer to input from Mr A's family in regard to the end-of-life plan, or what was discussed with Mr A's family in relation to his condition in the days leading up to his death. Radius Althorp has not provided a reasonable explanation of the approach it took in involving Mr A's family in his end-of-life care. While I acknowledge that Radius Althorp stated that it activated the end-of-life care plan on 23 Month2, there is no specific record of this, or of what input the family had in relation to the end-of-life care plan. I consider it more likely than not that Mr A's end-of-life care lacked a holistic and family-centred approach. In addition, I am critical that the information in Mr A's advance directive and end-of-life care plan was not up to standard, and that 30-minute checks were not completed between 23 and 26 Month2. Overall, I consider that the quality of end-of-life care provided to Mr A was inadequate.

Standard of documentation

96. An interRAI assessment for Mr A was completed on 17 Month1. It identified that an EPOA was in place, but that this had not been activated. The assessment summary recorded that physical activities were to be promoted (staff were to encourage Mr A to join physical activities), that Mr A needed assistance with daily living activities, and that Mr A preferred to stay in his room and could become aggressive if his personal space was invaded. Mr A was assessed as being at a high risk of undernutrition and urinary incontinence. Progress notes, care plans and charts were completed while Mr A was a resident at Radius Althorp.

97. RN Johnson-Bogaerts advised:

> "Reviewing [Mr A's] Care plans I found that these did not cover the care needs identified by the above mentioned interRAI assessment. The limited care plans were incomplete, the content was poor and not person centric. I did not find evidence that the care plans were discussed and agreed with the EPOA. There was no care planning relating to his end of life care."

98. RN Johnson-Bogaerts was also critical that the progress notes did not provide a good overview of findings, opinions, clinical reasoning or what happened on a particular day. She noted that there was no detail of communications or mention of the incidents with Mr M. The complex healthcare procedure charts were completed for care activities but contain very limited entries on what activity Mr A was doing at the time of the check. RN Johnson-Bogaerts stated:

> "Nursing documentation is essential for good clinical communication and assuring a continuity of care across time and the care teams. Appropriate documentation provides accurate reflection of nursing assessments, changes in clinical status, care provided and pertinent information to support the multidisciplinary team to deliver great care."

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99. RN Johnson-Bogaerts advised that she found the standard of documentation in relation to Mr A to be of poor quality and unfinished. She stated that there was insufficient documentation and completion of care plans, progress notes, and charts, which she considered to be a "significant" deviation from accepted practice. I accept RN Johnson-Bogaerts' advice, and am critical that the incidents involving Mr M were not documented consistently across the progress notes, care plans or behaviour identification charts. Good documentation allows for good continuity of care, and this was not the case for Mr A.

Staffing levels

100. At the time of these events, Radius Althorp cared for up to 117 residents across four service levels — dementia, hospital, psychogeriatric and some rest-home care. Radius Althorp has four separate units for the dementia service, and each unit has 15 beds. The staffing roster for the week of 20–26 Month2 shows that one healthcare assistant night-shift position was unfilled on 23, 24, 25 and 26 Month2. On 16 July 2020, Radius Althorp told HDC that at the time of the incident at 6.45am on 26 Month2, staffing ratios for the night shift (11pm until 7.15am) were one registered nurse and four healthcare assistants to 58 dementia care beds. Radius Althorp accepted that the staffing levels were inadequate. In a further response on 6 May 2021, Radius Althorp told HDC that at the time of the incident there was one healthcare assistant rostered to care for 15 psychogeriatric residents, and one registered nurse to oversee 34 psychogeriatric residents.

101. RN Johnson-Bogaerts stated that it is accepted practice not to fill the duty of a person on leave if occupancy levels on the day are significantly lower. It is also accepted practice to add extra staff when needs are increased and/or provide "one-on-one" care if and when warranted in emergency situations. However, RN Johnson-Bogaerts advised that at the time of the incident on 26 Month2, staffing levels were inadequate given the increased need relating to the provision of end-of-life care and the management of the resident with territorial behaviour. RN Johnson-Bogaerts also advised that if one of the duties on the roster was not filled during 23–26 Month2 and staff were not working according to required staffing-to-resident levels, this would constitute a significant deviation from accepted practice.

102. While Radius Althorp has said that the positions on the unfilled shift roster on 23, 24, 25 and 26 were filled by staff, the original roster from the time of the events indicates that these positions were not filled, and that staff were not working according to required staffing-to-resident levels. I find it more likely than not that the duties on the roster were not filled appropriately. I am therefore critical that Radius Althorp did not adjust its staffing levels, given that Mr A was in the last days of his life, together with the escalating behaviour of Mr M. I agree with RN Johnson-Bogaerts that this is a significant deviation from accepted practice.

Communication with Mr A's family

103. As noted above, there were at least five altercations and/or incidents between Mr M and Mr A that started shortly after Mr A was admitted to Radius Althorp. There was also one incident on 18 Month1 that involved an unnamed resident. Mr A's family were informed about the first incident on 2 Month1, but there is no documentation to suggest that they

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were informed of the subsequent incidents on 18 Month1, 24 Month1 and 23 Month2 (noting that they were present for the incident on 25 Month2).

104. On 26 Month2, following the final and most severe incident between Mr A and Mr M, Ms B contacted Radius Althorp at 8am but was not advised of the incident or asked to attend Radius Althorp. At 11am, Radius Althorp staff called Ms B to ask what time she would be coming in, and, when she asked whether her father was all right, she was told that he was "about the same". Again, she was not informed of the incident that had occurred that morning.

105. In my view, adequate communication with the family is important in situations where the consumer is cognitively impaired and family are part of the support network. Mr A's family had asked to be kept informed of Mr A's condition, and they should have been advised of any issues concerning his health and safety. While I acknowledge that on 26 Month2 Radius Althorp wanted to inform the family of the incident in person, I am very concerned that Ms B was not advised of the incident when she rang at 8am, or when staff contacted her at 11am. Mr A passed away shortly after Ms B arrived, and she then had to contact the family, who were unable to be present when Mr A passed away.

106. I am critical of the lack of communication with Mr A's family after each incident, as well as the delay in informing them of the incident on 26 Month2. I acknowledge that Radius Althorp staff were surprised to find that Mr A was taking his last breath when they went to check on him at 1pm. I do not expect them to have known that he would die shortly after the incident, but I am concerned that Radius Althorp staff did not recognise the potential significance of his head injury. The open disclosure requirement set out in the serious and sentinel events policy states that an open and transparent discussion is required following an incident of unintended harm to a resident. This includes an acknowledgment of the incident occurring, apologising, and learning to prevent reoccurrence. There is no documentation to suggest that discussions were held with Mr A's family following the initial incident on 2 Month1, and this failure continued through to the day of Mr A's passing.

Audit results

107. Radius Althorp has referred to the surveillance audits completed by HeathCERT in 2020 and 2021 as demonstrating that Radius Althorp is meeting industry standards in the provision of care for its residents.

108. I do not accept this statement. While the surveillance audit in 2020 identified no "partial attainments", the surveillance audit completed in August 2021 identified shortfalls in relation to quality programme, monitoring of care, and medication management and administration.

Conclusion

109. Radius Althorp had a responsibility to operate the psychogeriatric unit in a manner that provided its residents with services of an appropriate standard. The overall deficiencies in the end-of-life care provided to Mr A, the inadequate documentation and staffing levels at Radius Althorp, and the inadequate communication with Mr A's family demonstrate a

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pattern of suboptimal care and a lack of critical thinking from Radius Althorp staff members. I consider the above shortcomings to be service delivery failures that are directly attributable to Radius Althorp. In my view, Radius Althorp failed to provide services to Mr A with reasonable care and skill and, accordingly, I find that Radius Althorp breached Right 4(1)[20] of the Code.

110. Radius Althorp also had a duty to keep Mr A safe from harm. I consider that Radius Althorp failed to manage Mr M's behaviour towards Mr A adequately and to put in place effective measures to minimise harm to Mr A. I find that Radius Althorp failed to provide the services required to minimise harm to Mr A and to optimise the quality of his life, and accordingly that Radius Althorp breached Right 4(4)[21] of the Code.

Changes made since events

111. After these events, Radius Althorp undertook the following:

a) Provided training to all new staff on incident/accident reporting and to notify senior staff of any incidents.

b) Increased staffing levels to ensure that all residents receive regular checks, and provided training on the importance of regular checks.

c) Confirmed that its processes for end-of-life care were audited in July 2020[22] and there were no partial attainments. Radius Althorp also stated that all documentation was reviewed and updated as a result of the corrective action plan,[23] and workflow and documentation is now monitored daily at team meetings with regular reviews in place as part of an internal audit programme at Radius Althorp being managed by its senior clinical team.

d) Confirmed that staffing levels have been adjusted in line with the Safe Staffing Index guidelines, and that staffing levels are adjusted in accordance with need and acuity. Staffing levels were reviewed as part of the Surveillance Audit on 30 July 2020 and found to be sufficient.

e) Put in place a corrective action concept plan to allow for further development of person-centered outcomes, as well as a review of dementia services and support in clinical assessments and decision-making.

112. In addition, as a result of Radius Althorp's internal review, the following recommendations were made and completed:

[20] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

[21] Right 4(4) states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

[22] Surveillance Audit completed on 30 July 2020.

[23] The corrective action plan was completed on 30 March 2020.

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- To use and adapt the current Radius "Getting to know me" document to ensure that all staff have a person-centred quick reference page on each person to identify strategies to de-escalate and manage each person.
- To review staffing levels across a 24-hour period in the dementia services.
- To give additional importance and reinforcement to programmes now in place, such as the registered nurse and healthcare assistant leadership programme.
- To promote timely interventions by registered nurses for reassessment and change in the level of end-of-life care, in communication with Needs Assessment and Service Co-ordination (NASC) services.
- To provide education for the team around early detection of families who may be unhappy with the service being provided to their relative.
- To re-train staff in the Radius education programme that focuses on person-centred care.
- To shape and reinforce the confidence in healthcare assistants and registered nurses to report forward concerns with residents and families.
- To develop a clear line of communication with families, led by the Facility Manager and Clinical Manager.

Recommendations

113. I recommend that Radius Residential Care Ltd — Althorp:

a) Provide a written apology to Mr A's family for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

b) Within three months of the date of this report, provide HDC with a further update on the implementation of the corrective actions set out in Radius Althorp's internal investigation.

c) Conduct a random audit of end-of-life care plans, progress notes and charts for ten residents over the past six months, to ensure compliance with relevant Radius Althorp policies. Radius Althorp is to report the results of the audit to HDC within six months of the date of this report. Where the audit results do not show 100% compliance, Radius Althorp is to advise what further steps will be taken to address the issue, and undertake a further audit to confirm compliance.

Follow-up actions

114. A referral to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 was initially considered to be appropriate. However, in light of the family's wishes, the changes that have since been implemented by Radius Althorp, and public interest considerations, I now consider that a referral is not required in this case.

115. A copy of this report will be sent to the Coroner.

116. A copy of this report with details identifying the parties removed, except the advisor on this case and Radius Residential Care Ltd — Althorp, will be sent to HealthCERT and Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Hilda Johnson-Bogaerts, Clinical Advisor, Aged Care:

"1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Radius Althorp (RA) to [Mr A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Specifically I was asked to review the provided documentation and advise on the following:

i. The adequacy of actions taken to ensure [Mr A's] safety.
ii. The quality of [Mr A's] end of life care.
iii. The standard of documentation, including for the care plan and progress notes.
iv. Sufficiency of staffing on the ward and actions taken by Radius Althorp.
v. Any other matters you consider warrant comment.

I would like to express my condolences to the family of [Mr A].

2. Documents reviewed

- Radius corrective action plan dated 24 Month3
- Notification of an incident under section 31 form
- Progress notes, Care plan, GP notes, Observation charts, Complex health care procedure charts
- Medication order chart, Medication signing sheets
- [Four provider responses]
- Emails relating to the incidents between DHB Portfolio Manager to Temporary Facility Manager Althorp

3. Review of clinical records

[Mr A] was a resident at the psychogeriatric long term aged care facility RA since 1 [Month1]. His medical diagnosis included: cardiovascular disease, advanced dementia requiring psychogeriatric care, pancreatic cancer, atrial fibrillation. Assessments completed by RA nurses in [Month1] noted that [Mr A] preferred to spend most of his time in his room and rarely participated in group activities. He was highly sensitive to his personal space being invaded which could trigger aggression. He was fairly independent. He had a supportive family who were very involved with his care and visited frequently.

During [Month2] he experienced a significant deterioration in his health and entered end of life care on 23 [Month2].

During his stay there were a number of reported incidents where another resident (who we shall call [Mr M] for the purpose of this advice) entered his room believing it was

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his, leading to a number of aggressive altercations between the two men ([Mr M] had previously occupied [Mr A's] room). Actions put in place to manage [Mr A's] safety included the installation of a sensor mat which would activate the nurse call when stepped on, the fire doors in the corridor were closed putting in an extra barrier, and 30 min. checks were implemented as part of [Mr A's] end of life care.

On 26 [Month2] at approximately 6.45 hrs the same resident had gone into [Mr A's] room despite these safety measures in place. The staff member who heard the fire doors went to [Mr A's] room to find [Mr M] yelling and shaking [Mr A] who was in an unconscious state as part of his dying process. The staff member unable to intervene left the room to activate the emergency call bell which was situated in the day room. When she came back [Mr A] was on the floor beside his bed. Three other staff arrived in response to the emergency call bell and [Mr M] was removed from the room.

[Mr A] was checked for injury and put back to bed. He had sustained a skin tear on the back of his head and remained unresponsive. While the nurse was dressing the wound [Mr M] entered the room again, the emergency bell was activated to call for help while two staff held [Mr M] again showing physical and verbal aggression. [Mr M] was removed from the room.

The nurses decided to let the family know in person rather than ringing them immediately after the events. That day at around 13.00 hrs [Mr A] passed away with family present.

4. Clinical advice

i. The adequacy of actions taken to ensure [Mr A's] safety.

Physical aggression is a known behavioural manifestation in dementia patients, and is usually related to identifiable triggers, communication challenges, and/or an unmet need. Managing challenging behaviour in residents with dementia asks for a systematic and multidisciplinary approach, focusing on finding and treating the underlying problems and health issues. This multidisciplinary approach includes input from the local DHB's Psychogeriatric Team and/or Mental Health Team. Typically aged care nurses will complete and document observations when a resident shows behaviour that challenges in an attempt to identify triggers or unmet needs. This is followed by the development of a care plan/behaviour plan with input from the multidisciplinary team. Where interventions are not effective this would be escalated with input from the GP. Where the behaviour includes physical aggression/assault of another resident this should be escalated to the clinical manager immediately and referred for a medical review. Keeping all residents and staff safe is top priority.

There were a number of incidents involving [Mr M] who was convinced [Mr A] was occupying his room. Reportedly [Mr M] had tried multiple times to go to [Mr A's] room and staff had been able to redirect him most of the time. Family raised their concern on 14 [Month2] and they were assured that staff were able to redirect [Mr M].

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It was reported that on the following dates staff failed to prevent an encounter and this resulted in physical violence between the two men: 2 [Month1], 24 [Month1], 23 [Month2], 25 [Month2], and twice on 26 [Month2]. The provider reported the following actions to ensure [Mr A's] safety: half hourly checks and the installation of the sensor mat (26 [Month2]) and the shutting of the fire doors between two wings. I note that the half hourly checks were not completed that morning and were completed every two hours that morning.

In my opinion these actions were insufficient to prevent [Mr M] from entering the room and keeping [Mr A] safe from aggression. I would expect that [Mr M's] care plan included interventions to prevent and manage his territorial behaviour, that these were communicated to all care staff and implemented, regularly reviewed, adjusted and appropriately escalated to relevant mental health clinicians. The provided documentation did not include clinical information about [Mr M] however I note an email from the DHB dated [2019] from DHB Portfolio Manager to Temporary Facility Manager Althorp in which serious concerns were raised about the implementation of recommendations made by the DHB.

I have concerns that staff needed to go to the day room to raise an alarm and request assistance. For safety reasons, staff within a psychogeriatric service should be able to raise an alarm from every room.

In addition and due to the seriousness of the incidents I would have expected that the on call manager who was notified of the incidents on 25 [Month2] and 26 [Month2] would have provided a more involved approach in managing the situation.

Based on the information provided and the fact that [Mr M] continued to be able to enter [Mr A's] room and exhibited physical aggression over the period of two months and twice on 26 [Month2], I am of the opinion that the provider failed to put effective interventions in place to keep [Mr A] safe.

Deviation from accepted practice — significant.

i. The quality of [Mr A's] end of life care.
16 [Month2], the progress notes include that [Mr A] experienced an episode where he '*turned greyish'* witnessed by his daughter. He had verbalised during that time '*I feel like I am dying'*. This was escalated to his GP who considered '*possible pending last days of life'* and completed anticipatory prescribing as part of end of life care planning.

On the morning of 22 [Month2] [Mr A] had been unwell but he said he was not in pain and was okay. The notes include a conversation with family to update them on the current situation, the notes do not include detail of the content of this conversation.

On 23 [Month2] it was decided with the GP to commence focusing on symptom management and provide comfort cares only. The notes include an entry that the EPOA wanted to be contacted any time of the day or night if he should deteriorate or pass away. 30 min. checks were implemented during the times family were not present. The

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observation chart shows that the checks were completed consistently during the night on an hourly basis however checks during the day seem to have gaps. It is not clear from the documentation that this was due to the fact that family were present. On the morning of 25 [Month2] checks were completed on an hourly basis while in the afternoon the frequency was every 30 min. I am concerned that on the morning of 26 [Month2] [Mr A's] checks were reduced to two hourly.

The documentation includes entries relating to communication with family. I did not find detail on the content of this communication but generally they were referred to as '*keeping them informed*'.

I note that the progress notes did not include observations of changes that indicated he was entering last days of life and the activation of care for the dying care plan. Good practice requires for this to be documented and that at that time, the 'last days of life' care plan be initiated or that the current care plan be reviewed and updated, based on key care needs assessments carried out by a registered nurse, and the establishment of a new baseline. The new and updated care plan is to be explained and agreed with the EPOA and wider family as appropriate. The progress notes include general observations taken relating to signs of discomfort, turns while in bed as part of prevention of pressure injury, food and fluid intake, etc. The Complex Health Care Procedure Chart used to document the 30 min. checks included a comments box with some limited observations entered in these. The implementation of 30 min. checks as a minimum are consistent with good practice.

The reviewed clinical documentation in the format of Progress Notes, the Complex Health Care procedure Chart, and Medication Charts shows that [Mr A] received care that is consistent with end of life care, keeping him as comfortable as possible. I am concerned however that I did not find a Last Days of Life Care plan consistent with New Zealand's best practice model Te Ara Whakapiri[1]. The use of this tool would have guided a more holistic and family centric approach to care during these last days.

In conclusion, I did find the quality of end of life care provided to be inadequate with a lack of a holistic and family centred approach, no care planning for end of life care, no evidence of input from the EPOA. In addition there was a poor implementation/ adherence of the nurse initiated 30 minute checks especially on the day he died**. In the circumstances, this would be seen by my peers as a moderate to significant deviation from accepted practice.**

ii. The standard of documentation, including for the care plan and progress notes.
Nursing documentation is essential for good clinical communication and assuring a continuity of care across time and the care teams. Appropriate documentation provides accurate reflection of nursing assessments, changes in clinical status, care provided and pertinent information to support the multidisciplinary team to deliver great care.

[1] https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

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[Mr A] received an interRAI assessment which was completed on 17 [Month1]. The assessment summary identifies items that are triggered and require attention for care. The items triggered from [Mr A's] assessment included: the promotion of physical activities, assistance with ADL, prevention of cognitive decline, mood (low risk), prevention of challenging behaviour, high risk for undernutrition, and urinary incontinence.

Reviewing [Mr A's] Care plans I found that these did not cover the care needs identified by the above mentioned interRAI assessment. The limited care plans were incomplete, the content was poor and not person centric. I did not find evidence that the care plans were discussed and agreed with the EPOA. There was no care planning relating to his end of life care.

Progress notes serve as a record of events, allow clinicians to compare past status to current status, serve to communicate findings, opinions and plans between members of the care team, and allow a retrospective review of case details for a variety of interested parties. They are the repository of findings, facts and clinical thinking, and are intended to be a concise vehicle of communication about a resident's condition to those who access the health record. Reviewing [Mr A's] progress notes I found that the quality of nurse entries were variable. The notes did not provide a good overview of findings, opinions, clinical reasoning or what happened on a day. There was no detail of communications, no mention of the incidents with [Mr M]. The complex Health Care Procedure Charts were completed for care activities as for example 'Checks for residents'. These were completed starting 2 [Month1] hourly at night and two hourly during the day. They include in the comments column very limited entries on what activity [Mr A] was doing at the time of the check. [Mr A's] behaviour chart includes the incidents with [Mr M] on the dates mentioned above.

I found the standard of documentation to be of poor quality and unfinished. There was insufficient documentation and completion of care plans, progress notes, and charts. **Deviation from accepted practice — significant.**

iii. Sufficiency of staffing on the ward and actions taken by Radius Althorp.
RA provides residential aged care at hospital, rest home and dementia level care to a maximum of 117 residents. There are four separate units for the dementia services. Each unit has 15 beds. Three of these units provide psychogeriatric care. Generally clients in psychogeriatric level care (D6) have similar medical requirements to people in hospital level care, requiring total assistance with activities of daily living in addition to mental health issues.

The aged residential care agreement requires providers to '*provide sufficient staff to meet the health and personal care needs of all residents at all times*' and '*the distribution of care staff over a 24 hour period is always to be in accordance with the needs of the residents and determined by a registered nurse*'.

The provider response of 14 July 2020 includes that '*At the time of the incident on [the D6 ward] on 26 [Month2] at 6.45am, staffing ratios were 1 RN to 58 dementia care beds,*

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and 1 HCA to 15 dementia care beds, who worked on a night roster (23.00 to 07.15). The team were however supported by RN and Team leaders from the Hospital services (45 Beds)'.

In the provider's response dated [2019] Radius states that they accept the finding '*that there was inadequate staffing levels in the dementia unit at the time of the incident*' and '*Following a review of staffing levels at Althorp, Radius has increased its staffing levels to ensure that all residents receive their necessary cares and regular checks*'. Staff rosters were provided for the week 20 [Month2] to 26 [Month2]. It appears that during the night duties of 23, 24, 25 and 26 [Month2] one of the HCA duties (HCA nights …) was not filled. The name of the HCA was crossed off with no alternative name added.

It is accepted practice not to fill a duty of a person on leave if occupancy levels on the day are significantly lower. It is also accepted practice to add extra staff when needs are increased and/or provide 'one on one' care if and when warranted in emergency situations.

I consider the staffing ratios as per the provider's response to be adequate for a night roster at times where acuity levels are stable. I agree with the provider that at the time of the incidents on 26 [Month2] staffing levels were inadequate given the increased need relating to the provision of end of life care and the management of the behaviour of the resident with territorial behaviour. **In the situation that one of the duties on the roster was not filled during these 4 days and staff were not working according to required staffing to resident levels, this would be seen by my peers as a significant deviation from accepted practice. In the circumstances that all duties on the roster were filled and staffing levels were not adjusted to the increased need due to behaviour issues of [Mr M] and end of life care of [Mr A], this would be seen in this situation as a moderate deviation from accepted practice.**

ADDENDUM

Thank you for giving me the opportunity to review the responses and see if these would change my previously provided advice.

Reviewing the additional information you forwarded I see that there are some items that could be corrected. The provider response clarified that there are nurse call points in every room but the person could not physically get to it and therefore went to a different room to activate the emergency call bell. I also note that the on call Nurse Manager was not notified of the incident and therefore was not involved at the time. The provider accepts that the Nurse Manager should have been notified at the earliest opportunity. These clarifications however do not change my overall advice and opinion that the provider failed to put effective interventions in place to keep [Mr A] safe.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

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Appendix B: Relevant policies and standards

Standards

The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) state:[1]

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 the organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> Standard 2.3 the organisation has an established, documented, and maintained quality and risk management system that reflects the continuous quality improvement principles.
>
> Standard 2.4 all adverse, unplanned, or untoward events are systematically reported by the service and reported to affected customers and where appropriate their family/whānau of choice in an open manner.
>
> …
>
> Standard 2.6 Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.
>
> ….
>
> Standard 2.8 consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.
>
> Standard 2.9 consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible where required.
>
> Standard 3.3 consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes/goals.
>
> ….
>
> Standard 4.7 consumers receive an appropriate and timely response during emergency and security situations."

Radius Althorp policies and procedures

Handover and communication (IBSAR)[2]
This policy relates to the ISBAR communication tool, which is to be used to facilitate efficient verbal communications between clinical staff relating to requests for assistance, resident

[1] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.
[2] Reviewed in December 2018.

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transfers, and communicating concerns to on-call management in the situation of a deteriorating resident.

Serious and Sentinel Events[3]
This policy describes the process for identifying and reporting serious and sentinel events at Radius Althorp. The policy provides that for effective management of these incidents, it is necessary to ensure that it is safe for residents and their families, and that the process is open and transparent.

Accident/Incident Report[4]
This policy describes the process for reporting and investigating accidents or incidents and the corrective actions to be taken to prevent re-occurrences.

[3] Reviewed in June 2018.
[4] Reviewed in June 2018.

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