Bupa Care Services NZ Limited

Facility Manager, RN B

Clinical Manager, RN C

Registered Nurse, RN D

Health Care Assistant, HCA E

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC01571)

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Executive summary

1. On 26 May 2014, while in a public hospital's intensive care unit, Mr A had a respiratory arrest and sustained a hypoxic brain injury. The DHB (DHB2) referred Mr A to a needs assessment and service coordination service (NASC) to be assessed for placement in a residential care facility. On 8 October 2014, an InterRAI assessment was undertaken.

2. It was decided to transfer Mr A to a private hospital which provided residential care facility for dementia and psychogeriatric residents. The InterRAI assessment was sent to the private hospital on Monday 20 October 2014. On Tuesday 21 October 2014, Mr A was admitted.

3. From 21 October until 23 October Mr A was reasonably settled, but his behaviour changed on 24 October 2014 in that he was less settled and began refusing some of his medications. That afternoon he became agitated, and took off his glasses and squeezed them, causing a lens to fall off, which he then put in his mouth. No injuries were recorded but his monitoring was increased.

4. On 24 October 2014, at around 6.15pm, Mr A fell and hit his head. A health care assistant (HCA), HCA E, who observed the fall, did not record it in the progress notes, and did not complete an incident form until the following day.

5. At 6.29pm, HCA E informed the duty leader, Registered Nurse (RN) RN D, of the fall. RN D did not make any record of the fall or request a referral of Mr A to another health professional or DHB2. RN D did not notify Mr A's family of the incident, or hand over information about the fall to the night registered nurse.

6. On 25 October 2014, RN H was working the morning shift. She noticed bruising of Mr A's left eye, but did not record the injury or any assessments having been performed. HCA E completed an incident form on 25 October 2014.

7. At 4pm, RN D recorded Mr A's fall the previous day as a retrospective entry in the progress notes. RN D recorded that there was grazing on Mr A's forehead, that Mr A had been resistive and agitated, that observations could not be done on 24 October, and that Mr A had been placed on the list for a post-fall doctor's review.

8. At around 4.40pm on 25 October 2014, Mrs A visited her husband and was distressed to find him lying in bed, injured and unkempt, with HCA E sitting in the room with his feet up.

9. From 26–28 October Mr A's condition deteriorated and he became more aggressive and resistant to cares. Mr A had been increasingly violent over the previous few days, and had assaulted six staff members. On 29 October, assistance was requested from DHB2's mental health team because the private hospital staff felt it was unsafe to look after him, and asked for him to be removed from the facility.

10. On 29 October 2014, Mr A was transferred to back to the public hospital.

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Findings summary

Bupa Care Services NZ Ltd

11. Bupa had overall responsibility for ensuring that staff at the private hospital provided Mr A with services of an appropriate standard, and that complied with the Code of Health and Disability Services Consumers' Rights (the Code).

12. It appeared at the time of admission that the private hospital indicated that it could provide adequate care for Mr A. However, he was not provided with services with reasonable care and skill in that:

- The care planning was inadequate.
- Bupa failed to take sufficiently prompt action when Mr A's behaviour deteriorated.
- The management and follow-up of Mr A's fall, including assessment and monitoring, was poor.
- The oversight of HCA E was inadequate.
- No plan was put in place to obtain support over the long weekend following admission, if required.

13. These failings cumulatively amount to a breach of Right 4(1)[1] of the Code.

RN D

14. RN D failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

15. On 24 October, RN D failed to record any information about Mr A's fall. Accordingly, RN D failed to comply with professional standards and also breached Right 4(2)[2] of the Code.

HCA E

16. HCA E failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

RN B

17. Adverse comment is made about Facility Manager RN B.

RN C

18. Adverse comment is made about Clinical Manager RN C.

Recommendations

19. It is recommended that Bupa Care Services NZ Limited:

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

[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

HDC

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a) Provide HDC with its policy for one-to-one specials.
b) Provide HDC with its policy for at-risk admissions to enable it to assess the suitability of prospective patients for admission to its facilities.
c) Review the implementation of the recommendation from its internal review, and report the outcome to HDC.
d) Provide HDC with the outcome of the review of its Medication Administration policy, and evidence of staff training on medication administration, including the documentation of PRN medication.
e) Review how it manages clinical and care staff resourcing and what safeguards it has in place to arrange for additional staffing, including agency staff.
f) Ensure that all registered nurses and health care assistants receive training in neurological observations and behaviours that challenge.
g) Undertake an audit of the effect of the changes made since this incident, and provide the outcome to HDC.
h) Ensure that all registered nurses receive training on their responsibilities with regard to the oversight of health care assistants.

20. It is recommended that Bupa Care Services NZ Limited, RN D, and HCA E each separately apologise to Mrs A.

21. It is recommended that the Nursing Council of New Zealand consider whether a competence review of RN D is warranted, should he return to practise in New Zealand.

Complaint and investigation

22. The Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A, at the private hospital.

23. The following issue was identified for investigation:

The appropriateness of the care provided to Mr A by Bupa Care Services NZ Limited in October 2014.

24. On 16 February 2016, the investigation was extended to include the following further issues:

- *The appropriateness of the care provided to Mr A by RN B in October 2014.*
- *The appropriateness of the care provided to Mr A by RN C in October 2014.*
- *The appropriateness of the care provided to Mr A by RN D in October 2014.*
- *The appropriateness of the care provided to Mr A by HCA E in October 2014.*

25. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

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26. The parties directly involved in the investigation include:

Mrs A	Complainant/consumer's wife
Bupa Care Services NZ Limited	Provider
RN B	Facility Manager
RN C	Clinical Manager
RN D	Registered nurse
HCA E	Health care assistant
Dr F	General practitioner
RN G	Provider/nurse practitioner
District health board	Provider

Also mentioned in this report:

RN H	Registered nurse
Dr I	Consultant psychiatrist
RN J	MHSOP coordinator
Dr K	Psychiatrist
RN L	Registered nurse

27. Information from the NASC was also reviewed.

28. Independent expert advice was obtained from in-house nursing advisor RN Dawn Carey (**Appendix A**), and RN Christine Howard-Brown (**Appendix B**).

Information gathered during investigation

Background

29. On 21 May 2014, Mr A (aged 59 years at time of these events) was admitted to Hospital 1 with an aortic dissection[3] distal to the left subclavian artery.[4] On 22 May 2014, he was transferred to Hospital 2 for a thoracic endovascular aneurysm repair (TEVAR) stent graft.[5] On 26 May 2014, while in the Intensive Care Unit, he had a respiratory arrest and sustained a hypoxic brain injury. He was diagnosed with anoxia encephalopathy.[6]

30. On 19 July 2014, Mr A was transferred back to Hospital 1. During that admission, he was aggressive and agitated and needed to be under a constant watch. On 23 September 2014, Mr A was transferred to Hospital 2 for rehabilitation. It was decided that he should be assessed with a view to transferring him to facility-based care. Meetings were held with Mr A's wife regarding discharge planning and his future placement.

[3] Aortic dissection is a separation of the layers within the wall of the aorta, the main artery that branches off the heart.
[4] The left subclavian artery supplies blood to the left arm.
[5] TEVAR is a minimally invasive alternative to open surgery for the treatment of thoracic aortic aneurysms.
[6] A condition where brain tissue is deprived of oxygen and there is a global loss of brain function.

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Assessment

31. DHB2 referred Mr A to the NASC[7] to be assessed for placement in a residential care facility. On 8 October 2014, an NASC assessor commenced an InterRAI assessment.[8] Mr A was accompanied by his son during the assessment.

32. The 14-page InterRAI assessment notes that Mr A required two people to assist him to mobilise, and needed supervision for 24 hours 7 days a week. The NASC assessor noted that Mr A had experienced multiple falls whilst at Hospital 1[9] and following his transfer back to Hospital 1 in July 2014, and had exhibited agitation and aggression that occasionally required sedation and "ongoing consult[ant] liaison input". The NASC assessor recorded that Mr A's family were not able to care for him, and his home environment was not suitable and would require renovations if Mr A was to return home. It also recorded that Mr A had impaired communication (speech dysarthria),[10] diverticular disease,[11] hypertension,[12] asthma, lumbar discectomy,[13] gout, multiple renal calculi,[14] depression, bipolar disorder, and hyperlipidaemia.[15]

33. Mr A required the use of a gutter frame when walking,[16] and slept in a low bed with "crash mats" around the bed in case he fell out. The NASC assessor noted that Mr A could have "aggressive outbursts", and recorded a number of episodes, which could not be de-escalated, of him allegedly punching, shouting, grabbing and pushing, and not being able to work with staff. It is noted in the InterRAI assessment that fatigue was an issue that required management in order to reduce Mr A's agitation. It is also noted that Mr A sometimes crawled, and that care staff should not restrain him when he wished to crawl. The InterRAI assessment notes that Mr A required "full support for decisions regarding his safety". It also noted that Mr A had become "more settled" over the past three days.

34. On 15 October 2014, DHB2 consultant psychiatrist Dr I reviewed Mr A in the rehabilitation ward. Dr I noted that Mr A required "significant amounts of PRN [as

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[7] A community-based organisation that provides a needs assessment and service coordination service for people with disabilities. It carries out comprehensive assessments to determine the person's support needs, and then identifies suitable support services, arranges them, and reviews whether the arrangement is working for the client.

[8] A care co-ordination assessment system that guides comprehensive care and service planning in community-based settings. Also known as an InterRAI MDS-HC.

[9] The assessment states that Mr A had had some 20 falls prior to admission to Hospital 2.

[10] A motor-speech disorder. It results from impaired movement of the muscles used for speech production, including the lips, tongue, and vocal chords.

[11] A condition in which muscle spasm in the colon (lower intestine) in the presence of diverticula causes abdominal pain and disturbance of bowel function without inflammation.

[12] High blood pressure.

[13] Surgery to remove lumbar (low back) herniated disc material that is pressing on a nerve root or the spinal cord.

[14] Kidney stones, or renal calculi, are solid mineral deposits that usually originate in the kidneys.

[15] Elevated levels of any or all lipids (fat-soluble molecules) and/or lipoproteins in the blood. Lipid and lipoprotein abnormalities are common in the general population, and are regarded as a modifiable risk factor for cardiovascular disease.

[16] A rigid steel frame with forearm gutter support used for movement and manoeuvering around furniture and through doorways. Mr A usually required two people to assist him. The assessment noted that Mr A could manage 5–30 metres, depending on his level of alertness.

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needed] benzodiazepines on top of his regular diazepam[17] dose of 2 mg twice a day". Dr I noted that Mr A had been receiving on average 6–8mg of diazepam on top of his usual dose, and that in the last three days he had been requiring intramuscular lorazepam.[18] Dr I stated: "[Mr A's] current presentation on the ward suggests that he needs to be in permanent residential care and I understand that this will need to be a psychogeriatric hospital." Dr I noted that he would follow up on Mr A's transfer to the private hospital.

35. On 17 October 2014, a senior medical officer certified that Mr A was mentally incapable of making decisions about his personal care and welfare. Mrs A was, at that time, making an application to the Family Court to be appointed as her husband's welfare guardian.

36. On 20 October 2014, the Mental Health Services for Older Persons (MHSOP) coordinator at DHB2, RN J, added an addendum to the InterRAI assessment stating:

> "Following extensive consultation with all parties involved in [Mr A's] care both historically and currently, the decision has been made for [Mr A] to be placed in a residential care facility to meet his ongoing daily care needs."

37. RN J noted that Mr A required "a very high level of care in a psycho- geriatric hospital to enable his extensive daily care needs to be met safely". She recorded that the placement was to be on an interim basis, and noted: "This decision for level of care has been accepted by all parties concerned."

38. RN J noted that an ACC application should be made, a rehabilitation centre[19] should assess Mr A to ascertain his suitability for its brain injury unit, and that there should be consideration of possible residential units closer to Mr A's home.

39. RN J recorded that DHB1 was to fund an extra staff member for each shift for Mr A in the initial phase of his care, and that Mr A had been approved for hospital specialised level 1 care (psychogeriatric care).[20] DHB2 said that that level of care was appropriate, as Mr A was moving from an open ward and did not require level 2 care.

40. It was decided to transfer Mr A to the private hospital[21]. DHB2 told HDC:

> "The decision around the appropriateness of this facility was agreed following the assessment and the involvement of the geriatrician, the inpatient multi-disciplinary team at [DHB2] and its lead clinician, [the NASC's] MHSOP coordinator, the [DHB1] clinicians and ACC responses. All were in agreement that this was the

[17] Diazepam, first marketed as Valium, is a medication of the benzodiazepine family that typically produces a calming effect. It is used to treat anxiety disorders.
[18] Lorazepam is a benzodiazepine medication used to treat anxiety disorders.
[19] The centre specialises in rehabilitation after traumatic brain injury and stroke.
[20] Residential care falls into four levels: rest home care, long-term hospital care, dementia care, and psychogeriatric care. Psychogeriatric care has two levels. Level 1 is the lower level of psychogeriatric care.
[21] Owned and operated by Bupa Care Services NZ Limited.

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most appropriate facility available, and this was also agreed by the private hospital."

41. The InterRAI assessment was sent to the private hospital on Monday 20 October 2014.

42. DHB2 said the private hospital received the assessment, discharge summary, and inpatient notes as handover. The discharge summary, dated 21 October 2014, states: "[Mr A] is to be discharged to [the private hospital]. [Mrs A] would like this to be a temporary placement in the hope of being able to have him be at [the rehabilitation centre] for brain injury patients." The summary lists Mr A's medications, and notes: "[M]ay consider clonidine patch for [blood pressure] control due to unpredictable oral compliance with medications."

43. Mrs A told HDC:

> "The transfer of [Mr A] from [Hospital 2] to [the private hospital] was at all times without my consent … As I was given no choice as to the transfer occurring, I had no option but to concede. I had no alternative placement for him, and stipulated that it could only ever be for the shortest window of time. I had only just been able to action a request for assessment by [the rehabilitation centre]."

Private hospital

44. The private hospital is certified to provide aged residential care services, and holds a contract with DHB2 to provide aged residential hospital specialised services under a national agreement. It is a specialist facility for dementia and psychogeriatric residents. The private hospital specialises in caring for residents with challenging behaviours such as hitting or kicking out, displaying aggression in other ways, or refusing to eat or take medications.

45. RN B, the private hospital's Facility Manager,[22] told HDC:

> "I had met with [Mr A's] wife on the Saturday before the admission, she was distressed and upset that her husband was sent to us (Psychogeriatric Hospital) as her wish was for him to be sent to rehabilitation and get him better."

46. RN B told HDC that she discussed in detail with the Clinical Manager, RN C, the decision to accept Mr A's admission. RN B stated that the decision to accept Mr A for admission was appropriate based on the InterRAI assessment and other information provided by the Needs Assessment and Service Coordination (NASC). She noted that the NASC had assessed Mr A as requiring hospital specialised level 1 care, which is not the highest level of care provided at the private hospital, and said that, with hindsight, she considers that Mr A should have been assessed as requiring a higher level of care. She stated that RN J telephoned her prior to Mr A's admission and told

[22] RN B is a registered nurse who had worked at the private hospital for several years and had experience in dealing with residents with challenging behaviours, including those with dementia and other mental health conditions. She had completed Dementia Unit Standards as well as other relevant education. RN B was out of town over the weekend of 24–26 October 2014.

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her that DHB2's view was that the private hospital was "an ideal facility for [Mr A] to come to until he could be placed in a residential rehabilitation facility".

47. RN B stated: "[I]f I had thought at the time that the assessment indicated that Mr A had higher or more complex needs than the private hospital was able to provide, I would have had no hesitation at all in declining the referral."

48. RN C told HDC:

> "[RN B and I] were confident in the NASC's assessment, based on our collective previous experience and the fact that the NASC would have reviewed [Mr A] during the period of the InterRAI assessment. While the assessment indicated that he would be a high needs resident and that a 'special'[23] would be funded for the initial stages of the admission, that did not necessarily tell us that his needs would be higher than level 1."

49. RN C said that level 1 psychogeriatric patients generally have challenging behaviours, including verbal and physical aggression, and damaging their surroundings, and the staff were experienced in dealing with such behaviours.

50. RN B stated that prior to the admission she was unaware that there would be no mental health clinicians available over the long weekend following Mr A's admission.

51. DHB2 had emergency mental health services available via its mental health crisis team (the Crisis and Assessment Treatment Team (CATT) team) over the weekend. The CATT team is available for 24 hours 7 days a week. DHB2 stated that the private hospital was "well aware" of how to access acute support assistance if the placement proved to be unsustainable or the situation escalated. DHB2 said:

> "[The private hospital] spoke to Mental Health Services both before and after the weekend when issues arose. They would have been able to access support at the weekend through the same processes if they had determined it was urgently required. They did not."

Admission to the private hospital

52. On Tuesday 21 October 2014, Mr A was admitted to the private hospital. That day, general practitioner (GP) Dr F reviewed Mr A and recorded in her notes:

> "Not sure of permanent stay at the private hospital: possibly interim plan until ACC approves admission to [Brain Injury Unit] … [Mr A] exhausted."

53. Dr F completed an admission medical summary, which records Mr A's general appearance, level of verbal and auditory perception, and other vital signs. In particular, it notes:

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[23] One staff member solely responsible for the resident, ensuring that someone is with the resident (or observing the resident) at all times.

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"[Mr A] on floor mattress — appears exhausted. Has been @ [the private hospital] x 3 hours and spent all this time resistive of cares and agitation ++. Understandable [with] transfer. … [Mr A] appears to understand what we are saying — responsive to giving information and then responsive with squeezing my hand. Lots of drooling … Appears generalised and profound muscle weakness … Not able to assess mental state. … Commence all meds as per discharge for now.

- Stop [intramuscular] lorazepam
- Introduce diazepam 5mg [3 times per day] as per psychiatrist's suggestion.

Let settle [and] will then review on Friday [24 October]."

54. Dr F also completed a medication chart, which included 11 medications to manage Mr A's blood pressure, agitation, mood, and pain, among other conditions. In addition, several drugs were prescribed as PRN (as required) medication, including diazepam 2mg.

55. Mr A did not have an enduring power of attorney or welfare guardian at the time of admission.[24] However, his wife and family were closely involved in his care.

56. Mrs A told HDC that, when they arrived at the private hospital, Mr A's room was in an "unhygienic and dirty" state, and that someone else's clothes and personal items were in the room.

Care planning

57. An initial care plan meeting was held on Tuesday 21 October 2014. RN C, RN B, Mrs A, Mr A's son, and Dr F were present. A one-page checklist was completed, which summarises Mr A's short-term goal as: "Get to [Acute Brain Injury Unit]. Reach stabilisation and keep him comfortable and safe." Mr A's long-term goal was recorded as: "[T]o get back home."

58. The private hospital completed an admission assessment as part of the resident assessment booklet. This comprised a brief record of Mr A's current medical issues; nutrition; hygiene; communication ability; pain level; sleep pattern; mobility; and falls risk. The assessment scored Mr A at "high risk" of falls (20/20) and that he had a "very high" dependency level (73/100). An admission checklist summarised the assessments contained in the resident assessments booklet, which indicates that approximately one-third of the 23 assessments were completed within the first few days of admission.

59. The "Plan for Mr A" sheet states Mr A's preferences for the day, including the time he would wake in the morning; when to return him to his room; and his lunch and afternoon bath times. An undated and unsigned one-page care summary notes key care information.

60. An admission information sheet containing family contact details records Mr A's son and Mr A's wife as the first contacts. The sheet is signed by Mrs A.

[24] The Family Court subsequently appointed Mrs A as her husband's Welfare Guardian.

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61. RN C told HDC that Bupa's policy required that a care plan be developed within three weeks of admission, and said that Mr A was not at the private hospital for long enough to develop a full care plan. RN C said that during the "whole period" of Mr A's admission, "[staff] were still monitoring and assessing his needs so that a fully informed care plan including behaviour management could be completed".

62. Mrs A told HDC that she was assured that staff caring for Mr A were to be rostered on in pairs for the safety of staff and patients, and as a safeguard for any potential incidents.

63. RN B told HDC: "After the admission, [Mr A's] behaviour was reasonably settled."

21–23 October

64. RN C told HDC that handover (including history, behaviour management, de-escalation techniques, and mobility) was completed on three consecutive days on all shifts. RN C stated that this was standard for all new admissions to the private hospital.

65. RN C said that Mr A's family were with him all day on the day of his admission. Bupa told HDC that during the initial few days of his care at the private hospital, Mr A was supported constantly by either his family members or senior staff. Thereafter, an extra carer was put on in order to allow for 1:1 care for Mr A. However, when the family was visiting, "they requested staff to leave as they said they could manage [Mr A] on their own and they wanted to have their privacy with him". Furthermore, RN C said that Mr A did not have 1:1 care at night, as all the other residents were sleeping and there were four staff available to check on Mr A regularly, and one would stay with him if required.

66. Bupa said that three staff were needed to mobilise Mr A, and he was responsive to staff and seemed very motivated and keen to mobilise.

67. The progress notes record that on Tuesday 21 October 2014, Mr A injured his finger by banging on his door. At 6.35pm RN C completed an incident form and left a message about the incident on Mr A's son's answerphone. At 10.00pm Mr A was very confused, resistive, and agitated during cares, which required four staff to assist. He then removed his clothing and lay on the floor.

68. The progress notes record that thereafter Mr A was more settled. RN C and RN B assisted Mr A with morning walks to promote his mobility. RN C said that Mr A was cooperative during the first three days of his admission, particularly in the mornings when he was being assisted to walk.

69. RN B told HDC that she was more involved in Mr A's care than would usually be the case with psychogeriatric residents because he could have had a chance to rehabilitate, whereas the private hospital residents are not usually for rehabilitation. She said that Mr A was frustrated because he wanted to walk and, as she thought his medication might be limiting him, on Thursday 23 October 2014 she sought a medication review.

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70. At midday on Thursday, 23 October 2014, RN B emailed the DHB2 mental health team to request a review of Mr A and referral to a brain injury rehabilitation unit. RN B said she was concerned that, at times, Mr A refused his medication, and she believed that his medication needed to be reviewed because it was limiting his attempts to rehabilitate and mobilise. She stated in this email that Mr A "can communicate well and his aggression is minim[al]", and that Mr A needed to be placed in a residential rehabilitation facility.

71. RN B said that the referral was not on account of the private hospital's inability to manage Mr A's cares and behaviour. She acknowledged that there had been changes in his moods, which was part of her concern about his medication, but he was reasonably settled at the private hospital, and his family had been present continuously during the day. She also noted that, since arriving at the private hospital, there had been only a single incident, in which Mr A had injured his finger. RN B said that the reason she requested the referral was because, after two days with him, she and RN C thought the best place for Mr A was a residential rehabilitation facility.

72. With regard to her email of 23 October 2014 seeking medical review, RN B said that it was usual for mental health clinicians to attend the same or the next day when requested, but RN J, the NASC service coordinator, advised that given the upcoming long weekend, Mr A would be reviewed the following week.

73. DHB2 responded that a referral was in process, and that psychiatrist Dr K would be forwarded RN B's email. DHB2 told HDC that the referral was not indicated as being urgent and, if it had been, it would have been dealt with accordingly.

Friday 24 October 2014

74. RN L worked the night shift on 23/24 October 2014. He told HDC:

> "[O]ne Care Staff was doing 1:1 for [Mr A]. [At] the start of the shift [Mr A] was agitated, restless and resistive to cares. 1:1 interaction was maintained throughout the shift. Snacks and fluid offered and he was regularly repositioned on his bed by three [staff members] … [Mr A] continued to get out of bed and crawled on the floor. … [After 4 am Mr A] was agitated, crawling in the room and he disassembled the water pipes of the wash basin in his room. All the four staffs were mobilised to put him back to bed and I changed the dressing on his right middle finger as the wound was reopened and causing a slight bleeding. The broken pipes were removed and the wash basin was compacted with a large piece of sponge for preventing self-injury."

75. RN C completed an incident report regarding "multiple scratches and bruising on [Mr A's] legs" which he had noticed at 7am. RN C recorded:

> "[Increase in] staff monitoring really needed but the NASC re-assessment may be necessary as we tried to accommodate [Mr A] even though he did not fit dementia criteria, but we were willing to give it a go as the NASC assessed him as [psychogeriatric] level."

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76. RN B told HDC that Mr A's behaviour changed on 24 October 2014, when his family left to return home, in that he was less settled and began refusing some of his medications. RN B said that at around lunchtime on 24 October 2014, Mr A spat out the PRN medication she tried to administer (but took it subsequently), then refused his medication later in the day. RN B recorded in the Care Home Manager's report:[25] "If there's an issue walk away as per doctor — if he is agitated … About 11.45am [on 24 October 2014] [Mr A] became very agitated/anxious and a bit in pain …"

77. RN B completed an incident form which records that, at 4.20pm, Mr A became agitated when looking at family photographs, and took off his glasses and squeezed them very hard, causing a lens to fall off, which he then put in his mouth. No injuries were recorded, and for follow-up actions RN C noted that staff monitoring would be increased, "especially when [Mr A] is agitated — to keep him safe".

78. On 24 October, Dr F undertook a follow-up review of Mr A and prescribed an increase of diazepam to 5mg three times a day "for agitation". Dr F noted:

> "Although intermittent difficult and challenging behaviours, [Mr A] is clearly expressing a desire to walk and over [the last] two days has determinedly increased his walking distance with the aid of staff and walker. He is phenomenally proud of his achievement …
>
> Well done to all staff who are working with [Mr A] and also to physio. Active move towards finding appropriate rehab facility for [Mr A] to be encouraged."

79. On the afternoon of 24 October, the roster indicates that two registered staff were on duty in the hospital (RN D and Enrolled Nurse (EN) EN M). The roster shows seven caregivers but does not specify who worked in the hospital area. In addition, HCA E was the 1:1 special for Mr A. There is a gap in the roster stating "No cover", which suggests that there was one fewer caregiver than usual on duty. In response to the provisional opinion, RN D said that he worked the afternoon shift from 3pm until 11pm, and "a number of staff called in sick for the afternoon shift", meaning that they had "three or four health care assistants (and one more who was fully occupied providing 1:1 care for [Mr A])". RN D stated that the ratio of staff to patients was approximately 1:10 and, as a result, the shift was "hectic, overwhelming and stressful".

80. Bupa said that RN D was looking after 14 residents with EN M (a ratio of 1:7) and, as the preferred ratio is 1:6, there was a slight staff shortage on that shift.

HCA E

81. Training records provided for HCA E include attendance at in-service training sessions during 2014 covering abuse and neglect, accident incident reporting and disclosure, behaviours that challenge, cultural awareness/Māori health, dementia, emergency procedures, falls prevention and management, fire safety and fire drill,

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[25] The Care Home Manager's report covers a 24-hour period and is completed at the end of each shift by the registered nurse or duty leader. It is the responsibility of the Care Home Manager and Clinical Manager to read it daily and ensure effective follow-up of recorded issues.

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health and safety and security, infection control (precautions), restraint, and wound management.

82. HCA E completed NZQA Health, Disability and Aged Support (foundation skills, level 2) training on 4 September 2014.

83. In response to the provisional opinion, RN D told HDC that he had worked with HCA E on a number of occasions and found him to be a good HCA, and he (RN D) considered that HCA E would be aware of his responsibilities.

Fall

84. HCA E was assigned to one-to-one care of Mr A for the afternoon shift on 24 October 2014. That evening, Mr A fell and hit his head. HCA E completed an incident form the following day (25 October 2014), which states:

> "Was sitting in lazy boy facing garden. He stands up and lunges to walk after a step he trips, falls and smacks his head on a concrete wall."

85. The injury is described as being a "scrape" and "grazing" on Mr A's forehead. The incident report form states that there was no other visible injury, but that "bruising may appear later". The fall is recorded as having occurred at 6.15pm, and the incident form states that the duty leader, RN D, was informed at 6.20pm. In response to the provisional opinion, RN D told HDC that EN M was the nurse assigned to Mr A. However, given Mr A's aggressive behaviour, HCA E would call RN D rather than EN M. RN D said that he does not "clearly remember" the time that HCA E reported the fall to him, but he recalls that HCA E did not tell him straightaway, and that it was around 11pm, just before he (RN D) was due to give handover to the night shift.

86. RN D told HDC that he assessed Mr A on 24 October 2014, and said:

> "Apart from [a] scratch on [his] forehead, Mr [A] did not sustain any visible injury. Both eyes were alright. As Mr [A] was very aggressive, in spite of many tries I could not do any [neurological observations]."

87. RN D said that, after he was notified of the fall, he "then completed a head to toe assessment of [Mr A]" and found no visible injury apart from the graze on his forehead, and did not consider Mr A to be in pain. RN D said that he did not request a referral of Mr A to another health professional or DHB2 because Mr A was his normal self, and he (RN D) "did not feel immediate threat to [Mr A's] health". RN D said that it is not unusual for psychogeriatric patients to refuse assessments. Mr A's family were not notified of the incident that day. In response to the provisional opinion, RN D said that it was too late in the evening to contact them.

88. The incident form completed the following day records that Mr A refused to have observations performed, and that "the manager was informed … On manager's book". However, there is no record relating to the fall in the Care Home Manager's report.

89. RN D said that he "clearly" remembers giving a verbal handover to the night registered nurse (RN L), before he finished his shift, to try to get neurological

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observations from Mr A once he calmed down. However, there is no record of the handover, or that medical advice was sought about the inability to undertake such observations on 24 October 2014. The incident form completed on 25 October notes that Mr A was "on Dr list" — to be seen when the doctor next visited.

90. Bupa told HDC that HCA E's failure to complete an incident form at the time of Mr A's fall was unacceptable. Bupa said that it was HCA E's responsibility to complete an incident report and document the fall in the notes. According to Bupa, RN D said that he was told about the incident late in his shift, and attended to Mr A, but did not record the incident because he "was clear the HCA had recorded the incident in the notes". In response to the provisional opinion, RN D said: "Given that [HCA E] only had one patient to look after I relied on and trusted him to complete the documentation he was required to complete." RN D said that he is "pretty sure" he would have asked HCA E to complete an incident form; however, RN D does not recall HCA E doing so. RN D also said that, as EN M was Mr A's assigned nurse, it was his expectation that she would have countersigned HCA E's incident report.

91. The fall was not documented in the progress notes until the following day (25 October).

92. RN D told HDC that, at the time, Bupa was going through a "severe staff shortage", and staff levels were low on 24 October 2014. He said that he was the only registered nurse on duty that day, and that, in addition to nursing duties, he was "working as a caregiver as well, doing 12–14 residents' cares". RN D stated:

> "Because of such a hectic shift somehow I missed to mention this incident in Mr [A's] progress notes, which I did as [a] late entry [the] next day."

93. RN D also stated that on 24 October he was responsible for medication administration for "about 25 residents and cares of all residents in [the] wing".

94. Bupa said that, despite the slight staff shortage on the shift, "the proper notes should have been completed". EN M later told Mrs A that there was no bruising apparent on Mr A that day, and she was not aware of any significant event having occurred.

95. That evening, Mr A refused his "dinner time" medications, and his "bed time" medications were not administered as he was sleeping. The progress notes record that Mr A was agitated and restless overnight, with administered diazepam having little effect. The Behaviour Monitoring Chart reports Mr A having approximately three hours' sleep overnight, with escalating challenging behaviours.

96. RN L worked the night shift on 24/25 October 2014. She told HDC:

> "In the case of [Mr A], on 24.10.14, I had no handover from PM shift of having any Falls, no documentation in the Care Day Manager's book, no Incident & Accident Form and no mention in his progress notes.
>
> …

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> [At] the start of the shift, [Mr A] was settled … At around 00.30 AM, [on Saturday 25 October 2014] he was agitated and restless. … when asked if he was having pain, he voiced no and he did not display or grimace any sign of being in pain … One staff [member] was on the watch so as to prevent [Mr A] from any self-injury. Till the end of the shift [7am], no bruising on his eye was seen by the care staffs or by me."

97. RN L stated that as she was not aware of the fall, she did not conduct any neurological observations during the shift.

Saturday 25 October 2014

98. On 25 October 2014, RN H and another RN were the registered staff working the morning shift. HCA E was on duty and provided 1:1 care for Mr A. An HCA said that she assisted HCA E with Mr A's cares in the morning. That HCA said that she noticed the bruise on Mr A and asked HCA E whether he had completed an incident form, and he replied that "he had only written in the notes".

99. RN H said that she noticed bruising on Mr A's left eye at 8am on 25 October 2014. RN H completed an incident form, which states as the cause of the injury: "? previous fall". She told HDC that the night shift nurse, RN L, had not mentioned the bruising or Mr A's fall at handover, but another staff member told her that Mr A had fallen the previous day. RN H said that she applied arnica cream on the bruising and administered Mr A's regular breakfast and lunch medications, but did not administer any PRN antipsychotic medication as HCA E did not advise her of any concerns.

100. RN H said:

> "I have missed documenting [Mr A's] bruising on his left eye as well as the physical assessment and intervention that I have done. I have utilised physical assessment form, pain assessment chart and Neurological observation chart after discovering [Mr A's] left eye bruising to evidence that I have indeed tried and completed my assessment."

101. A record in the progress notes made by HCA E on 25 October states:

> "Black eye noted in [morning] during serving of breakfast. Refused meals all day. Agitated and hard to redirect. …"

102. RN D and EN M worked the afternoon shift on 25 October 2014. RN D told HDC that he was called in to work the afternoon shift at the "very last moment" as it was not his rostered shift. He said that he came to help out "in the short staff situation". EN M said that she was not aware of Mr A's fall the previous day.

103. At 4pm, RN D recorded Mr A's fall the previous day as a retrospective entry in the progress notes. RN D noted that there was grazing on Mr A's forehead and that a dressing had been applied. He recorded that Mr A had been resistive, agitated, that observations could not be done (on 24 October), and that Mr A had been placed on the GP list for post-fall review.

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104. Mr A's injury was recorded in a wound initial assessment and plan and described as "superficial" and "grazing". The incident was also recorded on the incident/infection record as "25.10.14 on 24.10.14 Fall. Graze on forehead" and "25 October 2014 found bruise and swollen left eye ? due [to abovementioned fall]". There is no record of who made those entries.

Visit by Mrs A

105. At around 4.40pm on 25 October 2014, Mrs A visited her husband. She told HDC:

> "I entered his room and saw [Mr A] on the uncovered mattress on the floor, leaning up against the back wall, slouched over the right as he perpetually does. His head was lying up against the metal framework of the bed. He had crusted drool and phlegm coated into his moustache from his mouth and down the front of his pyjama shirt, which was not his, and 3 sizes too small.
>
> I looked twice because the bruising on the left side of his face and his eye was extreme. He was fast asleep. Pale and parched dried lips. His body i.e. Leg, feet and hands were covered in bruises and lacerations that were not there 3 days ago.
>
> His feet were dirty, cold and covered with blood. His [left] eye was deep purple and black and closed shut with swelling exuding out over and above his temple. There was a laceration on the top of his head which was taped up, and several other small ones. He was unkempt, unshaven and very hard to rouse. Next to him his bed was bare with a plastic mattress, the linen was dirty and all bunched up at the end of his bed.
>
> The Health Care Assistant … was sitting on the armchair to the side of [Mr A] with his feet up."

106. Mrs A said that the walls were covered with dirty smears and blood. She provided HDC with photographs she took of Mr A. In a photograph provided to HDC labelled 24 October 2014, Mr A has no visible injuries. In photographs provided to HDC that Mrs A took of Mr A on the afternoon of 25 October 2014, Mr A has a dressing on his head above his forehead, a visible injury on his nose, and a bruised black right eye. Another photograph shows bruising on his right knee and leg.

107. HCA E told Bupa during a meeting on 4 November 2014 that he did not know that he was responsible for cleaning the walls, as he thought that was a cleaner's job. He said that he was talking to Mr A when his wife arrived, and that Mr A was not asleep. HCA E said that he had cleaned Mr A's face "several times during the day", but he also said that he did not wipe Mr A's face because "in [my] culture you don't wipe the faces". He said he now realises that he did not have the skills for the job.

108. According to EN M, HCA E told her that Mrs A wanted to speak to one of the nurses on duty, so she (EN M) went to Mr A's room. EN M told HDC that when she entered Mr A's room, Mrs A expressed concerns about her husband's condition. EN M told HDC:

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> "I had informed [Mrs A] that I was on duty on the 24th (the previous) day and bruising was not present then. To my knowledge, no significant incident had occurred to cause such bruising … Only when I opened [Mr A's] file to do my documentation I saw a late entry made regarding a fall that [Mr A] had."

109. According to EN M, Mr A was very sleepy and difficult to rouse. EN M called for assistance from HCA N and HCA O. HCA N told HDC that when she arrived, Mr A was "laying on his bed, half off and half on with no linen present", and had snot on his face and beard.

110. HCA N and HCA O both stated that they noticed that Mr A had a black eye.

111. Together, EN M, HCA N, and HCA O cleaned Mr A, made his bed, and made him comfortable on his bed before cleaning his room. HCA N stated: "We ha[d] to remove the mattress on the floor so we could clean the rubbish and blood on the wall, floor and the door. …"

112. RN D said that he became aware of Mrs A's concerns when the nurse on duty asked him to talk to Mrs A. RN D said that "[t]hings could have been better if we had full staff on board", and that many HCAs were reluctant to care for Mr A because of his aggression.

113. EN M said that on 25 October she commenced a neurological observation sheet at 6pm. The behaviour monitoring chart dated 25 October 2014 states that Mr A was "[a]ggressive all day".

114. RN B told HDC that on 25 October she received a call from Mrs A, who was distressed and crying and "talking about the state that [Mr A] was found in". RN B said that she was out of town when Mrs A called her, so she (RN B) asked RN C to go to the private hospital to see what had happened.

115. RN C, who was on call, went to the private hospital on 25 October. He told HDC that neurological observations were started on the morning of 25 October 2014, but Mr A refused the observations three times that morning. RN C said that they were able to be completed at 6pm, 8.30pm, and 10.45pm. He stated that it appears that the occasions on which Mr A refused neurological observations are not documented. Bupa stated that its staff are made aware that they should never force a resident to have neurological monitoring, because often this can increase the level of aggression; however, Bupa considers that the records could have made this clearer. RN C recorded on the incident form that Mrs A was notified of the fall at 7pm on 25 October 2014.

116. Mrs A told HDC that Mr A was unable to stand, walk or step unassisted, and that as a "primary safety measure, he was always belted into his chair. This was a mandatory requirement of his care." She said that Mr A should have been sitting in his chair and "away from pending hazards such as concrete walls".

117. The Care Home Manager's report for this incident stated: "[Mrs A] unhappy re. [Mr A's] wellbeing. [Facility Manager] aware as she spoke to her. [Clinical Manager]

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came. Nurse practitioner [RN G] informed re. bruised eye. Will come and review. [A HCA] asked to do [1:1]."

Visit by nurse practitioner

118. RN G told HDC that she is a part owner and employee of the company which is contracted to provide general practice services to the private hospital's residents. She said that she is a nurse practitioner,[26] and was on call on 25 October 2014. That evening a staff member contacted RN G and asked her to visit Mr A. RN G said that she drove to the private hospital immediately and assessed Mr A with his family present. RN G recorded in her clinical notes:

> "On examination has a closed left eye due to bruising and a contusion to forehead. Had fallen in garden. On palpation is only very slightly tender over eyebrow with no underlying deformity. Plan — for [neurological observation] for 24 hours. Ice pack as tolerated. Head injury [information given] to staff so they can identify any changes in health state. Reassure wife no X-ray required at this stage."

119. RN G said that she expected the neurological examinations to be undertaken hourly in accordance with the private hospital's policy.

26–29 October 2014

120. According to the clinical notes, overnight on 25/26 October no further neurological observations were carried out "because it might disturb his sleep". On 26 October there is a record: "Started checking [neurological observations] @ 6am." There are further observations recorded at 6.30am and 7.20am. There is no further reference to the neurological observations in the clinical records.

121. The private hospital completed a detailed "My Day-My Way" plan, dated 26 October 2014, showing what Mr A wanted to do independently. The plan sets out Mr A's preferences for morning, afternoon, evening, and night, and the agreed support for those times. With reference to managing Mr A's behaviour, the plan states that staff needed to be patient, calm, and respectful to Mr A, and ask him what he wanted and give him choices. However, the plan does not specifically refer to the information in the NASC assessment.

122. On 26 October 2014 Mr A's family were present, and initially his behaviour was settled. However, at around 8pm when staff were taking him to the toilet he scratched and attempted to bite a health care assistant.

123. Monday 27 October 2017 was Labour Day, a public holiday. That day, several incident reports were completed after Mr A punched staff members. One incident report notes, "Resident not suitable for this level of care", and follow-up notes signed off by RN B state: "Keep distance where possible. To refer to mental health to review medication [as soon as possible]."

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[26] Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. Nurse practitioners prescribe medicines within their specific area of practice.

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124. The progress notes record that overnight on 27/28 October 2014 Mr A was unsettled and agitated, and was given PRN diazepam with little effect. The notes state that Mr A was awake all morning, "crawling on the floor, gripping on the water sink, kicking on the wall, constantly repositioned … aggressive and resistive, hitting and biting staff".

125. At 11.30am on Tuesday 28 October 2014, Mr A was seen by Dr F for review. She recorded that Mr A had had a "difficult and traumatic weekend", and that he had sustained an open wound and contusion to his left eyebrow region, with bruising on periorbital swelling[27] and left upper eyelid swelling. Dr F recorded:

> "[Mr A] was able to indicate that he had sustained this injury [himself] and that it was not inflicted [by the private hospital staff] … [Mr A] is refusing/spitting out most of his medications which makes it even more difficult to help manage [Mr A's] unpredictable, erratic and aggressive behaviour."

126. Dr F noted an "injury to left forehead and eyebrow region … with bruising and swelling ++ … slightly mucky open wound on top of head". She recorded:

> "[Mr A's] significant brain injury remains a challenge for all to manage and he would really be best managed in a brain injury unit where medication can be administered under [a] different criteria of care."

127. RN B said that she contacted the mental health team again on the morning of Tuesday 28 October 2014, in order to follow up her referral to the mental health team of 23 October 2014, and requested an urgent assessment for Mr A. The DHB2 Mental Health progress notes record that Dr K performed a mental health assessment for Mr A the same day. There is a record that Dr K contacted the CATT team[28] to request assistance to administer intramuscular haloperidol.[29] Dr K called again at 6.30pm to advise that Mr A's family had managed to administer oral medication, so CATT assistance was not needed. There is no record of Dr K's visit in the private hospital progress notes.

128. On the afternoon of 28 October 2014, Mr A's son visited his father and was informed that Mr A had been agitated and was "difficult with cares". He tried to give his father his medication but it was refused. Mr A's son asked the staff to leave, took over his father's care, and stayed with his father overnight.

129. Progress notes for 29 October 2014 record that Mr A was refusing personal cares, was left alone in his room surrounded by cushions, and was monitored from outside the room. Mr A's son assisted with Mr A's cares and feeding.

130. During the afternoon, Mr A became "very agitated +++ and aggressive", and was hitting staff and wanting to get out of his wheelchair. The progress notes state that in the afternoon Mr A's son "left for a few hours", and that after his son left Mr A

[27] The eyelid and portions of skin around the eye.
[28] Crisis Assessment & Treatment Team.
[29] Haloperidol is an antipsychotic drug used to treat acute psychosis.

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became very agitated. Later in the afternoon, Mr A's son returned to the private hospital, and PRN diazepam was given. Mr A became more settled.

131. On Wednesday 29 October 2014, Dr K recorded in the DHB2 Mental Health progress notes that Mr A had been increasingly violent over the previous few days and had assaulted six staff members. Dr K noted: "Staff now feel unsafe to look after him and are asking for him to be removed from the facility today." Dr K called Mrs A to discuss the use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), and recorded that Mrs A "was adamantly against the use of the MHA and will not agree to him being moved into psychiatric care". Mr A's family continued to request that he be transferred to the rehabilitation centre.

132. That day, Dr K completed an Application for Assessment under section 8A of the MHA. Mr A was transferred to Hospital 2 to undergo an assessment examination pursuant to section 9 of the MHA. On the same day, Mrs A sent the private hospital a written complaint about the care it provided to Mr A.

Subsequent events

133. Bupa commenced an investigation into the care provided to Mr A. On 3 November 2014 RN B interviewed RN D. Notes of the interview made by RN B record that RN D said that on 25 October Mr A "already had the bruise on his left eye [noticed after starting his shift (approximately 3pm)]", and that RN D "did not notice anything on the walls [of Mr A's room]".

134. On 4 November 2014, Bupa management held a meeting with HCA E to discuss his involvement in Mr A's care. HCA E said that he had written "one or two times in the notes on the 25/10 AM shift, filled in an incident form on 24/10 but didn't write in the notes about the fall".

135. HCA E said that he did not write about the fall in the progress notes because he was not aware of his role or responsibilities. He said that he called for assistance three times, and that staff often checked on him and helped him make Mr A's bed several times. He said that when Mrs A arrived on 25 October 2014 he was waiting for staff to take over care because he thought he could not leave Mr A. Bupa pointed out to HCA E that he could have used the call bell in the room if he required assistance.

136. HCA E said that he did not write in the notes on 25 October 2014 because he was told to go home.

137. Also on 4 November 2014, RN B wrote to Mrs A with an outline of the events during Mr A's stay at the private hospital, and enclosed copies of relevant incident forms. RN B told Mrs A that HCA E was providing 1:1 care to Mr A from 1pm on 25 October 2014, and that he had said that "all the injuries, including the bruised eye were there on the beginning of his shift". RN B said that HCA E told her that Mr A's bed was unmade because it had been "stripped off" by Mr A, and that Mr A wanted to stay on the floor mattress after getting agitated, and had settled there.

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138. Bupa sent DHB2 a copy of Mrs A's complaint and Bupa's response. In reply to follow-up queries by DHB2 about concerns raised by Mrs A, RN B told DHB2 on 6 November 2014 that Mr A's clothes were in a bag waiting to be labelled, and that the bruises on Mr A's legs, feet, and hands were "hard to explain".

139. On 14 November 2014, Bupa wrote to the manager of Health of Older People at DHB2, and stated: "The Care Home Manager advises that staff leaving [Mr A's] bedroom, bed and clothes in the condition [Mrs A] found them was unacceptable practice." Bupa said further: "[HCA E] apologised for sitting in the chair and for the state of [Mr A's] room", and acknowledged that "without regular medication, it became increasingly difficult to manage [Mr A's] behaviour and keep both [Mr A] and the staff safe".

Further information

Bupa

140. Bupa provided HDC with a record sheet of a 30-minute training talk RN C gave to staff on 25 October 2014 about "1–1 Interaction/Monitoring", and said that HCA E had attended the training. The sheet records what was discussed, in particular:

> "When the resident is getting aggressive and you cannot handle it by yourself even though you are supposed to be doing 1–1, you are always allowed to ask [for] help from anyone (RN/HCA to keep resident safe and keeping the resident's dignity). Staff who are doing 1–1 and who [are] already tired should never ever have [their] rest with the resident as this can lead to mistakes. Staff are expected to do their duties well whenever they are with a resident as per policy. However, if staff [are] really tired he or she can ask an RN to relieve them with another staff [member] but never leave the person needing 1–1 alone."

141. Bupa also said that the incident on 21 October 2014 in which Mr A injured his finger would not be regarded as unusual, and would not be indicative of an inappropriate placement in the psychogeriatric context or demand an urgent referral. Bupa said that there was no evidence on file that an urgent mental health referral was necessary on 23 October 2014, and that Mr A's family were resistant to any involvement by mental health services, and the family "made it clear they did not want [Mr A] readmitted to hospital".

142. Bupa said that RN C and RN B were aware of Mr A's escalating behaviour concerns, but his behaviour, as reported in the incident reports, was of varying levels of seriousness. It said that none of the incidents required an immediate decision by management to insist on a transfer out of the private hospital. Bupa said that it has carefully reviewed its decision to admit Mr A and, in its view, there was a lack of appropriate DHB support for discharge into residential care just prior to the long weekend.

143. Bupa said that staff documentation was not "perfect" in every instance, and that it is continuously improving its recording-keeping. It said that the Care Home Manager reports are not intended to be contemporaneous notes for the purposes of patient care, and are not part of a resident's record.

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144. Bupa stated that, with regard to staffing, it follows the safe staffing guidelines developed for Aged Residential Care, but that a planned roster can change for a number of reasons, and it makes every effort to replace absent staff members. It noted that Mr A had a 1:1 special in addition to the regular staffing.

RN C

145. RN C told HDC that during the first few days of Mr A's admission, he (RN C) felt confident with the NASC referral. RN C said that he read and discussed it with RN B, and agreed with her that the placement would be suitable. Mr A had been assessed as needing hospital specialised level 1 care, and the private hospital is permitted to take residents assessed at level 1 and level 2.

146. RN C said: "The understanding was that the referral was on an interim basis." He said that all staff were given handover information in relation to Mr A's behaviour, and that no plan was put in place for managing escalating behaviour at the beginning of admission, as there was no particular expectation that such behaviour would occur.

147. RN C told HDC that after a few days they realised that Mr A required more staff input than suggested in the InterRAI assessment, and at that stage he thought that the NASC had understated Mr A's level of need.

148. RN C told HDC that information relating to Mr A's challenging behaviour was not transferred to Bupa's care planning documentation because staff were still getting to know Mr A, who was at the private hospital for only eight days. RN C said that usually full care plans are completed within three weeks from admission. In addition, Mr A was not at the private hospital long enough to be the subject of a monthly behaviour focus team meeting.

149. RN C said that an extra health care assistant was assigned to Mr A from the day after he arrived. RN C stated that some of the incidents reported (such as removing fixtures) would not be regarded as particularly serious in the context of psychogeriatric care.

150. RN C told HDC that "the [NASC] referral assessment was not in line with what [was] actually happening [with Mr A]". RN C said that dressing Mr A required four staff members to help keep Mr A safe from himself and to help staff to be safe from Mr A, and that three staff were required to keep Mr A from falling when mobilising. RN C stated that prior to Mr A's fall, he had discussed with RN B that Mr A needed a "specialised and higher level of care". RN C said that they were aware that the mental health clinicians were not available over the long weekend, and so he felt that they needed to manage Mr A until psychiatrist Dr K was available on 28 October 2014.

151. RN C said that he now considers that they should have contacted DHB2 when Mr A began refusing and/or spitting out his medications, which happened "on and off" from 24 October 2014. RN C stated that managing Mr A at the private hospital over the long weekend with no DHB backup was "not an acceptable state of affairs", and there should have been an arrangement with DHB2 for easy referral back to hospital or to

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mental health clinicians. RN C said that in future he would insist on a more robust discharge plan if a DHB did not offer such an arrangement.

RN B

152. RN B said that the InterRAI assessment was not an accurate reflection of Mr A's needs and behaviours, but that on the basis of the information contained in the assessment, level 1 appeared to be a reasonable assessment of the care Mr A required. She noted that, in her view, the onus was on DHB2 to ensure that proper arrangements were made on discharging Mr A. RN B said that if she were to receive a similar case in the future, she would ensure that DHB2 provided some suitable backup. She told HDC that at the time of accepting the admission, she was not aware that the mental health team would not be available over the weekend.

153. RN B told HDC that the incident reports were based on a "range of behaviours and circumstance, which did not necessarily indicate until later in the long weekend that Mr A was not manageable for us". She said that Mr A's family told her that Mr A was "much better with us than any other place he had been in". RN B said that Mr A's family were with him all day on 27 October 2014, and were reluctant for mental health services to intervene.

154. RN B explained that there were discrepancies between the medication chart and the progress notes because, on occasion, Mr A would spit out medication after staff had documented the medication as given, and staff would later note in the progress notes that the medication was not given. She said that a second dose was not given when medication was spat out because it was hard to judge how much had been ingested. RN B said that staff with Mr A at the time should have advised the registered nurse responsible what had happened, so that the information could be transferred to the medication chart.

RN D

155. RN D told HDC that he trusted management's decision to allocate HCA E to look after Mr A, and that HCA E was told to report any concerns to the duty nurse.

156. RN D said that he felt overwhelmed by his workload. He also said that there was no policy for calling in agency staff, "which made it harder to manage with available staff". He stated: "Things could have been better if I could concentrate on my nursing duties only and I had enough staff."

157. RN D no longer works at the private hospital, and resides overseas.

DHB2

158. DHB2 stated that the private hospital is a funded provider, and accessing support services is part of its contractual obligations and responsibilities when it is identified that a resident may require an increased level of support or emergency services.

159. DHB2 said that staff at the private hospital were aware of the direct MHSOP contact telephone number to use during working hours, and how to contact the CATT team after hours.

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Bupa's policies

160. Bupa provided HDC with relevant policies in place at the time of the events in question. The "Access to Services" policy dated May 2010 provides that the Facility Manager or other delegated staff member will assess the suitability of a resident seeking placement, and the ability of staff to meet any complex or specific needs. Under the heading "special requirements" it states:

> "In cases where untoward expense, special expertise or safety issues pose possible barriers to admission, the Facility Manager and the Operations Manager will discuss the individual case and will make the final decision re. suitability of placement.
>
> …
>
> Where a facility is requested to admit a resident with behaviours that may endanger others (staff or residents), cause self harm or cause excessive property damage, the Facility Manager and Operations Manager will assess risk management prior to admission."

161. The "Care Planning" policy dated July 2014 provides that all residents are required to have a care plan written within three weeks of admission. Health and personal care needs are assessed on admission by way of an admission nursing assessment, and "staff refer to this until the care plan has been developed". The admission nursing assessment is the same document as the admission assessment.

162. Bupa's "Progress Notes" policy dated July 2014 states that staff are required to clearly outline the status of the patient, the care provided, and any actions to be taken by staff on subsequent shifts. Notes should record the onset of any new condition; the deterioration of an existing condition; staff members' response to needs or complaints; where an accident/incident has occurred; or any other matter that staff consider is warranted.

163. The "Behaviours that Challenge" policy dated April 2013 defines behaviour that challenges as such behaviour that causes distress or puts the resident or others at risk of harm. The policy states that in the case of behaviour threatening the safety of others and where the responses of staff are not having an effect, care staff must seek assistance from qualified nursing staff; where such behaviour is increasing in severity, behaviour monitoring should occur.

164. Bupa's "Falls — Prevention and Management of" policy dated July 2014 states that an incident report is completed as soon as possible after the event, "which includes as much information as possible about the possible cause of the fall, and any assessment or treatment given afterwards". It notes that a resident's falls risk may need to be reassessed and his or her care plan updated.

165. The "Category one Incidents" policy dated September 2014 defines category one incidents, including a "significant behaviour incident", which means behaviour of "such a serious nature as to significantly injure another or jeopardise the safety of self

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or others". The policy states that it is the responsibility of the Care Home Manager to ensure that category one incidents are correctly identified, reported, and investigated.

166. The "accident/incident forms — use of" policy dated February 2013 states that incident forms must be completed as soon as possible after the event, and must be countersigned by the duty or shift leader, who checks the accuracy of the account "and that all necessary data has been entered and documents what action was taken in response to the event". The policy says that an incident report should record a full description of the event; which family member was informed; and whether a doctor was contacted, and should document any care or treatment given. The policy requires that a category one incident is reported on.

167. Bupa told HDC that it is in the process of developing a 1:1 "specials" policy.

Job descriptions

168. Bupa provided HDC with copies of job descriptions for its Facility Manager and Clinical Manager, and for its registered nurses and health care assistants. These documents state that the Facility Manager should "use accepted safe practice methods to enhance the lives and wellbeing of all residents within the facility". The Facility Manager has functional relationships with all senior staff, including the Clinical Manager.

169. The Clinical Manager is required (among other duties) to:

- Support and assist clinical and care staff to ensure that optimal care is provided to residents.
- Assist the Facility Manager in effective management of the facility and ensure appropriate use of clinical staff to maximise resident care and safety.
- Ensure that admissions to the facility are managed as per Bupa policy (access to services).
- Develop individualised care plans in accordance with assessed needs, using evidence-based tools.
- Provide oversight of all resident clinical records.

170. RN D's job description includes the following:

- Establish effective working relationships by ensuring communication and liaison with all members of the healthcare team.
- Maintain documentation that is logical, concise, comprehensive, and accurate.
- Ensure effective supervision of caregiving staff.
- Demonstrate initiative and leadership in the management of residents who display challenging behaviours.
- Actively promote the minimisation of risk and harm occurring.

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171. HCA E's job description states that the purpose of the job is to provide residents with a "high level of care and comfort". Key competencies and responsibilities include:

- Show an ability to recognise concerns or changes in a resident's well-being and directly provide help and support or seek advice from other qualified staff.
- Document relevant information accurately and report problems, concerns or changes in the resident's condition immediately to the senior member of staff.
- Show an understanding of safe care and practice in one's daily work.
- Treat all residents with respect and tolerance.
- Help to maintain all areas in a clean, tidy state.
- Report and document all incidents of harm to staff or residents immediately to senior member of staff.

Responses to provisional opinion

172. The parties were provided with the relevant sections of the provisional opinion for their comment. Responses were received from Bupa, RN C, RN B, and RN D. HCA E did not provide a response to the provisional opinion. The responses have been incorporated into the "information gathered" section of the report where appropriate. In addition, the following comments were received.

RN D

173. RN D stated that at the time of these events he thought that he had provided reasonable care to Mr A in difficult circumstances. He said: "With the benefit of hindsight I realise that documenting my care and asking for help from managers is best practice."

174. RN D said that he has put the following measures in place:

- He makes priority lists to ensure that the most important things are addressed first.
- He prioritises nursing duties even if he is also undertaking HCA duties.
- He provides HCAs with support and guidance, and follows up to make sure they do what they are asked to do.

175. RN D also told HDC that he has undertaken further education to enhance his knowledge, and has reflected on these events.

Mrs A

176. In response to the provisional opinion, Mrs A said that the private hospital was never going to be a safe placement for Mr A because of the physical environment and the lack of staff experienced in managing a person with a severe hypoxic brain injury.

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Relevant standards

177. The New Zealand Health and Disability Sector (Core) Standards (NZS 8134.1.2008) (Disability Core Standards) state that the standards are to enable consumers to be clear about their rights, and providers to be clear about their responsibilities, for safe outcomes. The Disability Core Standards require the following:

> "a) Consumers receive safe services of an appropriate standard that comply with consumer rights legislation.
>
> b) Consumers receive timely services which are planned, coordinated, and delivered in an appropriate manner.
>
> c) Services are managed in a safe, efficient, and effective manner which complies with legislation.
>
> d) Services are provided in a clear, safe environment which is appropriate for the needs of the consumer."

178. The Disability Core Standards also provides (among other standards) the following:

> "1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.
>
> …
>
> 3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function."

179. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "4.8 Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been.
>
> …
>
> Complete records as soon as possible after an event has occurred.
>
> …
>
> 6.8 When you delegate nursing activities to enrolled nurses or others ensure they have the appropriate knowledge and skills, and know when to report findings and ask for assistance."

180. The NCNZ publication *Guideline: delegation of care by a registered nurse to a health care assistant* (May 2011) states:

> "Health care assistants are also legally accountable for their actions and accountable to their employer. They must therefore have the appropriate skills and

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knowledge to undertake activities, and be working within policy and the direction and delegation of a registered nurse. They must be careful not to lead health consumers to believe they are a nurse when undertaking aspects of nursing care.

Understanding delegation

Delegation is the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome.

Direction is the active process of guiding, monitoring and evaluating the nursing activities performed by another. Direction is provided directly when the registered nurse is actually present, observes, works with and directs the person; direction is provided indirectly when the registered nurse works in the same facility or organisation as the supervised person but does not constantly observe his/her activities. The registered nurse must be available for reasonable access, i.e. must be available at all times on the premises or be contactable by telephone (in community settings).

The principles of delegation

1 The decision to delegate is a professional judgment made by a registered nurse and should take into account:

- (a) the health status of the health consumer
- (b) the complexity of the delegated activity
- (c) the context of care, and
- (d) the level of knowledge, skill and experience of the health care assistant to perform the delegated activity.

2 The decision to delegate must be consistent with the service provider's policies.

3 The registered nurse must ensure the health care assistant who has been delegated the activity:

- (a) understands the delegated activity
- (b) has received clear direction
- (c) knows who and under what circumstances they should ask for assistance
- (d) knows when and to whom they should report.

4 The registered nurse is responsible for monitoring and evaluating the outcomes of delegated nursing care.

The responsibilities of the registered nurse

1 Assessment and monitoring of the health status of the health consumer

- (a) The health consumer must have a plan of care developed by a registered nurse who has undertaken a comprehensive assessment.
- (b) The registered nurse must determine the level of skill and knowledge required to ensure the safety, comfort and security of the health consumer before delegating care. This must be based on an assessment of the health consumer including consideration of the complexity of the care required rather than the tasks to be performed.

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(c) The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible. This must be planned along with the necessary support and guidance that will be provided to the health care assistant performing the delegated activity.

(d) The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation."

Opinion: Bupa Care Services NZ Limited — breach

181. Bupa is required to adhere to the Disability Core Standards, which require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.

182. In accordance with the Code, Bupa had overall responsibility for ensuring that the staff at the private hospital provided Mr A with services of an appropriate standard. Mr A was let down by several aspects of the care provided to him by staff at the private hospital during his stay.

Admission and planning

183. Mr A was a vulnerable consumer who had a brain injury and extensive daily care needs. He had experienced many falls and, following his transfer back to Hospital 1 in July 2014, had exhibited agitation and aggression that occasionally required sedation and "ongoing consult[ant] liaison input".

184. Mr A required at least two people to assist him to mobilise, and slept in a low bed with "crash mats" around the bed in case he fell out. He had aggressive outbursts and episodes of punching, shouting, grabbing, and pushing staff, which could not be de-escalated. Mr A's family were not able to care for him at home, and he required a very high level of care in a psychogeriatric hospital to enable his needs to be met safely.

185. The NASC InterRAI assessment sent to the private hospital on 20 October 2014 states that Mr A had been approved for hospital specialised level 1 care (psychogeriatric care). The recommendation was for Mr A to have an interim placement in a psychogeriatric hospital with a high level of care, with the mental health service for older people available to monitor him. The InterRAI assessment also refers to funding an extra staff member for each shift in the initial phase of transferring care to the private hospital.

186. The "Access to Services" policy required the Facility Manager or other delegated staff member to assess the suitability of a resident seeking placement, and the ability of staff to meet any complex or specific needs. As there were potential safety issues, the policy required the Facility Manager and the Operations Manager to discuss the individual case and make the final decision regarding the suitability of the placement.

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187. The Facility Manager, RN B, told HDC that the decision to accept Mr A's admission, which she discussed in detail with the Clinical Manager, RN C, was appropriate, based on the InterRAI assessment and other information provided by the NASC. She noted that hospital specialised level 1 care is not the highest level of care provided at the private hospital, and that she was told that DHB2's view was that the private hospital was "an ideal facility for [Mr A] to come to until he could be placed in a residential rehabilitation facility".

188. Likewise, RN C was confident in the NASC's InterRAI assessment of Mr A, based on the private hospital's previous experience with the NASC's assessments. Although the InterRAI assessment indicated that Mr A would be a high-needs resident and that a "special" would be funded for the initial stages of the admission, RN C did not consider that this meant that Mr A's needs would necessarily be higher than level 1. RN C said that level 1 psychogeriatric patients generally have challenging behaviours, including verbal and physical aggression and damaging their surroundings, and the private hospital's staff are experienced in dealing with such behaviours.

189. My expert advisor, RN Christine Howard-Brown, advised:

> "[M]ost psychogeriatric services other than perhaps a DHB run psychogeriatric service which has better access to general hospital specialists and a potential for a shared care arrangement would have declined the referral based on careful review of [Mr A's] history, assessed needs and need for specialist brain injury rehabilitation. Or if accepting the referral would have questioned the level of care required (more likely the higher level of care than referred) and have a crisis management plan in place …"

190. RN Howard-Brown advised that management of Mr A's symptoms, as described in the NASC InterRAI assessment, would be nearing or exceeding the maximum capability of a psychogeriatric service. She observed that Mr A required 1:1 supervision (which is typically not provided in a level one psychogeriatric service), and that his history of public hospital admissions indicated that he had highly complex needs. She concluded that the private hospital would be "unlikely to be an appropriate facility without significant planning".

191. I consider that it was not unreasonable for Bupa to have accepted Mr A's admission. In my view, the private hospital had sufficient information to recognise that caring for Mr A would be challenging. Bupa had access to information and should have been able to gauge the seriousness of Mr A's condition. The extra support funded should have indicated that Mr A had the potential to require more complex support. The onus was on the private hospital to ensure that there was a contingency plan in place to obtain support if required, particularly over the long weekend. I am critical that the private hospital accepted Mr A with no contingency plan in place. In my view, Bupa should have developed a management plan with DHB2 and the NASC so that Mr A could have been returned to hospital promptly, if necessary. I agree with RN Howard-Brown's advice that the plan should also have included arranging for a mental health team to visit, and alerting DHB2 crisis team (the CATT team) that it might be required over the upcoming long weekend.

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192. Bupa submitted that there was a lack of appropriate DHB support for discharge into residential care just prior to the long weekend. In this respect, I acknowledge DHB2's statement that the private hospital was "well aware" of how to access acute support assistance via the CATT team should the situation escalate over the weekend.

Care planning post admission

193. Once the decision was made to accept Mr A's admission to the private hospital, it was important that adequate care planning was undertaken and recorded so that Bupa staff had detailed and up-to-date information to refer to, particularly in light of his complex needs.

194. In this respect, there is no mention in the care planning records of the need for a 1:1 special, or the requirement for completion of behavioural monitoring as required by the Bupa "Behaviours that challenge" policy.

195. RN C said that all staff were given handover information in relation to Mr A's behaviour, but no plan for managing escalating behaviour was put in place at the beginning of the admission because there was no particular expectation at that time that such behaviour would occur. RN C also told HDC that information relating to Mr A's challenging behaviour was not transferred to Bupa's care planning documentation because Mr A was at the private hospital for only eight days, and full care plans are usually completed within three weeks from admission.

196. RN Howard-Brown advised that the standard of the initial admission assessment is consistent with usual processes, but that more information from the InterRAI assessment could have been transferred to this form, to assist staff with planning and managing Mr A's challenging behaviour, particularly the techniques that had worked to de-escalate his behaviour when he was in the public hospital. RN Howard-Brown further stated that the unsigned and undated summary care plan does not fully reflect Mr A's assessed needs, and the "my day, my way plan" lacks sufficient reference to the information in the NASC assessment, and does not provide specific guidance in how to manage Mr A's behaviour.

197. I am left with the impression that Bupa's senior staff failed to recognise that Mr A's presentation differed from that of other psychogeriatric residents and, as such, they failed to plan adequately to manage his behaviour and provide appropriate care for him. Bupa staff should have been more alert to the possibility that Mr A's condition might deteriorate in a new environment. I consider that Bupa should have put in place a plan to address the potential for deterioration.

Care provided

198. Bupa had a responsibility to ensure that Mr A received appropriate and safe services from suitably skilled and experienced support workers. My in-house nursing advisor, RN Dawn Carey, advised that there is evidence that the private hospital attempted to cater for Mr A's needs, was responsive to his escalating needs and, in the context of a weekend and public holiday, responded in a timely manner in seeking reassessment of Mr A. I also note that my external independent nursing expert, RN Howard-Brown, considered that Bupa was committed to supporting staff to meet minimum skill

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requirements. I accept the advice of RN Carey and RN Howard-Brown, but also consider that there are several instances where the care Bupa provided to Mr A fell short of the accepted standard.

199. Bupa told HDC that Mr A was reasonably settled during the initial few days of his stay; however, nursing records note that from 22 October, Mr A was resistant to cares. On 23 October RN B requested that DHB2 mental health team review Mr A and refer him to a brain injury rehabilitation unit. RN B believed that his medication needed to be reviewed because it was limiting his attempts to rehabilitate and mobilise, and that he needed to be placed in a residential rehabilitation facility.

200. RN B said that it was usual for mental health clinicians to attend the same or next day when requested, but in this case she was told that Mr A would be reviewed the following week.

201. On 24 October, it was noted at the start of the shift that Mr A was agitated, restless, and resistive to cares, and that he had disassembled the water pipes of the wash basin in his room. Four staff members were required to put him back to bed. That afternoon, Mr A put his glasses lens in his mouth after becoming frustrated. RN B noted that Mr A's behaviour changed on 24 October after his family left, and he became less settled and began refusing medications. A further request for reassessment could have been made around 24 October when Mr A's behaviour began to escalate.

202. By the fifth day of his stay (26 October), a number of incident reports had been completed, which include injuries sustained by staff in response to increasingly challenging behaviour from Mr A. RN Howard-Brown advised that by that time, reassessment by a mental health team was required urgently. I agree. I consider that in light of the rapid deterioration in Mr A's condition over the weekend, RN B should have ascertained the availability of emergency mental health support.

203. RN B stated that Mr A's family was with him all day on 27 October, and that they were reluctant for mental health services to intervene in his care. I accept that Bupa were constrained somewhat by the family's wish that the mental health team not be involved. However, in my view, the referral should have been discussed with Mrs A earlier than 28 October, and treated with more urgency in light of Mr A's non-compliance with medication and increasingly unmanageable behaviour after 24 October.

Management and follow-up of Mr A's fall

204. HCA E was assigned to one-to-one care of Mr A on the afternoon of 24 October 2014. That afternoon, Mr A fell and hit his head. HCA E completed an incident form the following day (25 October 2014), which states:

> "Was sitting in lazy boy facing garden. He stands up and lunges to walk after a step he trips, falls and smacks his head on a concrete wall."

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205. Mr A had a scrape/graze on his forehead. The incident form states that there was no other visible injury, but that "bruising may appear later". RN D was informed of the fall and assessed Mr A, but made no record of the assessment. RN D said:

> "Apart from [a] scratch on [his] forehead, Mr [A] did not sustain any visible injury. Both eyes were alright. As Mr [A] was very aggressive, in spite of many tries I could not do any neurological observations."

206. Mr A's family were not notified of the fall on 24 October. There is no record of the fall in the Care Day Manager's report. RN D said that he gave verbal handover to the night registered nurse to try to get neurological observations from Mr A later. However, RN L, who worked the night shift on 24/25 October 2014, told HDC that there was no handover from the afternoon shift that Mr A had fallen, no documentation in the Care Day Manager's report, no Incident & Accident Form, and no mention of the fall in Mr A's progress notes.

207. Given the lack of documentation and the evidence of RN L, I find it more likely than not that RN D did not hand over (either verbally or in writing) to RN L that Mr A had experienced a fall, or that neurological observations of Mr A were required. Consequently, RN L did not perform any neurological observations and was not able to hand over any information about the fall to RN H the following morning. In my view, that situation was very unsatisfactory.

208. I have concerns about the management of Mr A's fall. RN Carey stated: "I consider that the initial — 12 hours — management of [Mr A's] fall on 24 October 2014 demonstrates a moderate departure from accepted standards." In particular, there is no contemporaneous reporting of Mr A's fall, or evidence of any nursing actions/assessments taken following the fall.

209. The Bupa incident reporting policy requires documentation as soon as possible following an event, including documentation of how the event occurred. RN Howard-Brown advised that the incident form should have been reported at the time the incident occurred, and noted that it is usual for incident forms to be completed by the staff member most proximal to the event. She advised that HCA E should have completed the incident form, and RN D should have countersigned the form.

210. I am critical that there is no record of the fall in the progress notes for 24 October, and that no incident form was completed that day. I am also concerned that two staff knew of the fall on the evening of 24 October, and several others noticed Mr A's injuries on 25 October, but Mr A's family were not advised of the fall or injuries, which meant that Mrs A was surprised and distressed when she visited on 25 October and saw her husband's injuries.

211. Registered nursing staff were responsible for monitoring Mr A following his fall. The Bupa Neurological Observations policy allows health care assistants who have been trained, and are competent, to complete neurological observations, and requires health care assistants to report any concerns to a registered nurse without delay.

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212. The incident form completed the following day (25 October) records that Mr A refused to have observations taken on the day of the fall. However, there is no contemporaneous record of Mr A's refusal, and no record that medical advice was sought about the inability to undertake such observations. RN Carey advised that a resident's refusal or staff's inability to carry out a nursing intervention should be documented, and I agree.

213. There is sporadic reporting in the progress notes by registered nurses and enrolled nurses of either having completed, or attempted to complete, neurological observations following the fall. RN C said that neurological observations were started on the morning of 25 October, but Mr A refused the observations three times that morning. RN C said that observations were able to be completed at 6pm, 8.30pm, and 10.45pm. He stated that it appears that there were occasions that are not documented when Mr A refused neurological observations. Bupa stated that its staff are made aware that they should never force a resident to have neurological monitoring, because often this can increase the level of aggression; however, Bupa considers that the records could have made the refusal of observations clearer.

214. The incident form notes that Mr A was on the list to be seen when the doctor next visited. RN Howard-Brown advised that the description of the incident in the incident form as "smacks head on concrete wall" warranted a medical assessment as soon as practicable. I am critical that, in light of Mr A's history, an urgent medical assessment was not sought in relation to the head injury. Although the head injury did not appear to be severe, this was in the context of Mr A having a brain injury, which increased his risk of complications should he receive a further head injury.

215. Nurse Practitioner RN G was contacted on 25 October 2014 and asked to visit Mr A. RN G assessed Mr A with his family present, and recorded in her clinical notes that the plan was for neurological observation for 24 hours. RN G gave head injury information to staff so that they could identify any changes in Mr A's health.

216. The behaviour monitoring chart states for 25 October 2014 that Mr A was "[a]ggressive all day". RN Howard-Brown also noted that several incident forms noted the need for increased monitoring, but that there was no increase in behaviour monitoring of Mr A, which would have been expected. I agree. In my view, the overall management of Mr A after his fall was poor.

Staff levels

217. RN D told HDC that at the time of these events, Bupa was going through a "severe staff shortage", and staff levels were low on 24 October. He said that he was the only registered nurse on duty that day, and that, in addition to nursing duties, he was "working as a caregiver as well, doing 12–14 residents". RN D stated: "Because of such a hectic shift somehow I missed to mention this incident in Mr [A's] progress notes, which I did as [a] late entry [the] next day."

218. Bupa said that RN D was looking after 14 residents with another qualified staff member (EN M) (a ratio of 1:7) and, as the preferred ratio is 1:6, there was a slight staff shortage on that shift.

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219. RN Howard-Brown advised that it appeared that staffing at the private hospital was "very lean" during Mr A's stay. She noted that there are gaps in the roster stating "no cover", and that Care Manager reports include references to short staffing.

220. RN C advised that one-to-one specialling was not formally put in place at the commencement of the admission. He noted that Mr A's family were with him all day on the day of his admission. RN C said that thereafter an extra carer was put in, but when the family was visiting "they requested staff to leave as they said they could manage [Mr A] on their own and they wanted to have their privacy with him". RN C said that Mr A did not have a one-to-one special at night, as all the other residents were sleeping and there were four staff available to check on Mr A regularly, and one would stay with him if required.

221. I note that RN D told HDC that on the day of Mr A's fall, staff levels were low and that there was no policy regarding calling in agency staff.

222. I accept that a planned roster can change for a number of reasons, and that replacing staff at short notice can be challenging. However, I would be concerned if there were inadequate staff levels, given the challenges posed by caring for Mr A.

HCA oversight

223. The NCNZ publication "Guideline: delegation of care by a registered nurse to a health care assistant" requires the registered nurse to ensure that a health care assistant who has been delegated an activity understands the delegated activity, has received clear direction, knows who and under what circumstances he or she should ask for assistance, and knows when and to whom he or she should report. The registered nurse remains responsible for monitoring and evaluating the outcomes of delegated nursing care.

224. I am concerned that, on 24 October, RN D failed to supervise HCA E following Mr A's fall, to ensure that the appropriate documentation was completed. Similarly, on 25 October, RN H did not administer any PRN antipsychotic medication because HCA E did not advise her of any concerns. However, HCA E made a record in the progress notes stating that Mr A had been agitated and hard to redirect. In my view, RN H should have overseen the care being provided to Mr A. In the afternoon of 25 October, RN D was the registered nurse on duty. He was aware of the fall the previous day, but again he failed to supervise HCA E adequately. If RN D had done so, he would have been aware of Mr A's bruising and his unkempt state, and been able to take action before Mrs A arrived.

225. The guideline requires registered nurses to provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible, and be directly involved with the health consumer when the consumer's responses are less predictable or changing, and/or the consumer needs frequent assessment, care planning, and evaluation. It is clear that Mr A's condition was changing after 24 October.

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226. On the afternoon of 25 October, RN H and another RN were on duty until around 3pm. EN M and RN D were on duty from around 3pm. In addition, there were health care assistants on duty, who assisted HCA E. RN D said that after he started his shift at around 3pm, he noticed that Mr A had a bruise on his left eye. RN D said that he did not notice anything on the walls of Mr A's room.

227. HCA E, who was providing 1:1 care to Mr A, said that he called for assistance three times, and that staff often checked on him and helped him to make Mr A's bed several times. HCA E said that when Mrs A arrived on 25 October 2014 he was waiting for staff to take over care because he thought he could not leave Mr A. Notwithstanding this, HCA E could have rung the call bell to obtain assistance.

228. At around 4.40pm, Mrs A found her husband asleep in an unkempt state with a number of injuries. HCA E was sitting with his feet up in an armchair.

229. I am concerned that, for a period of more than 20 hours following the fall, no other staff had reviewed the care being provided to Mr A by HCA E, monitored Mr A's condition, discovered the situation, and intervened. In my view, Bupa had an organisational responsibility to provide appropriate oversight of HCA E, especially when he was providing care for a challenging resident.

Conclusion

230. Bupa had overall responsibility for ensuring that staff at the private hospital provided Mr A with services of an appropriate standard, and that complied with the Code. As this Office has noted previously:[30]

> "That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It includes responsibility for the actions of its staff."

231. I accept that, as he had been assessed as level 1, it appeared at the time of admission that the private hospital could provide adequate care for Mr A and that the facility had experience in supporting even more complex residents. However, Mr A was not provided with services with reasonable care and skill in that:

- The care planning was inadequate.
- Bupa failed to take sufficiently prompt action when Mr A's behaviour deteriorated.
- The management and follow-up of Mr A's fall, including assessment and monitoring, was poor.
- The oversight of HCA E was inadequate.

[30] See Opinion 10HDC01286 (18 November 2013). See also 12HDC01091 (13 June 2014) and 15HDC00420 (15 June 2016). Available at www.hdc.org.nz.

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232. Overall, I am of the view that these failings cumulatively amount to a breach of Right 4(1) of the Code.

Opinion: RN D — breach

233. On 24 October 2014, Mr A had a fall, which HCA E reported to RN D. RN D was the duty leader on 24 October and was responsible for assessing Mr A following his fall, recording the incident in the progress notes, and monitoring Mr A's condition.

234. RN D said that he assessed Mr A and found no visible injury other than a graze/scratch on his forehead. RN D said that he could not do any neurological observations because of Mr A's aggression; however, RN D did not record his assessment, contact more senior staff at the private hospital, obtain medical assistance, or notify Mr A's family about the incident. In response to the provisional opinion, RN D said that he does not "clearly remember" the time that HCA E reported the fall to him, but he recalls that he was advised of Mr A's fall only at the end of the shift. However, the incident report form (completed the day after the incident) states that the fall occurred at 6.15pm, and the duty leader, RN D, was informed at 6.20pm.

235. Bupa said that RN D did not record the incident because he "was clear the HCA had recorded the incident in the notes". However, the fall was not documented in the progress notes or the incident form until the following day.

236. It was RN D's responsibility, as specified in the NCNZ Code of Conduct for Nurses, to ensure that the health care assistants (including HCA E) had the "appropriate knowledge and skills, and [to] know when to report findings and ask for assistance". Under the NCNZ publication "Guideline: delegation of care by a registered nurse to a health care assistant", RN D was required to ensure that the health care assistants understood what was required of them and received clear directions.

237. That guideline further required RN D to ensure the "ongoing monitoring of the health status of the health consumers for whom he/she is responsible. This must be planned along with the necessary support and guidance that will be provided to the health care assistant performing the delegated activity." The "accident/incident forms — use of" policy states that incident report forms must be completed as soon as possible after the event, and must be countersigned by the duty or shift leader, who checks the accuracy of the account "and that all necessary data has been entered and documents what action was taken in response to the event". The policy says that an incident report should record a full description of the event; which family member was informed; and whether a doctor was contacted, and document any care or treatment given.

238. In response to the provisional opinion, RN D said that EN M was Mr A's assigned nurse; however, he acknowledged that HCA E contacted him (RN D) regarding Mr A's behaviour, rather than EN M. RN D also said that having worked with HCA E previously, he considered that HCA E would be aware of his responsibilities. I remain of the view that RN D was responsible for overseeing HCA E and, in this case,

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should have checked the notes and overseen the completion of the incident report form as soon as practicable after the incident, to make sure that HCA E had recorded the appropriate information about the fall.

239. I also note RN D's submission that when he was made aware of the fall, it was too late to contact the family. However, I remain of the view that RN D should have informed Mr A's family of his fall.

240. RN D said that he gave verbal handover to the night registered nurse to try to do the neurological observations when Mr A was calmer. However, RN L, who worked the night shift on 24/25 October 2014, told HDC that there was no handover from the afternoon shift that Mr A had fallen. Furthermore, there was no documentation about the fall in the Care Day Manager's book, no Incident & Accident Form, and no mention of the fall or the failure to perform neurological observations in Mr A's progress notes. Given the lack of documentation and the evidence of RN L, I find it more likely than not that RN D did not hand over (either verbally or in writing) to RN L that Mr A had experienced a fall, or that neurological observations of Mr A were required. Consequently, RN L did not perform any neurological observations and was not able to hand over any information about the fall to RN H the following morning. In my view, that was very unsatisfactory.

241. RN D knew that Mr A had fallen and hit his head, and also knew Mr A's neurological history and behavioural symptoms. RN Howard-Brown advised that RN D's assessment and management of Mr A's fall was insufficient in that he did not document his assessment, put onward actions in place, contribute to completion/review of the incident report, request a medical assessment, notify next-of-kin, or document handover to oncoming staff. RN Howard-Brown advised that neurological observations should have been performed, and a medical assessment arranged, as soon as practicable following the event.

242. RN Carey advised that, following a resident's fall, pain assessment and need for analgesia should be evaluated, the resident's falls risk and specified interventions re-evaluated with further interventions incorporated as required, and a plan made as to the required frequency of checks, observations, and pain assessments.

243. I agree with my experts' advice, and I am critical of RN D's actions following Mr A's fall. In my view, if RN D was unable to perform the necessary observations, he had a responsibility to escalate the matter to his manager to determine whether a medical review was necessary.

244. RN D told HDC that, at the time, Bupa was going through a "severe staff shortage", and staff levels were low on 24 October. He said that he was the only registered nurse on duty that day and that, in addition to nursing duties, he was also working as a caregiver. However, I note that another registered staff member, EN M, was also on duty, as well as health care assistants.

245. Bupa said that RN D was looking after 14 residents with a caregiver (a ratio of 1:7) and, as the preferred ratio is 1:6, there was a slight staff shortage on that shift;

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however, Bupa stated that, despite that, "the proper notes should have been completed". In my view, the staff shortage was not ideal. However, this does not excuse RN D's inadequate oversight of HCA E, poor response to Mr A's fall, and inadequate record-keeping.

246. I find that RN D failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

247. Furthermore, the *Code of Conduct for Nurses* requires nurses to keep clear and accurate records of discussions, assessments, care, and medicines given, and how effective these have been. The records must be completed as soon as possible after an event has occurred. RN D's failure on 24 October to record any information about the fall resulted in the night staff being unaware of the fall, or the need for neurological assessments. Accordingly, RN D failed to comply with professional standards and also breached Right 4(2) of the Code.

Opinion: HCA E — breach

248. HCA E was assigned to 1:1 care of Mr A for the afternoon shift on 24 October 2014. That afternoon, Mr A fell and hit his head. HCA E completed an incident form the following day (25 October 2014), which states:

> "Was sitting in lazy boy facing garden. He stands up and lunges to walk after a step he trips, falls and smacks his head on a concrete wall."

249. The "accident/incident forms — use of" policy states that incident forms must be completed as soon as possible after the event, and must be countersigned by the duty or shift leader, who checks the accuracy of the account "and that all necessary data has been entered and documents what action was taken in response to the event". The policy says that an incident report should record a full description of the event; which family member was informed; and whether a doctor was contacted, and document any care or treatment given. In my view, HCA E should have completed an incident form as soon as possible on 24 October. HCA E also did not record the fall in the progress notes, and he told Bupa that this was because he was not aware of his role or responsibilities. In my view, HCA E was adequately trained and should have known his role.

250. HCA E was again assigned 1:1 care of Mr A on 25 October. HCA E recorded in the progress notes:

> "Black eye noted in [morning] during serving of breakfast. Refused meals all day. Agitated and hard to redirect. …"

251. However, HCA E did not contact the registered nurse on duty, RN H, about any concerns with regard to Mr A and, as a result, RN H did not administer any PRN antipsychotic medication.

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252. HCA E's job description required him to show an ability to recognise concerns or changes in a resident's well-being and directly provide help and support or seek advice from other qualified staff, and document relevant information accurately and report problems, concerns, or changes in the resident's condition immediately to the senior member of staff. In my view, HCA E should have drawn RN H's attention to Mr A's agitation and refusal of meals, especially in light of the fall the previous day. At around 4.40pm on 25 October 2014, Mrs A visited her husband and found him unkempt and with a number of injuries. Mrs A said that HCA E was sitting to the side of Mr A with his feet up on an armchair.

253. HCA E told Bupa that when Mrs A arrived on 25 October he was waiting for staff to take over care because he thought he could not leave Mr A. In my view, that does not explain or excuse Mr A's unkempt condition. HCA E had a responsibility to provide Mr A with appropriate personal cares. HCA E's job description states that the purpose of the job is to provide residents with a "high level of care and comfort", and his key competencies and responsibilities include showing an understanding of safe care and practice; treating all residents with respect and tolerance; and maintaining all areas in a clean, tidy state.

254. I acknowledge that working with a resident with complex needs can be challenging. However, failing to provide appropriate cares is unacceptable — whatever the circumstances. HCA E's response to the situation was clearly inappropriate.

255. HCA E had worked at the private hospital for several months, and had completed training, including training on "behaviours that challenge". I note that disciplinary records following the fall incident record that he told Bupa that he was unsure of his responsibilities when working 1:1. Given HCA E's training, I do not accept that he was unaware of his duties. Furthermore, if that were the case, he should have sought guidance from the registered nurse on duty. In addition, he had experience in supporting complex residents, and the care plan had the rudiments of the support required. In any event, I consider that he should have been aware that the condition in which Mrs A found her husband on 25 October 2014 was unacceptable.

256. In my view, for the reasons above, HCA E failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: RN B — adverse comment

257. RN B was the private hospital's Facility Manager. Her responsibilities included ensuring that every resident received optimal care and support within the facility. She had worked at the private hospital for several years, and had experience in dealing with residents with challenging behaviours, including those with dementia and other mental health conditions. She had completed Dementia Unit Standards as well as other relevant education. Ultimately, RN B was responsible for accepting Mr A's admission to the private hospital.

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258. Prior to accepting Mr A to the private hospital, RN B had access to the InterRAI assessment, which indicated that he required a high level of care. The information included the following: Mr A required two people to assist him to mobilise, and needed supervision for 24 hours 7 days a week; he had exhibited agitation and aggression that occasionally required sedation and "ongoing consult[ant] liaison input"; he had "aggressive outbursts", and there had been a number of episodes, which could not be de-escalated, of him allegedly punching, shouting, grabbing and pushing, and not being able to work with staff; and his fatigue required management in order to reduce his agitation.

259. On 20 October 2014, the MHSOP coordinator at DHB2, RN J, added an addendum to the InterRAI assessment that Mr A required "a very high level of care in a psycho-geriatric hospital to enable his extensive daily care needs to be met safely". She noted that the placement was to be on an interim basis.

260. RN B considered that, on the basis of the information contained in the InterRAI assessment, level 1 appeared to be a reasonable assessment of the care Mr A required. She noted that hospital specialised level 1 care is not the highest level of care provided at the private hospital, although, with hindsight, she considered that Mr A should have been assessed as requiring a higher level of care.

261. RN B said that, at the time of accepting the admission, she was not aware that the mental health team would be unavailable over the weekend. RN B discussed with RN C in detail the decision to accept Mr A's admission. Overall, I consider that RN B's decision to accept Mr A's admission was not unreasonable in light of the information she had been provided. On 21 October, Mr A injured his finger and he was very confused, resistive, and agitated during cares, which required four staff. Thereafter, Mr A was more settled. RN C and RN B assisted Mr A with morning walks to promote his mobility. RN B said that Mr A was frustrated because he wanted to walk.

262. On 23 October 2014, RN B emailed the DHB2 mental health team to request an assessment of Mr A and referral to a brain injury rehabilitation unit. RN B said she was concerned that, at times, Mr A refused his medication, and she believed that his medication needed to be reviewed because it was limiting his attempts to rehabilitate and mobilise. In her email requesting the referral, she stated that Mr A "can communicate well and his aggression is minimal", and that Mr A needed to be placed in a residential rehabilitation facility.

263. RN B said that the request was not made because the private hospital was unable to manage Mr A's cares and behaviour, and that, at that stage, there had been only a single incident, when he injured his finger. Rather, it was to have his medications reviewed. She said that there had been changes in his moods, which was part of her concern about his medication, but he was reasonably settled at the private hospital, and his family had been present continuously during the day.

264. RN B signed incident forms on 22 October, 25 October, 26 October, 27 October, and 28 October indicating that she had reviewed the forms and had knowledge of each incident. RN Howard-Brown advised: "Until notification occurred on 28 October to

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DHB2 of an inability to safely provide care to [Mr A], her response to such a high number of serious incidents is inconsistent with expectations as set out in policies and how in my experience other facility managers would have responded."

265. RN B said that the incident reports were based on a "range of behaviours and circumstance, which did not necessarily indicate until later in the long weekend that [Mr A] was not manageable for us". She said that Mr A's family told her that Mr A was "much better with us than any other place he had been in".

266. RN B said that Mr A's family were with Mr A all day on 27 October 2014, and were reluctant for mental health services to intervene. However, she requested an urgent re-assessment of Mr A on 28 October 2014.

267. On 24 October, it was noted at the start of the shift that Mr A was agitated, restless, and resistive to cares, and that he had disassembled the water pipes of the wash basin in his room. Four staff members were required to put him back to bed. That afternoon, Mr A put his glasses lens in his mouth after becoming frustrated. RN B noted that Mr A's behaviour changed on 24 October after his family left, and he became less settled and began refusing medications. A further request for re-assessment could have been made around 24 October when Mr A's behaviour began to escalate. I consider that in response to the rapid deterioration in Mr A's condition, RN B should have ascertained the availability of emergency mental health assistance over the weekend.

268. RN Howard–Brown advised that RN B provided good support to Mrs A as part of the admission process, and responded appropriately at the time Mrs A's complaint was made on 25 October 2014 by arranging a medical assessment and directing staff. I accept that advice. However, I am critical of some aspects of RN B's subsequent actions, in particular the length of time she took to seek an escalation of the request for re-assessment of Mr A to an urgent request, given the number of incidents that had occurred.

Opinion: RN C — adverse comment

269. RN C was the private hospital's Clinical Manager. His responsibilities included providing leadership and clinical supervision to clinical and care staff, active involvement in quality management, monitoring the provision of clinical care, oversight of clinical records, and ensuring a safe environment.

270. RN C and RN B discussed Mr A's admission. RN C said that they were confident in the NASC's assessment, based on their collective previous experiences with the NASC. He said that although the assessment indicated that Mr A would be a high-needs resident, and that a "special" would be funded for the initial stages of the admission, that did not necessarily indicate that his needs would be higher than level 1. RN C said that level 1 psychogeriatric patients generally have challenging behaviours, including verbal and physical aggression, and damaging their surroundings, and the staff were experienced in dealing with such behaviours.

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271. RN C did not formally put in place a one-to-one special at the commencement of the admission; however, he said that Mr A's family were with him all day on the day of his admission. RN C said that thereafter an extra carer was put in, but when the family was visiting "they requested staff to leave as they said they could manage [Mr A] on their own and they wanted to have their privacy with him". RN C said that Mr A did not have a one-to-one special at night, as all the other residents were sleeping and there were four staff available to check on Mr A regularly, and one would stay with him if required.

272. RN C signed reviews of incident reports on 21 October, 24 October, 25 October, and 28 October. RN Howard-Brown said that this suggested that he was aware that Mr A's level of need exceeded the facility's ability to provide the care, but did not act with sufficient urgency. RN C did not put in place a plan for dealing with Mr A's escalating behaviour to give staff more guidance. He also did not negotiate a plan with DHB2 and NASC for managing any issues, particularly in light of the upcoming long weekend.

273. On 24 October, it was noted at the start of the shift that Mr A was agitated, restless, and resistive to cares, and that he had disassembled the water pipes of the wash basin in his room. Four staff members were required to put him back to bed. That afternoon, Mr A put his glasses lens in his mouth after becoming frustrated. RN B noted that Mr A's behaviour changed on 24 October after his family left, and he became less settled and began refusing medications. RN Howard-Brown was critical that, when Mr A's behaviour escalated after 24 October, RN C did not direct the use of the mental health on-call service (the CATT team). RN C stated that managing Mr A at the private hospital over the long weekend with no DHB backup was "not an acceptable state of affairs", and there should have been an arrangement with DHB2 for easy referral back to hospital or to mental health clinicians. RN C said that in future he would insist on a more robust discharge plan if a DHB did not offer such an arrangement.

274. A further request for reassessment could have been made around 24 October when Mr A's behaviour began to escalate, or assistance could have been sought from Mr A's GP. I am critical of some aspects of RN C's actions, in particular the length of time he took to seek an urgent reassessment of Mr A, given the number of incidents that had occurred.

Recommendations

275. I recommend that Bupa Care Services NZ Limited report back to HDC with the outcome of the following recommendations, within three months of the date of this report:

a) Provide HDC with the policy for one-to-one specials.
b) Review the "Access to Services" policy and provide the outcome of the review to HDC.
c) Review the implementation of the recommendation from its internal review and report the outcome to HDC.

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d) Provide the outcome of the review of the Medication Administration policy and evidence of staff training on medication administration, including the documentation of PRN medication.
e) Review how it manages clinical and care staff resourcing and what safeguards it has in place to arrange for additional staffing, including agency staff.
f) Ensure that all registered nurses and health care assistants receive regular training in neurological observations and behaviours that challenge.
g) Undertake an audit of the effect of the changes made since this incident, and provide the outcome to HDC.
h) Ensure that all registered nurses receive regular training on their responsibilities with regard to the oversight of health care assistants.

276. I recommend that Bupa Care Services NZ Limited apologise to Mrs A for its breach of the Code. The written apology is to be forwarded to this Office within three weeks from the date of this report, for forwarding to Mrs A.

277. I recommend that RN D apologise to Mrs A for his breach of the Code. The written apology is to be forwarded to this Office within three weeks from the date of this report, for forwarding to Mrs A.

278. I recommend that the Nursing Council of New Zealand consider whether a competence review of RN D is warranted should he return to practise in New Zealand.

279. I recommend that HCA E apologise to Mrs A for his breach of the Code. The written apology is to be forwarded to this Office within three weeks from the date of this report, for forwarding to Mrs A.

Follow-up actions

280. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services NZ Limited, will be sent to DHB2, the Nursing Council of New Zealand, and an overseas health practitioner regulation authority, and they will be advised of RN D's name.

281. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services NZ Limited, will be sent to HealthCERT and the NASC, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was received from RN Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided by [the private hospital] to her husband, [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.

Comments made as an addendum have been added in bold type.

2. I have reviewed the following documentation: complaint from [Mrs A]; response and correspondence from the provider including restraint policy, clinical notes; response and consultation notes for 21 October from [Dr F] — GP.

3. Complaint background and advice request
[Mr A] was admitted to [the private hospital] on 21 October 2014 following a hypoxic brain injury. The clinical notes indicate that he was difficult to manage due to his aggressive behaviour and was prescribed diazepam to manage this and was also nursed 1:1.

   On 25 October [Mr A] was noted to have sustained an injury to his left eye that was, according to the incident form, caused by a fall and resulting trauma to the side of his head. The family are concerned that [Mr A] was in fact assaulted by a staff member. On 29 October, [Mr A] was discharged from [the private hospital].

I have been asked to review the clinical documentation and respond to the following questions:

- Was the nursing care provided upon detection of this injury appropriate?
- Should the suitability of his placement have been reassessed in a timelier manner?

4. **Provider response(s)**

The provider has provided a comprehensive response to [Mrs A's] complaint issues. I have reviewed the provider response and correspondence. I have not received two referenced attachments — (i) letter from provider to [DHB2]; (ii) G1, G2 relating to GP review and recommendation for referral to Mental Health and Rehab facilities. For the purposes of brevity I have not detailed the provider response in this advice.

I have now received and reviewed the two referenced attachments from the provider.

5. **Review of clinical records**

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a) **Fall management 24 October 2014:**
No contemporaneous documentation relating to the fall has been submitted. As the relevant Care Home Manager's Report (CHMR) also does not reference [Mr A's] fall, I am unsure as to whether the occurrence was handed over to the night shift team. All reportage relating to the fall was completed on the following day after the completion of the Accident/Incident form (A/IF) — 25 October at 8am — noting [Mr A's] black eye. Documentation also reports [Mrs A] being notified on the evening of 25 October and that the Nurse Practitioner review was initiated at [Mrs A's] request. Neurological observations from 6pm on 25 October have been submitted. On 28 October [Mr A] was reviewed by his GP.

I note that on 24 October, [Mr A] refused his 'dinner' time medications and his 'bed time' medications were withheld as he was sleeping. Analgesia in the form of paracetamol was prescribed for both these times. Progress notes (PN) report [Mr A] being agitated and restless overnight, with administered diazepam having little effect. There is no reportage relating to staff considering pain as a possible factor in [Mr A's] agitation. The Behaviour Monitoring Chart reports [Mr A] having approximately three hours sleep overnight with escalating challenging behaviours.

While I agree with the provider that all interventions are dependent on the resident/patient being accepting of them, I consider that resident refusal or staff's inability to carry out a nursing intervention should be documented.

In my opinion, the overall quality of provided and documented care concerning the management of [Mr A's] witnessed fall is not consistent with accepted standards. Following a resident's fall I would expect that the resident be checked for injuries and the documented entry to include commentary on existing/new injuries; the duty RN be informed; a full set of observations be taken and documented; pain assessment and need for analgesia be evaluated; an incident form be completed, the resident's falls risk and specified interventions be re-evaluated with further interventions incorporated as required; and a plan made as to the required frequency of checks, observations and pain assessments. If care is delegated to non registered care givers, then instructions as to when to seek further RN input must also be given and documented. Family member/EPOA also need to be notified in accordance with the agreed time frame.

I am critical that there is no contemporaneous reportage of [Mr A's] fall or evidence of the nursing actions/assessments that were taken following his fall. I consider that the initial — 12 hours — management of [Mr A's] fall on 24 October 2014 demonstrates a moderate departure from the accepted standards of care. In my opinion, subsequent care and documentation were consistent with the accepted standards.

b) **Recognition of changing needs and need for reassessment:**
As referenced in section 4, the provider response refers to attachments that have not been submitted to me for review. His initial needs assessment which identified him as suitable for psycho-geriatric level of care or transfer documentation have also not been submitted. I note that the provider reports that severely brain injured

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residents will no longer be accepted into [the private hospital]. Acknowledging the complexity of caring for acquired brain injury patients I would agree that this is appropriate.

I note that on admission to [the private hospital] [Mr A's] initial dependency rating was assessed as *very high,* with a score of 73. On 23 October email communication to [the private hospital] reports that he would be reviewed the following week by a Psychiatrist from [DHB2]. From 25 October [Mr A] received 1:1 supervision from a dedicated care giver with the purpose of maintaining his safety. PN entries and A/IF detail escalating challenging behaviours resulting in [Mr A] sustaining self inflicted injuries — skin tears and bruising. There is also daily reportage of staff members receiving physical injuries whilst attempting to complete his cares or maintain his safety. Documentation shows a consistent and ongoing lack of sleep and [Mr A] refusing to take his prescribed medications.

In my opinion, there is evidence of [the private hospital] attempting to cater for [Mr A's] needs and being responsive to his escalating needs. In the context of a weekend and public holiday coinciding with his escalating needs I consider that [the private hospital] responded timely in seeking reassessment of [Mr A's] needs.

6. **Clinical advice**

- Was the nursing care provided upon detection of this injury appropriate?
  I consider that the initial — 12 hours — management of [Mr A's] fall on 24 October 2014 demonstrates a moderate departure from the accepted standards of care. In my opinion, subsequent care and documentation were consistent with the accepted standards.

- Should the suitability of his placement have been reassessed in a timelier manner?
  In my opinion, there is evidence of [the private hospital] attempting to cater for [Mr A's] needs and being responsive to his escalating needs. In the context of a weekend and public holiday coinciding with his escalating needs I consider that [the private hospital] responded timely in seeking reassessment of [Mr A's] needs.

Following a review of the two referenced attachments — (i) letter from provider to [DHB2]; (ii) G1, G2 relating to GP review and recommendation for referral to Mental Health and Rehab facilities, my opinion as expressed in section 5b and section 6 remains unchanged.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

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Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from RN Christine Howard-Brown:

"Thank you for your request on behalf of the Commissioner to provide an opinion on a number of issues related to the complaint concerning [Mr A]. I am a registered nurse, lead quality auditor and hold a Masters of Business Administration. I have worked in secondary and tertiary care hospitals including community services as a clinical nurse specialist, nursing advisor and duty manager before I commenced working as a quality auditor in health and disability services in 2003. The majority of my experience in aged residential care relates to service reviews, programme evaluations, service improvement initiatives, audits and inspections undertaken in the last eleven years. I am also a part time PhD candidate at Otago University. My thesis relates to primary healthcare and aged residential care.

To the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have been asked to provide an opinion on the care provided by Bupa to [Mr A] in October 2014 responding to specific issues raised by the Health and Disability Commissioner.

I have reviewed care records and correspondence documented on file and issues presented in the letter requesting an opinion. I have also reviewed results of the last certification audit of [the private hospital], and selected Bupa policies, procedures and position descriptions which were additionally requested.

To support my opinion I have referred to the Aged Residential Hospital Specialised Services Agreement for the Provision of Aged Residential Hospital Specialised Services 2013; the Health and Disability Services (Safety) Act 2001; The Health and Disability Services Standards NZS8134:2008; and the Employment New Zealand website[1].

Background

In May 2014, [Mr A] suffered a brain injury and spent several months in Hospital. In October 2014, [Mr A] was assessed by [the NASC] as requiring two people to assist him with daily activities, requiring 24/7 watch, and a 'very high level of care in a psychogeriatric hospital'.

[The private hospital], a Bupa facility, was identified as the only appropriate facility for [Mr A] in the [region] (the only facility with psychogeriatric beds in the [region]) and they accepted him for admission. This was to be an interim placement. [Mr A] was admitted to [the private hospital] on 21 October 2014. Staff at [the private hospital] assessed [Mr A's] dependency as 'very high'.

[1] https://employment.govt.nz/

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Bupa told HDC that he appeared settled for the first few days. However once his family left, he was unsettled and refused to take his medications.

On 23 October 2014, [the private hospital] facility manager emailed Mental Health Services for Older People (MHSOP) requesting an assessment of [Mr A] and a review of his medication.

Health Care Assistant [HCA E] was assigned to [Mr A's] care on 24 October (PM shift) and 25 October 2014 (AM shift until 5pm).

Fall — 24 October 2014
Records indicate that [Mr A] fell and hit his head on a concrete wall in [private hospital] gardens on 24 October 2014, although there are no contemporaneous records. An incident form recorded a fall at 6.15pm on 24 October and that the duty leader RN D was informed at 6.20pm. It is unclear when this form was completed. The form noted that [Mr A] refused observations. [Mrs A] was not informed until her visit the following day.

25 October 2014
A further incident form (recorded at 8am 25 October by [HCA E]) recorded 'bruising on [left] eye'. Neurological observations are recorded from 6pm on 25 October.

[Mrs A] told HDC that she visited her husband at 4.40pm on 25 October 2014 and found [Mr A] in an uncomfortable looking position, with dry lips, 'crusted drool and phlegm' on his face, not wearing his own clothes, dirty feet, unshaven, hard to rouse, unsettled and not eating properly. She was concerned about bruising and lacerations on [Mr A].

On 26 October 2014, the progress notes indicate that [Mr A] became aggressive, recording 'kicking, biting, verbally abusive'.

On 28 October 2014, the facility manager again contacted MHSOP to request an urgent reassessment. MHSOP came that afternoon.

On 29 October 2014, [the private hospital] advised that they could not continue to care for [Mr A] as he had been refusing to take his medications and he had assaulted six staff members. That day, [Mr A] was discharged from [the private hospital].

[Mrs A] was appointed welfare guardian for [Mr A] on 13 November 2014. On 19 November 2014, [Mr A] was transferred to [the Brain Injury Unit].

An internal investigation by [the private hospital] resulted in a disciplinary process regarding [HCA E].

Opinion on specific issues raised by the Commissioner

1. Whether [the private hospital] was an appropriate facility for [Mr A's] needs?

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To determine whether the facility was appropriate for [Mr A's] needs, I have considered the needs assessment, certification of the facility, contract for services held with [DHB2], and Bupa policy.

Needs Assessment
[The NASC] determined [Mr A] was suitable for psychogeriatric care. This was stated as an interim measure awaiting processes for a possible transfer to a brain injury rehabilitation unit or another residential unit close to [Mr A's home]. Records indicate that [Mrs A] was in support of an interim placement at [the private hospital] and [Mr A] was unable to communicate his decisions.

A note in [the NASC] file completed 20 October by Service Coordinator, RN J indicates there was agreement between all parties that a residential care facility was the best option to meet [Mr A's] daily needs. Usually a specialist assessment is undertaken as part of the decision process for determining placement in a secure residential facility. A specific medical specialist assessment record was not provided for review that demonstrates medical decision making for the initial placement. There is reference by a consultant psychiatrist, [Dr I], in a progress note dated 15 October, that states 'his current presentation on the ward suggests that he needs to be in permanent residential care and I understand that this will need to be psychogeriatric hospital.' There is also reference in later correspondence by [DHB2] documented by [a nurse manager] that there was concern that the brain injury unit may have previously declined a referral and would likely decline a current referral given [Mr A's] current level of aggression and that his needs had been in excess of what the older persons rehabilitation unit at [DHB2] had been able to provide.

The level of need was informed by an interRAI assessment completed by Assessor/Coordinator [the NASC] assessor, who was employed by [the NASC]. An interRAI assessment is a comprehensive clinical assessment used to inform the development of a care plan to address clinical assessment protocols. The interRAI assessment information included ongoing issues [such] as [Mr A] mobilizing with two people and requiring 24/7 supervision by a health care assistant (HCA). The assessment provides a history of [Mr A's] behavioural symptoms and how these had been managed. InterRAI outcome scales generated by the completion of the assessment indicated an aggressive behaviour scale of 5 which represents the presence of severe aggression; a cognitive performance scale of 4 which indicates moderately severe impairment; an instrumental activities of daily living scale of 48 (for both capacity and performance) which is the highest score possible representing an inability to perform instrumental activities; pain scale of 2 indicating daily pain but not severe.

[The NASC's] recommendation was for a very high level of care in a psychogeriatric hospital as an interim placement and that the mental health service for older people would be available to monitor [Mr A]. The assessment record also includes a reference to funding an extra staff member for each shift specifically in the initial phase of transferring cares. The interRAI assessment in hard copy along with a referral facsimile was sent to [the private hospital] on 20

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October 2014. This included approval for hospital specialised level one care (psychogeriatric care).

In written statement from the clinical manager ([RN C]) and manager ([RN B]) they state there was a high reliance on the information provided from [the NASC] and its assessment for level one care as being a reason not to question the appropriateness of the referral. In his statement, [RN C] also states that in this case 'it (the interRAI assessment) referred for example to two staff being required to assist with cares, when it was clear upon admission that usually more staff were needed. This is the reason I thought that the assessment had understated his level of need'.

Certification and contract to provide services

[The private hospital] is certified to provide aged residential care services and holds a contract with the [DHB2] to provide aged residential hospital specialised services (ARHSS) under a national agreement.

Payment for services for [Mr A] was being made in respect of the ARHSS agreement as it had been determined by [the NASC] that [Mr A] was alike in age and interest.

The ARHSS contract agreement includes entitlement for a residential care subsidy where the person has been assessed as requiring long-term residential care in a hospital and who suffers from a psychogeriatric condition that is either dementia with high dependency needs and challenging/antisocial behaviour or a combination of an age related disability and mental health condition with high dependence needs and challenging/antisocial behaviour (reference A5.1).

The ARHSS contract agreement also includes a provision which requires that a person may only be admitted where it has been determined by a NASC that the person requires aged residential hospital specialised services (reference D4.2).

Under the ARHSS contract agreement (reference D16.4) the facility has a responsibility to inform [the NASC] if there is a significant change in the assessed level of need.

Bupa policy

The entry criteria for the service as set out in Access to Services policy includes a section that where there is special expertise or safety issues identified as possible barriers to admission the Facility Manager and Operations Manager will discuss the individual case and make a final decision regarding the suitability of a placement. From correspondence provided for review there is no way of knowing whether such a discussion took place.

The Facility Manager job description includes reference to demonstrating a sound understanding of policies and recognizes when to consult or involve senior management. The Operations Manager job description does not explicitly make reference to decision making where special expertise or safety issues have been identified.

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Conclusion

It is not uncommon that there are difficulties in determining the most appropriate placement for people with significant behavioural symptoms, especially where these are not directly related to dementia. [Mr A's] case was further complicated by an intent to commence an active rehabilitation programme once behavioural symptoms were better managed.

From information reviewed, it appears that a referral had not been made to the brain injury rehabilitation unit because [DHB2] was waiting for ACC approval of a claim that would therefore transfer payment for services from [DHB2] to ACC for rehabilitation and secondly that there was concern the referral would be declined by the brain injury service given [Mr A's] high level of aggression (however this wasn't recorded as having been tested).

The process for determining suitability of a psychogeriatric service by medical specialists is inadequately documented in records reviewed. There is no rationale provided as to why [the NASC] determined level one care as opposed to level two. From information available, the level of need was more likely the highest possible level, especially given a HCA special was required when he was in hospital and on occasions a security person.

Based on the interRAI assessment information, the service was provided with sufficient information to determine whether they had the capability to provide the services required. In my experience, management of symptoms as described in the referral assessment would be nearing or exceeding the maximum capability of a psychogeriatric service without careful planning if [the private hospital] was to accept the referral. This should have included a management plan developed in conjunction with [DHB2] and NASC should the placement not prove suitable. For example, putting [Mr A] on leave from [DHB2] ward for a few days so he could be returned there with a minimum of effort; arranging for the mental health team from the hospital to visit; alerting [DHB2] crisis team that they may be required over the upcoming long weekend.

On review of the information available, I expect most psychogeriatric services other than perhaps a DHB run psychogeriatric service which has better access to general hospital specialists and a potential for a shared care arrangement would have declined the referral based on careful review of [Mr A's] history, assessed needs and need for specialist brain injury rehabilitation. Or if accepting the referral would have questioned the level of care required (more likely the higher level of care than referred) and have a crisis management plan in place given [Mr A's] history including difficulties in administering medication and the need for both security and HCA monitoring in the form of a watch.

Despite [Mr A] having been assessed to receive psychogeriatric care, and referred to [the private hospital], it was unlikely to be an appropriate facility without significant planning because:

— [Mr A] required one-to-one supervision which is typically not provided in a level one psychogeriatric service

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- [Mr A's] history of his public hospital admission indicates he was highly complex requiring significant staff resources to ensure his safety
- [Mr A] had assessed needs nearing the limits of what a psychogeriatric service could reasonably provide
- there wasn't a good management plan in place should the placement prove to be unsuitable
- specialist rehabilitation services were also required (of which [the private hospital] does not specialise in providing and is not certified to provide rehabilitation as a medical service).

2. Whether [the private hospital] responded appropriately in light of [Mr A's] escalating needs, including the timeliness of his reassessment.

To consider the appropriateness of the response to escalating needs, I have considered both the indications of escalating needs and the response provided to them.

Indications of escalating needs included:

- a high number of incidents occurring resulting in injuries to [Mr A] and staff being assaulted
- challenging behaviour was not being managed through use of de-escalation techniques and medications
- a high number of staff were needed to provide personal cares to try to ensure the safety of [Mr A] and staff.

Progress notes and incident reports indicate [Mr A's] needs were extremely high. The general practitioner, [Dr F], made comment on 24 October 2014 of intermittent difficult and challenging behaviours and 'well done' to staff working with [Mr A]. However, by 26 October 2014 there is an increasing number of incident reports where staff are receiving injuries in response to [Mr A's] challenging behaviour and medications are being refused or having little effect with multiple staff required to provide cares.

A formal arrangement to roster and use a special for one-to-one care does not appear to have been made on admission and it was only evident in documentation reviewed that one-to-one care was put in place across all shifts from 27 October 2014. I am drawn to this conclusion because there is no reference to [Mr A] requiring a special in the 'my day, my way plan' or 'care summary' or progress notes or care manager records until a specific reference on 26 October 2014 in one progress note '[Mr A] closely monitored by one staff' and from 27 October am shift where there are consistent references to [Mr A] being watched (1:1 or special being referenced) in progress notes. Staff rosters, although hard to read do not indicate additional staffing for the service to allow for a watch until 27 October 2014. Care manager summaries reference short staffing, staff statements and incident reports do not indicate a one-to-one special for each shift prior to 27 October. Despite a continuous watch not being documented for some time, it is obvious from written records that [Mr A] was consuming a lot of staff resources to

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deliver care (up to four staff at any one time) and that he was unsettled at night and was not receiving one-to-one care on night shift.

As [Mr A] had high and complex needs, significant staff time was directed to [Mr A], but injuries sustained and incident records indicates more supervision of [Mr A] was required than was being provided (irrespective of whether there was or wasn't one-to-one care).

A reassessment by the mental health team (using the on-call hospital service) or via the general practitioner service was indicated prior to the referral made on 28 October 2014. Despite it being a long weekend, in my opinion an urgent reassessment was required on the 26 October 2014 given five incident forms were completed that day in relation to staff injuries related to the management of [Mr A].

Advice should also have been sought in relation to the inability to undertake neurological observations as directed following the assessment of a head injury by nurse practitioner, [RN G], on the 25 October 2014. Although the head injury did not appear to be severe, this was in the absence of information about the presumed fall and the fact [Mr A] was trying to rehabilitate from a non-traumatic brain injury which increased his risk of complications should he receive an accidental head injury.

In summary, information which leads me to believe [the private hospital] did not respond appropriately include:

- a plan wasn't developed and implemented to manage escalating behaviour that was creating safety risks
- an initial request by the facility manager, [RN B] on 23 October 2014 for a reassessment of [Mr A's] medications by a psychiatrist understated [Mr A's] behavioural symptoms
- registered nursing staff didn't use 'as needed' medication as charted
- registered nursing staff didn't gather all relevant information from the HCAs caring for [Mr A] to inform their decision making and reporting for handovers between shifts and to the care manager
- a request for a medical assessment of physical injuries was not timely but was impacted by an incident reporting omission
- a request for urgent mental health team reassessment did not occur until 28 October 2014[2]
- documentation was insufficient to guide staff decision making
- family were not adequately involved (refer other information later in this report).

3. The appropriateness of the care provided by [the private hospital].

Specific areas of care are commented on as requested by the HDC.

[2] Mr A was seen that day and subsequently readmitted to public hospital the following day

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Care planning

Initial care planning for [Mr A] was undertaken by [an RN] in accordance with BUPA policies. The standard of documentation of the initial admission assessment is consistent with usual process. However more information from the interRAI assessment could have been transferred to this form to assist staff in managing [Mr A's] challenging behaviour, particularly using techniques that had worked to de-escalate behaviour when [Mr A] was in the public hospital. There is no mention of the need for a one-to-one special[3] in the care planning records[4], or the requirement for completion of behavioural monitoring (as required by Bupa behaviours that challenge policy).

A summary care plan was developed (but not dated or signed) which provided little more detail than the initial care plan and doesn't fully reflect [Mr A's] assessed needs.

A 'my day, my way plan' was developed 26 October 2014 but lacked detail to link and use the interRAI assessment information or provide specific guidance in how behaviours should be best managed. This plan was developed ahead of timeframes as required by Bupa policy.

Care provided in response to [Mr A's] fall

There is no progress record for the afternoon of 24 October 2014 when the incident occurred or associated care manager report. An incident report was retrospectively completed by [HCA E] and a progress note also retrospectively completed by [RN D] approximately 24 hours following the incident. The report completed by [HCA E] makes mention that [RN D] who was on duty at the time of the incident was notified of the incident. This is the same registered nurse that contributed to the late completion of the incident form and noted [Mr A] was on the doctor's list (to be seen when the doctor next visits).

Notification to family was recorded as occurring around the same time [Mrs A] had raised her concern about injuries her husband had sustained. Bruising had been noted by [HCA E] on the morning following the injury but had not been reported to the family. Upon [Mrs A] raising concern, staff had the on-call medical service (a nurse practitioner) attend [Mr A]. The nurse practitioner, [RN G] ordered neurological observations which were partially undertaken (as [Mr A's] challenging behaviour impacted on the ability to undertake them). The nurse practitioner also suggested a cold compression of the bruising but there is no record of this having been applied or tried.

The incident should have been reported at the time it occurred. [RN D] should have completed and documented an assessment. In my opinion given the incident

[3] One staff member solely responsible for the resident ensuring someone is with them (or observing them) at all times.

[4] Note the discharge summary from DHB2 included stating the patient still required a 24 hour watch (ie. A one-to-one special) throughout the admission. The interRAI assessment from the NASC also stated as ongoing issues assistance by two people for activities of daily life requiring 24/7 supervision healthcare assistant watch.

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report (retrospectively completed) stated 'smacks his head on concrete wall' and [Mr A's] current neurological history and behavioural symptoms, a medical assessment was warranted as soon as practicable following the event. The family should have also been notified as early as possible. Neurological observations ordered were important to complete or in the event were unable to be completed that there was agreement by the person that ordered them to discontinue them.

In my experience, staff take falls and head injuries seriously and follow policies closely.

<u>Who was responsible for completing the incident report following the fall</u>?
The BUPA incident reporting policy requires documentation as soon as possible following an event that includes documenting the sequence of how events occurred. The policy isn't explicit about who completes the form but it is implicit that it is the person that witnesses or notices the consequences of an event. The policy is explicit that all forms must be countersigned by the duty or shift leader who checks the accuracy of the information supplied; and that any witnesses to the event must sign the form.

In the fall that occurred on 24 October 2014, the HCA should have completed the form and the registered nurse in charge countersign the form. If the registered nurse completed the form the HCA should have signed as a witness.

It is usual process that incident forms are completed by the staff member most proximal to the event.

<u>The individuals responsible for monitoring [Mr A] after his fall</u>.
Registered nursing staff were responsible for monitoring [Mr A] following his fall. The Bupa Neurological Observations policy allows for HCAs who have been trained and are competent to complete neurological observations to complete them but need to report any concerns to a registered nurse without delay. Following suspicion and confirmation of a head injury there is sporadic reporting in progress notes by registered nurses and enrolled nurses of either having completed or attempted to complete neurological observations. There are no references by HCA staff in progress notes to completing neurological observations.

<u>Whether the monitoring of [Mr A] following his fall was appropriate</u>
Monitoring following [Mr A's] fall was not appropriate. Monitoring following the fall did not occur for approximately 24 hours following the fall (and should have occurred). The Bupa Neurological Observations policy requires neurological observations to be commenced upon an actual or suspected knock to the head in a fall (or at the request of a general practitioner).

Given the nature of the injury was not known at the time of the assessment by the nurse practitioner (some 24 hours following the fall) it was appropriate that neurological observations were ordered.

Where behavioural symptoms prevent completion of neurological observation, this should have been documented.

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Staff's response to [Mr A's] agitation

Progress records and the incomplete behaviour monitoring chart information provides little information of techniques actually used to de-escalate [Mr A's] challenging behaviour. Not all techniques suggested in the interRAI assessment for managing [Mr A's] challenging behaviour were transferred to care planning information (which could have been valuable for staff).

There was some consideration that increasing agitation may be related to delirium secondary to an infection which was ruled out. In staff written responses to the investigation, one registered nurse, [HCA E] also stated they considered pain but also ruled this out, although this is not otherwise documented (other than in material provided with the written statement).

It appears responses to incidents were managed by formalising the one-to-one special.

Education records were provided for two staff, ([RN D] and [HCA E]). However, from statements made by staff it is apparent that [HCA E] felt he did not have the necessary skill sets to manage a person with such challenging behaviour. There are multiple progress record entries and incident report entries which suggest that [Mr A's] needs were beyond the facility's ability to meet them. For example:

- 21 October 2014 progress notes — requiring four staff to do cares
- 24 October 2014 disassembling sink pipes to the hand basin as reported in progress notes and an incident report
- 24 October 2014 additional comments in an incident report by [RN C], the clinical manager 'increase staff monitoring really needed but DSC (NASC) reassessment may be necessary as we tried to accommodate him even though he didn't fit dementia criteria'
- 27 October 2014 (0640) incident report includes 'punched staff'
- 27 October 2014 (1530) incident report includes 'resident punched me on the back … The impact of the punch was so strong that it gave me headache and backache'
- 27 October 2014 (1900) incident report includes 'resident scratch me on my right upper arm and he was trying to bite me on the shoulder'
- 27 October 2014 (nocte) progress report 'it took four staff to control his behaviour'

Care manager reporting, incident reporting and progress note records includes instances where there is inconsistent information being escalated (from HCA to RN to care manager) which could have limited decision making by staff in charge or on-call. This is particularly evident for the fall suffered by [Mr A]. However, there are other examples:

- Progress report dated 28 October, 0600 hours, 'hitting and biting staff'. There is no corresponding incident report.
- Incident report 24 October, 1720 hours, agitated, broke glasses, put lens in mouth, hard to remove. There is no progress report written for this shift and no pm care manager report in respect of [Mr A].

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There was no documentation which indicated the registered nurse in charge on 26 October 2014 determined an urgent mental health or medical assessment was required in response to escalating agitation which could have been related to multiple causes (e.g. infection, head injury, sub-therapeutic levels of medications, tiredness, inexperienced staff management, pain etc.).

In summary, the response to escalating behaviour by staff was inadequate up until 28 October 2014.

The care provided to [Mr A] on 25 October 2014, until the time of his discharge
Documentation of care provided and accounts by [Mrs A] and other staff indicate care provided didn't meet standards expected of a psychogeriatric service.

A one-to-one special was in place during most of the admission and more formally documented from 27 October. Some senior staff and management statements suggest a one-to-one special was in place for some prior shifts including the 25 October afternoon shift.

Progress records indicate that bruising was noticed on 25 October 2014 in the morning shift and that [Mr A] was agitated and refusing meals. The behavioural monitoring chart scores [Mr A] as being confrontational but does not record how this behaviour was managed or de-escalated. There is an incident form completed by a registered nurse that records finding bruising at 0800 hours on the 25 October 2014 with an assessment completed and pain relief provided. No family notification or doctor notification occurred at that time. The neurological observations policy indicates that as a suspected fall was the cause of a head injury (bruising to left eye) that observations should have been commenced at that point, and consideration of the need for a medical assessment.

From the account provided by [Mrs A] and of other staff who provided assistance to [Mr A] following [Mrs A's] complaint, [Mr A] had not been appropriately cared for during the morning shift despite his challenging behaviour which would have made cares more difficult.

Following the complaint by [Mrs A], an assessment was undertaken by the on-call medical service (nurse practitioner), neurological observations were partially completed and a formal one-to-one special was documented. Staff report being able to complete personal cares and return [Mr A] to a dignified state.

[Mr A's] needs continued to escalate over the coming days and staff were unable to manage his behaviour appropriately.

Upon notification to [DHB2] on 28 October 2014 of concerns, [DHB2] responded that day and arrangements were made to transfer [Mr A] the following day back to [DHB2].

The documentation of the care provided to [Mr A]
A significant number of deficiencies are noted in documentation of care reviewed including:

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— some care manager reports not dated and did not all include handover information specific to [Mr A] (as per policy requiring Care Home Managers Reporting) (specifically there is no inclusion of [Mr A] for the pm shift 23 October 2014, pm shift 24 October 2014, or am shift 25 October 2014)
— one incident report was not completed at the time of the incident
— behaviour monitoring form was incomplete (particularly page two which requires a description of the behaviour and actions taken to de-escalate behaviour)
— neurological observation records were incomplete (and didn't record where they had not been undertaken due to behavioural symptoms)
— there were some occasions where medication administration records indicate medication had been administered but had not been administered. This is significant not only in terms of process but the fact that omission of administration of medicines were a likely major contributing factor to escalating behaviour
— three progress note entries were missing (22 October 2014 (am), 23 October 2014 (am), 24 October 2014 (pm) — retrospective entry by RN but no entry by the HCA for this shift)
— some progress notes were not dated and many not signed properly
— progress records did not follow the format required by the progress notes policy
— the running record of incidents was incomplete
— referrals to [the NASC] and mental health team were not documented in progress records (and were found in emails)
— the family communication form includes retrospective entries
— two care manager reports had been retrospectively altered as two versions were found within the information provided for review.

As mentioned previously, admission assessment information and care planning were undertaken in accordance with Bupa policy (but lacked some necessary detail such as the fact [Mr A] needed to mobilise with a gutter frame and all strategies available to staff which could be used to de-escalate challenging behaviour as written in the interRAI assessment report).

Training and induction/orientation provided to staff, in particular, to [HCA E]

Training records provided for [HCA E] included attendance at in-service training sessions during 2014 covering abuse and neglect, accident incident reporting and disclosure, behaviours that challenge, cultural awareness/Maori health, dementia, emergency procedures, falls prevention and management, fire safety and fire drill, health and safety and security, infection control (precautions), restraint, and wound management. [HCA E] had completed NZQA Health, Disability and Aged Support (foundation skills, level 2) training on 4 September 2014 and a limited credit programme in Community Support Services (residential) on 12 May 2015.

Completion of the above training and qualifications is consistent with the requirements of the ARHSS agreement and should have provided [HCA E] with sufficient skills to manage dementia residents who have challenging behaviour. Orientation records for [HCA E] are also recorded as being complete.

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Other training records provided included those for [RN D], a registered nurse, which included in-service training sessions during 2014 covering delirium, fire safety and fire drill, medication management and administration, and pain assessment and management. NZQA qualification included competency in unit standards in dementia care, and other externally completed courses included first aid and CPR, code of conduct workshop, medication updates, delirium study day, and wound management. These records indicate [RN D] had completed training necessary for maintaining skill sets.

[Training] completion records between 1 September 2014 and 19 June 2015 were also provided for review which showed 33 staff having completed various qualifications specific to aged residential care including dementia care. This suggests there is a high commitment from Bupa to support staff to meet minimum skill requirements.

The staff to client ratio at [the private hospital] at the time of [Mr A's] stay

The number of clients at [the private hospital] throughout [Mr A's] stay is not documented in information provided for review in order to determine staff to client ratios. However, the following observations can be made:

— the original rosters provided are extremely difficult to decipher and payroll records and staff allocation records would better provide evidence of who worked and didn't work for various shifts
— additional staffing to cover one-to-one specials is evident for the period 27–29 October 2014 but not for the period prior
— there are gaps in the roster stating 'no cover'
— the care manager reports include instances of short staffing ('care staff finished cares late and notes not done' for 14 residents on pm shift of 22 October; 'could not find a replacement' for 23 October am shift; 'five staff on floor' pm shift 23 October, 'very busy shift … if any incomplete task please excuse us', 'only six staff working on the floor' am shift 25 October, '2 HCA and 1 RN short' and 'very stressful shift' pm shift 25 October)
— there were instances where staff were doing longer than usual shifts.

These factors suggest staffing was very lean.

Bupa's policies and procedures

The following policies were reviewed:

— Access to services policy (see comments elsewhere in this report)
— Behaviours that challenge: this policy sets out education requirements, causes of behavioural symptoms, prevention, response, process for managing outbursts, standards of documentation, notifications and seeking expert advice. This policy was only partially followed in the care of [Mr A]. The biggest errors of omission in implementation of the policy relate to monitoring and seeking expert advice.
— Admission-nursing assessment (see comments elsewhere in this report)
— Care planning (see comments elsewhere in this report)

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- Incident reporting: Of note, there is nowhere on the incident forms to record the date on which the form is being completed. There is an assumption that the form is being completed at the time of the incident. (See also comments elsewhere in this report).
- Category one incidents[5]: Incidents in relation to [Mr A] resulting in staff injury meet category one requirements but were not managed as category one incidents. This requires notifying the care home manager (including after hours) and senior nurse on duty.
- Progress notes (see comments elsewhere in this report)
- Care home manager reports: requires reporting concerns about residents including unusual events. Note that the forms have a space for signing and timing of records for each shift but doesn't have a space for the date and so some reports provided were undated.
- Neurological observations (see comments elsewhere in this report).

In correspondence from Bupa it is noted there is no policy for providing one-to-one specials. The HCA who was disciplined raised this point as he stated he was unaware of the extent of his responsibilities when working in this capacity.

In general, Bupa policies and procedures would be considered by my peers to be of a high standard.

Bupa's response to these incidents

There were a total of eleven incidents (documented on fourteen incident reports) and an additional incident documented only in progress notes that related to [Mr A]. Of these, there are references to six injuries sustained by [Mr A] and seven staff assaults. There is also one non-injury related report and two that include significant environmental damage. This is a very high number of incidents which indicates each incident needs to be treated not just individually but collectively to identify trends and issues which require resolution. In addition, the general practitioner who was managing [Mr A] including his medication regime should have had visibility of all incidents to help inform her onward management of [Mr A's] challenging and escalating behaviour.

Several incident forms noted increased staff monitoring as a requirement but this was not associated with increased documentation of monitoring of behaviour as would have been expected on the behaviour monitoring log.

Some incident forms were incomplete (e.g. no indication of whether the manager was informed, doctor contacted). Most forms did not have a manager comment, however this would not be uncommon if the quality review had been completed by the clinical manager and the manager comment was yet to follow for that month. The manager's comments on staff incident reports were for staff to keep their distance, and have more staff mobilise the resident as part of manual handling. These comments do not adequately address the issue that [Mr A's]

[5] Defined in the policy as incidents that are significant and serious. Criteria that qualifies are outlined in the policy. One criterion includes significant behaviour incident where behaviour significantly injures another or jeopardises the safety of self or others.

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needs were beyond those that the facility could reasonably and safely provide whilst keeping staff safe.

Notification of incidents were generally made to the son and not the wife when next of kin notification was documented as being to the wife.

The appropriateness of Bupa's internal investigation and changes implemented by Bupa as a result of the incidents

The complaint made by [Mrs A] was taken seriously and resulted in a letter being written to her by way of explanation following an internal investigation. From the information reviewed, staff were asked to write statements and two staff were specifically interviewed.

As a result of the investigation it was acknowledged that there were issues in the delivery of care and that corrective actions were put in place. This included one staff member being sanctioned under a disciplinary process. The staff member identified by [the private hospital] as having breached its code of conduct was not suspended until 31 October 2014. It would be usual that the employment agreement would allow for suspension of the staff member (on full salary pending an investigation) effective immediately in the event of serious misconduct that poses a risk to the health and safety of others[6]. In this case there were grounds for considering this as serious misconduct requiring investigation and suspension as there was an unreported serious injury of a resident that through lack of appropriate onward action endangered the resident's health and safety, and in addition the resident was found neglected (as described in staff statements), and the HCA asleep (or resting).

I do not think the investigation was completed thoroughly enough as some of the root causes to issues were not identified and therefore this has limited appropriate onward actions to prevent a similar occurrence. Of note, the investigation in taking a narrow scope, did not appear to have considered wider issues or the conduct of the registered nursing staff who had knowledge of a serious incident and did not report it for over 24 hours, or that registered nursing staff were signing for administration of medications that were not administered, the lack of knowledge as to the appropriate use of as needed medication, the standard of documentation, the fact [the private hospital] state[s] there is no policy for one-to-one watches. This is in addition to simple but important things that required onward corrective actions such as notification of incidents to the family member nominated to receive those notifications; and ensuring residents have their own clothing.

Onward actions following the internal Bupa investigation were documented as a discussion of key learnings with staff, toolbox (close supervision and team work information) completion by staff and the suspension and disciplinary process of one HCA staff member.

[6] https://employment.govt.nz/resolving-problems/steps-to-resolve/disciplinary-action/suspension/

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There is also a follow-up letter from the national quality assurance coordinator to the HDC which notes changes to practice in addition to [the private hospital's] actions stated above as including a management decision not to accept severely brain injured residents to a psychogeriatric unit.

It can be concluded that the standard of the investigation, irrespective of documentation provided for review has been insufficient to provide confidence that all significant issues were identified and appropriately dealt with. In my experience, the conduct of the registered nurse who had knowledge of a serious incident and did not report it and hand this information on to the next shift would represent gross misconduct and would have been a significant part of the investigation.

Other comments
It is of serious concern, that some care manager reports have been amended by [the private hospital] as HDC has two copies of the same documentation provided at different times which show amendments.

The appropriateness of the care provided by [HCA E] to [Mr A].

[HCA E's] care of [Mr A] on 24 and 25 October 2014
From documents available for review, [HCA E] did not provide care consistent with the admission assessment care plan or care summary (undated) or as expected by a HCA (as detailed in the HCA position description) irrespective of any documented instructions. He was responsible for [Mr A] in a one-to-one capacity for at least part of the shifts he worked and did not provide care of an acceptable standard. He did not seek advice or assistance from senior staff other than reporting the head injury to a registered nurse which was not documented or handed over.

His documentation
There is one short progress note record written by [HCA E] on the morning of 25 October 2014 which contains some relevant information. There is no progress record written for the shift worked on 24 October. It would be usual that where a resident is receiving one-to-one care that progress is reported for each shift.

The behaviour monitoring chart was inadequately completed. It would be usual that where a resident is requiring one-to-one care to maintain their safety that the behavioural monitoring chart would be highly detailed for periods of agitation.

There is an incident record completed for the injury incurred on 24 October but by his own admission this was completed and put in the notes the following day. It would be usual that an incident record is completed at the earliest opportunity following an event and that this is also recorded in the progress notes and handed over to on-coming staff (consistent with Bupa policy).

Other comments
The disciplinary meeting record includes information that [HCA E] was unsure of his responsibilities when working one-to-one with a resident and that he was only

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working one-to-one with [Mr A] for part of one shift. He attributed his neglect of [Mr A] as relating to his lack of knowledge, yet he was a qualified HCA who had worked at the facility for several months and had completed an orientation.

4. The appropriateness of the care provided by [RN D] to [Mr A].

By accounts as recorded, [RN D] was notified of the incident where [Mr A] had a fall resulting in a head injury. [RN D] states in the incident report completed some 24 hours after the incident that a dressing was applied and [Mr A] refused observations to be taken and that the doctor was not contacted but [Mr A] was put onto the list to be seen by the doctor for the next routine visit. The accuracy of some of this information is questionable given progress records from other staff and their written statements do not report a dressing being in place.

The progress record written the following day by [RN D] as a late entry for the incident, is generally consistent with the incident report, however records the head injury as a graze to the head following a fall which suggests a relatively minor injury.

The assessment and management of this incident by [RN D] was insufficient. It would be usual practice that upon notification of the injury, [RN D] would complete and document his assessment, put onward actions in place (i.e. neurological observations), contribute to the completion or review of the incident report, request a medical assessment from the on-call medical service, notify the next of kin and ensure documented and verbal handover to on-coming staff occurred. If he was not the most senior nurse working, he should have also notified this incident to the nurse in-charge. As a registered nurse, he should be aware of the increased risk to a person with an existing head injury receiving any further head injury so would treat even a minor injury as significant.

5. The appropriateness of the care provided by [RN C] to [Mr A].

As the clinical manager, responsibilities include providing leadership and clinical supervision to clinical and care staff, active involvement in quality management, monitoring the provision of clinical care, oversight of clinical records and ensuring a safe environment.

In his statement, [RN C] noted acceptance of the referral on the basis on information supplied by [the NASC] which he considered understated [Mr A's] needs and that in discussion with the facility manager, a request for a re-assessment and transfer to a brain injury unit was made on 23 October 2014.

[RN C] didn't formally put a one-to-one special in place at the commencement of the admission or a plan for escalating behaviour (to give staff more guidance and agree with [DHB2] and NASC the process for managing any issues particularly over the upcoming long weekend). He didn't direct the use of the mental health on-call service or adequately set expectations for staff of their responsibilities.

His review of incident reports suggested he was aware the level of need exceeded the facility's ability to provide the care but did not treat this with sufficient

HDC

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urgency. It is possible this was partly related to him not being on shift during the full weekend, however reviews of incident reports were signed by him on 21 October, 24 October, 25 October and 28 October.

He notes in his written response that he personally assisted with mobilizing [Mr A] and arranged physiotherapy for him which was beneficial.

There are instances of retrospective record entries (both recorded as retrospective and some without) that were completed by [RN C].

6. The appropriateness of the care provided by [RN B] to [Mr A].

As the facility manager, responsibilities include ensuring every resident receives optimal care and support within the facility.

[RN B] maintained communication with [the NASC]. Although initial communication on 23 October 2014 was misleading as to how [Mr A] was progressing and how well the facility was managing, [RN B] provided good support to [Mrs A] as part of the admission process and responded appropriately at the time the complaint was made on 25 October 2014 to get a medical assessment and direct staff. She requested an urgent re-assessment on 28 October 2014.

Incident forms were signed by [RN B] on 22 October, 25 October, 26 October, 27 October, 28 October indicating she had reviewed and had knowledge of each incident. Until notification occurred on 28 October to [DHB2] of an inability to safely provide care to [Mr A], her response to such a high number of serious incidents is inconsistent with expectations as set out in policies and how in my experience other facility managers would have responded.

[RN B] was ultimately responsible for accepting the admission, for which her facility was ill-equipped to provide the level of care required.

7. If you have any comments or concerns about the care by any other individuals who cared for [Mr A], please outline these.

In addition to information provided above which indicates concerns related to [the NASC] referral process and Bupa employees [RN C], [RN B], [RN D] and [HCA E] there are general concerns noted below.

In general, the standard of some care related documentation does not meet accepted standards as:

— neurological observations were not completed by staff as indicated or ordered
— the behavioural monitoring form was not completed satisfactorily for episodes of aggression
— medications were recorded as administered on medication records but progress records indicate they were not administered
— progress reporting was incomplete

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— care manager reports did not include [Mr A] (and should have in accordance with the relevant policy)."

Further advice 7 August 2016

"I have reviewed the additional information provided by BUPA in response to the advice provided to HDC in the respect of the above case.

Additional information comprised:

— Letter dated 22 April 2016 from [a] Barrister
— Letter dated 21 April 2016 from [the] Acting Managing Director and Global Chief Nurse, Bupa
— Letter dated 21 April 2016 from [RN B], Care Home Manager, [the private hospital], Bupa Care Services
— Letter dated 21 April 2016 from [RN C], Clinical Manager, [the private hospital], Bupa Care Services
— Letter no date, [RN D], registered nurse.

Each response has been read and any concerns raised matched back to the source documents provided for the review. Comments are made in respect of any concerns raised below. In addition, the original advice provided to HDC has been updated (as tracked changes) to show how my opinion has differed in light of the responses received.

Letter — [barrister]

[The barrister] notes a difference in opinion between myself and RN Carey and that this demonstrates whether an urgent referral was required was not straight forward. I agree that this case was not straight forward and as such there may be differing expert opinions. In undertaking the review of information provided, the reviewer does not have the benefit of interviewing staff or observing the environment in which the care was delivered.

[The barrister] also refers to [Dr I] providing assent for the admission to [the private hospital]. The note to which he refers is inadequate to interpret this as endorsement for the admission. Additionally if it could be considered in this light, it would also be in the context of needing a one on one watch.

Letter — [Managing director]

Appropriateness of the referral

[The managing director] stated my assertion that 'management of symptoms as described in the referral assessment would be nearing or exceeding the maximum capability of a psychogeriatric service and careful planning would be required if [the private hospital] was to accept the referral' was incorrect on the basis that noisy challenging behaviours are typically demonstrated in clients of psychogeriatric services. I do not disagree with [the managing director] that residents of psychogeriatric facilities have challenging behavioural symptoms. However, I stand by the statement I have made because the referral information included that [Mr A]

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was mobilising with the assistance of two people, needed two people to assist with activities of daily life, was requiring 24/7 supervision by a health care assistant watch, and this would require careful planning by [the private hospital] if they were to accept this referral. It is not typical for psychogeriatric services to have health care assistants providing watches for 24/7 supervision.

It is also not typical that a resident would be receiving the amount of medication that this man was receiving as noted by [Dr I] in the progress note dated 15 October 2014 that [Mr A] had both a security member and healthcare assistant present with him and states:

> 'requiring significant amounts of PRN [as needed] benzodiazepines on top of his regular diazepam dose' and
>
> 'receiving on average 6–8 mg of additional diazepam of top of his usual dose' and
>
> 'in the last three days he has been requiring intramuscular lorazepam when they have been unable to get medication. I note he is also on a substantial dose of quetiapine.'

I have amended the statement referenced by [the managing director] to provide clarity.

Support from [DHB2] once admitted to [the private hospital]
[The managing director] noted that it is unlikely that the Crisis Assessment Team would have been likely to see [Mr A]. However, irrespective of how likely this would have been, no attempts were made to engage with this service. I also note on [the NASC] information that Mental Health Services for Older People would be monitoring [Mr A] whilst in [the private hospital], yet no arrangements were made for this follow-up at the time of discharge (as per the discharge summary). Note that being under the Mental Health Act is not a prerequisite for receiving services from the Crisis Assessment Team.

[The managing director] points out that getting support from a district health board on a long weekend as being impractical. Therefore this makes it even more important to have a plan in place for the safe and appropriate management should the resident's condition change or prove to be beyond their capability.

[The managing director] points out there was nothing they were aware of that would have necessitated an urgent referral on 23 October. The point I was making was that the information on the referral under stated [Mr A's] needs and as such, the referral would not have been treated with any urgency. I have amended this reference to provide clarification.

Insufficient examples to support opinion
[The managing director] disagrees with some details in the report due to insufficient detail (except for the reference to the failure to document the fall on 24 October 2014 and sequelae of events that followed). Additional information has been added to the report in response to provide further clarification.

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Examples of progress records and incident report entries which suggests [Mr A's] needs were beyond the facility's ability to meet them have been added to the report.

It is clear that Bupa has considered the statement as accusing them of not taking action quickly enough in response to staff assaults. I have removed the sentence about red flags as there is sufficient other content in the report about the assaults.

[The managing director] seeks clarification about neurological observations. An addition has been made to my report.

[The managing director] was unclear as to the reference to documentation of staffing education records. I have amended this to clarify the point.

Need for RN investigation
I disagree with the statement by [the managing director] that the reference to inclusion of the RN in the investigation was misconceived.

Rationale for not providing a watch
Note [the managing director] makes reference that there was no need for one-to-one on night duty as [Mr A] was generally sleeping. Progress notes indicate this was not the case.

Other points of clarification
[The managing director] was unsure why I had used the word formal arrangement for one to one special requirements. I have amended the report to include specifically rostering one to one staff.

Comment is made by [the managing director] that alteration of records are unfounded. I am not referring to late entries in progress notes but the changes in records provided to HDC at different times that indicates records have been amended. For example in amending the care manager record it provides the impression that information was handed over which in fact wasn't handed over. I have amended the wording slightly so that it is clear I am not commenting on late entries to progress notes (which is a separate issue).

[The managing director] states she was unaware of other incomplete progress notes. I have therefore stated the dates and times of missing progress records.

My reference to care manager records that exclude [Mr A] are now noted in my report given [the managing director] states there were references in care manager records for each day. This is true, except for the fact references should have been made for each shift.

[The managing director] registered her concern as to my understanding of the psychogeriatric environment which meant I had suggested this admission was not appropriate. This was not a routine case. I have added additional commentary to ensure this point is obvious. I am very familiar with the psychogeriatric environment and can provide additional information to HDC of my knowledge of psychogeriatric services if requested.

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Human resources issue
[The managing director] suggests no grounds for suspension. I have amended this paragraph as in my opinion there were grounds for suspension.

Letter — [RN B]

Points 12 and 15 of [RN B]'s] letter have been addressed based on a similar comment by [the managing director].

Point 29 suggests a lack of clarity in my report. I have amended my report to include that it was not only the need for a special in hospital but the patient's history which was also important.

Point 36 states [Mr A] had a watch when his family was not present. This information is inconsistent with [the managing director] which states that in addition to not having a watch when family were present that there was no night watch. There is insufficient documented evidence to know whether this statement is correct. I have added to the report to show where my assertion comes from in respect of a one-to-one special.

Letter — [RN C]

Information has been used from this letter to support consideration that [Mr A's] needs were nearing or exceeding the ability of the facility to care for him.

Clarification has been made as to the number of incidents in my report.

Other comments made by [RN C] have been addressed in changes made in respect of letters from and [RN B] and [the managing director].

Letter [RN D]

[RN D's] response shows a lack of insight into the management of the fall. The nurse practitioner's actions are many hours subsequent to the fall so the onward actions required are different from the assessment and response required at the time of the fall.

Although [RN D] mentions he thought he had handed over information to onward staff, this is not born out in other documentation and staff statements.

I note [RN D] also makes reference to the facility being short staffed as a rationale for incomplete documentation.

Thank you for sending me back the notes so I could review them alongside the response letters. Please find attached with this letter, revisions which aims to provide clarifications sought. It is pleasing to see this case has been taken seriously by Bupa with a number of changes having been taken or are underway to improve services.

Please do not hesitate to contact me should you need anything further."

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