Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 21HDC01877)

Introduction

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

2. The Commissioner received a complaint from Mr B about the care provided to his mother, Mrs A, by Oceania Care Company Limited (trading as Elmswood Care Centre (Elmswood)).

3. The following issues were identified for investigation:

- *Whether Oceania Care Company Limited (trading as Elmswood Care Centre) provided Mrs A with an appropriate standard of care.*
- *Whether RN C provided Mrs A with an appropriate standard of care.*

Names have been removed to protect privacy (except Oceania Care Company Ltd, Elmswood Care Centre and the advisor). Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

4. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr B	Complainant
Registered Nurse (RN) C	Provider/registered nurse
Oceania Care Company Limited	Provider

5. Further information was received from Health New Zealand|Te Whatu Ora (Health NZ).

6. In-house clinical advice was obtained from Nurse Advisor (Aged Care) RN Jane Ferreira (Appendix A).

Background

7. Elmswood is an Oceania Healthcare Limited facility that can provide care for up to 38 residents requiring dementia level of care.

8. Mrs A (aged in her seventies at the time of the events) had resided at Elmswood since being assessed as requiring dementia-level care. Mrs A's medical history included dementia, BPSD[1] in the form of aggression and agitation during cares, diabetes, congestive heart failure,[2] hypertension,[3] low mood, and anxiety. Mrs A passed away following her admission to Mental Health Services for Older People (MHSOP).[4]

9. This report concerns the care Mrs A received at Elmswood between Month1[5] and Month13, in particular relating to care delivery, communication, recognition of Mrs A's decline, falls management, monitoring, and a lack of escalation of care.

Mrs A's care plans/interRAI/advance directive

10. An interRAI assessment[6] was completed by staff at Elmswood on 9 Month2 after Mrs A was moved to the facility on 18 Month1 for dementia-level care. Mrs A was recorded as needing assistance with activities of daily living, bowel management, and support with mood and behaviour. She was noted as being anxious and physically and verbally aggressive to other residents and to staff when given her medication and assisted with cares. Her behaviour care plan[7] set out that staff were to give Mrs A space before assisting her with cares along with redirection to manage her if she was aggressive, partnered with PRN[8] medications. When unsettled at night, staff were to ensure that her room was warm and to offer warm food and drinks. The interRAI assessment was updated on 1 Month8 to include pain and

[1] Behavioural and psychological symptoms of dementia.
[2] In response to the provisional opinion, Mr B told HDC that he was not aware that his mother had congestive heart failure.
[3] High blood pressure.
[4] MHSOP is based at the public hospital.
[5] Relevant months are referred to as Months 1–13 to protect privacy.
[6] Long-term care facility assessment.
[7] Commenced 26 Month1. Reviewed Month12.
[8] '*Pro re nata*' (PRN), 'when required' or 'as needed'.

falls. The strategies in her communication care plan[9] included encouraging Mrs A to verbalise her thoughts and concerns and encourage her to interact with other residents. It was recorded that Mrs A could be 'upset most of the time, allow her space to vent out feelings and administer medications as required to help her calm down'.

11. A mobility care plan[10] identified Mrs A's falls risk as low but she was noted as being independent. Her footwear was to be checked for a safe fit and her mobility was to be assessed for any changes.

12. Mrs A's pain assessment plan[11] set out that Mrs A had a history of lower back pain. The non-verbal assessment section was completed setting out that staff should be attentive to non-verbal signs of pain such as 'confusion, restlessness, facial grimacing, decreased mobility, moaning, tenseness, refusing to eat, increase [in] pulse, blood pressure (BP), perspiring, flushing or pallor and physical changes such as skin tears [and] pressure injuries' in line with the Abbey pain scale.[12]

13. Mrs A was reviewed by MHSOP on 5 Month3 and it was noted that she had deteriorated since her previous review by MHSOP in Month2 when she was admitted to Elmswood. As Mrs A had been admitted to Elmswood shortly before lockdown, family had been unable to visit her, and in the month following the last review she was described as being 'distressed' and 'distraught'. Clonazepam (PRN medication)[13] drops were prescribed in addition to her regular medications.

14. In response to the provisional opinion, Mr B told HDC that the family were unable to visit Mrs A for a long period due to the COVID-19 lockdown, which resulted in a significant decline in Mrs A's condition. The lockdown occurred shortly after Mrs A was admitted to Elmswood, and there was no opportunity to visit her after she was admitted. Mr B told HDC that this would have been hard for Mrs A as she was always communicative and loved to see her family, and not seeing her family would have contributed to her being distressed and distraught.

15. At a further MHSOP review in Month6, Mrs A was described as still being resistant to cares but staff were able to manage, partly as a result of providing care during the night when Mrs A was sleepy and less resistive. It was noted that a move to psychogeriatric care was not required at this stage as staff felt that they were coping. However, a psychiatrist noted that this might need to change if the dementia unit was at a full capacity.

[9] Completed on 27 Month1. Reviewed on 5 Month8.
[10] Commenced 26 Month1. Reviewed 31 Month10.
[11] Completed on 18 Month1. Reviewed 7 Month8.
[12] The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to articulate their needs clearly, for example, patients with dementia, cognition or communication issues. The scale measures the severity of pain based on six categories: vocalisation, facial expression, change in body language, behavioural change, physiological change, and physical change.
[13] A medication used to prevent and treat anxiety disorders.

16. An advance directive form[14] was completed on 25 Month11 by a nurse practitioner (NP).[15] This set out that Mrs A did not have the capacity to make and communicate informed consent about her own medical and mental health treatment. Her daughter was recorded as her enduring power of attorney (EPOA) for personal care and welfare, and this had been activated. In the event of an acute medical illness, comfort care[16] was elected, and hospitalisation was indicated in the event of a traumatic injury.

Arm injury — 8 Month7

17. On 8 Month7, Mrs A's right arm was injured when she was 'grabbed' by another resident during her cares, and, following this incident, Mrs A started 'banging on the window'. She was redirected but she began to complain of pain in her arm. There is no record of this in the incident register, and no record that Mrs A's family were informed at the time.

18. In response to the provisional opinion, Mr B told HDC that the family were not informed of this incident.

19. Oceania told HDC that it is unclear from eCase records what caused the arm injury (discussed below),[17] but Oceania accepted that no incident report was entered into eCase for the event.

20. Following the incident, Mrs A's arm was assessed by staff, who noted that she had 'good circulation' and was able 'to move her fingers and arms'. No swelling, redness, or bruising was noticed.

21. Mrs A was given Rivotril (clonazepam) 'to [settle] her down', and staff applied an ice pack to her arm. Staff attempted to apply Tubigrip[18] and a compression bandage but Mrs A removed it. From time-to-time Mrs A cried with the pain, and she was given paracetamol.

22. On 9 Month7, Mrs A complained of a sore forearm and a nurse noted mild swelling and a potential bruise on her right forearm. The nurse queried whether Mrs A had hit her arm on the window by accident. No incident report or short-term care plan was put in place following the incident on 8 Month7. A further entry in the progress notes for the evening handover mentioned pain in Mrs A's right forearm and to watch for any changes to her arm. Mrs A was noted to be unsettled and 'crying out loud[ly] and overly anxious about her right hand'. Her arm was observed to be mildly swollen with no bruising. An ice pack was applied, and Mrs A was given Rivotril, paracetamol, and Rescue Remedy, which were noted to have

[14] An advance directive is a statement signed by a person setting out in advance the treatment wanted or not wanted in the event of becoming unwell in the future.
[15] A registered nurse with advanced education, clinical training, and demonstrated competency.
[16] Comfort care was recorded as: 'Keep warm, dry and pain free; Do not transfer to hospital unless absolutely necessary; only give measures that enhance comfort or minimize pain; Subcutaneous lines and injections only if it improves comfort; No x-rays, blood tests or antibiotics unless given for comfort.'
[17] Oceania noted the discrepancy in the nurse practitioner notes and the notes recorded by a healthcare assistant.
[18] A tubular bandage.

had little effect. The progress notes record that Mrs A was 'exaggerating' the pain due to her dementia and getting 'overly anxious about it'.

23. In response to the provisional opinion, Mr B told HDC that it was unbelievable that Mrs A was left in pain and that staff thought she was exaggerating.

24. On the morning of 10 Month7, Mrs A was still in pain and was clutching her right arm, which was observed to be red and hot to touch. She was guided to bed, and she settled a short time later. Mrs A was woken later in the morning and noted to be still in pain, with her arm red and swollen. The Clinical Manager was informed, and staff were advised to take Mrs A to hospital. Mrs A's family were advised, and she was taken to the public hospital,[19] where it was confirmed that she had a right ulnar fracture and mild displacement.

25. In response to the provisional opinion, Mr B queried why the Clinical Manager was only informed two days after the injury. Mr B told HDC that it was the family who took Mrs A to hospital, where it was confirmed that she had a fracture. Mr B said that this was not the care the family expected from Elmswood when the family were paying for Mrs A to be looked after. Mr B told HDC that he would have expected staff to take some initiative, as Mrs A was in pain, and this should have been looked at.

26. A case conference[20] was held with Mrs A's daughter[21] and a nurse on 10 Month7. The notes from the conference indicate that care plans were reviewed and discussed, and an advanced care plan was made, but there is no documentation relating to this. It is recorded that the incident register for the past three months was reviewed (including the recent injury, which is described as a 'bruise' in the conference notes).

27. Mrs A returned to Elmswood together with her family on the evening of 10 Month7. Her right arm was in a cast, and she wore a sling. It is recorded that Mrs A's family were unhappy that they had not been told about the injury to Mrs A's arm and had not been contacted when it had happened initially. It is documented that an apology was provided to Mrs A's family, and they were given a complaint form. They were told that it had been difficult to assess Mrs A as 'crying and unsettled behaviour' was not abnormal for her, and only minimal bruising and swelling had been noted. In addition, on the previous day (9 Month7) she had been assessed as moving her arm freely with 'minimal complaint', although when staff moved her arm for her, she became more unsettled.

28. In response to the provisional opinion, Mr B told HDC that there were several occasions on which Elmswood said that Mrs A's care was discussed with the family but there is no documentation of this, and Mr B said that the family were not advised of an advanced care plan. Mr B said that if an advanced care plan is discussed with family, this should be documented and family advised, and this did not happen.

[19] Operated by Health NZ.
[20] This was documented as a routine six-monthly meeting.
[21] Mrs A's daughter was Mrs A's enduring power of attorney for care and welfare.

29. Oceania told HDC that Mrs A was exhibiting both usual and unusual behaviour following the incident, and there was minimal external bruising to indicate a fracture. Oceania said that if the STOP AND WATCH assessment tool[22] in place at Elmswood at the time had been used, this may have reduced the delay in staff recognising the fracture.

30. Mrs A's medication administration chart shows that she continued to be prescribed pain relief for her injury throughout Month7. Her progress notes record that she continued to be agitated and distressed about the cast on her arm and attempted to remove it on several occasions, and on 16 Month7 she attended the public hospital to have it replaced.

31. A progress note written by a diversional therapist on 19 Month7 indicated that Mrs A was finding it particularly difficult to cope with her injured arm during sundowning,[23] when her agitation increased, and that staff were finding her behaviour severely challenging when providing cares during this time.

32. In response to the provisional opinion, Mr B told HDC that Mrs A should have been moved to a more suitable facility that had the ability to care for her.

MHSOP referral — Month12

33. On 23 Month12 a referral was completed, as staff at Elmswood were continuing to find it difficult to assist Mrs A with her personal cares, and often this required three staff. Strategies such as guiding Mrs A for toileting and showering and offering alternatives to showering were recommended to staff.

34. Oceania told HDC that this assessment was entered into the eCase gallery, but it accepted that progress notes contain no mention of the assessment by MHSOP or of any strategies outlined in the assessment.

35. In response to the provisional opinion, Mr B told HDC that this was a further example of the continued lack of communication from Elmswood, as well as a lack of initiative from staff to care for Mrs A properly.

Unwitnessed fall — 8 Month13

36. On 8 Month13 RN C documented that Mrs A had had an unwitnessed fall and had been found on the floor in the dining room at approximately 9.20pm. Progress notes recorded by healthcare assistants during the days leading up to the fall note that Mrs A had been wandering at night, was resistive to cares, and had swollen feet. Mrs A sustained a large lump to her forehead, and staff took neurological observations[24] at the time and again at 10pm when Mrs A had settled in bed. It was documented that Mrs A's family were to be informed in the morning.

[22] The Stop and Watch early warning tool helps staff to identify and report specific issues.
[23] A state of confusion occurring in the late afternoon and lasting into the night.
[24] Monitoring of a patient's vital signs and level of consciousness.

37. An incident review noted that staff were told to provide constant monitoring and to ensure that there were no hazards (no specific hazards were recorded), and the fall was entered into eCase.

MHSOP review — 9 Month13

38. Mrs A was reviewed by the psychiatrist. It was noted that Mrs A continued to be very resistive to personal cares and had periods where she was very distressed and unable to be comforted. Several psychotropics[25] had been trialled without success, and the addition of sertraline[26] appeared to make Mrs A worse. It was noted that Mrs A was at risk of falls, and that staff were aware that a lot of medication contributed to this in addition to her level of distress and dementia.

39. The psychiatrist's overall impression was that Mrs A probably did require a psychogeriatric level of care, but staff at Elmswood felt that moving her would make her more unsettled and they were keen to continue to try to manage her at Elmswood. Mrs A was to be reviewed by MHSOP in a month's time. Zuclopenthixol[27] was to be trialled to see whether this would help with her aggression and agitation, and staff were asked to monitor her sedation and worsening of mobility and to withhold the medication if necessary.

40. Staff advised Mrs A's family of the psychiatrist's recommendations and request for staff to monitor Mrs A's sedation and mobility, and the potential for Mrs A to require a transfer. No other concerns were documented, and there is no record of whether Mrs A's family were informed of the unwitnessed fall the previous day.

41. Progress notes completed by registered nurses in the days following recorded that Mrs A was 'walking independently' but that both her feet were slightly swollen.

42. In response to the provisional opinion, Mr B told HDC that he was contacted by staff at Elmswood and told that a drug was being trialled to help Mrs A. However, he told HDC that he did not understand nor realise the extent or the number of drugs that were being trialled on Mrs A.

43. Mr B told HDC that the family were not aware of the seriousness of the situation. He said that had they known, they would have requested that Mrs A be transferred. Mr B said that he cannot understand why Mrs A was not moved after the psychiatrist advised Elmswood that Mrs A needed a higher level of care. Mr B said that he does not accept Elmswood's reasoning that a transfer would make Mrs A more unsettled as she was already unsettled, and he cannot understand why Mrs A remained at Elmswood and queried whether this was to do with money or because there were no available spaces.

[25] Drugs that affect behaviour, mood, thoughts, or perception.
[26] An antidepressant.
[27] An antipsychotic medication used to reduce symptoms of certain mental health disorders.

44. Mr B also said that Mrs A was admitted to MHSOP while she was waiting for an available room at another facility for dementia-care patients, and family were told by the specialist that Elmswood would not be able to care for Mrs A in a suitable manner.

Unwitnessed fall — 11 Month13

45. On 11 Month13, Mrs A had been sleeping on a lounge chair when she had an unwitnessed fall at approximately 3.25am. A healthcare assistant heard a noise and checked on Mrs A and found her lying face down on the floor. Staff attempted to pick her up with a hoist, but Mrs A became aggressive, so staff assisted her to stand up manually.

46. Staff monitored Mrs A's neurological observations, completed a head-to-foot assessment, noted a bruise on her forehead, and entered the incident into eCase. Mrs A was noted to respond to light and to speech and to walk without difficulty. A pain chart documented that Mrs A was provided with pain relief along with her regular medications. Her lower legs were noted to be swollen and mildly red. Mrs A's daughter was informed of the fall, and Mrs A was booked for a GP review the following day. The progress notes document that staff were to encourage Mrs A to go to bed during the night, conduct regular monitoring, and ensure that she was wearing appropriate footwear.

47. During the day, healthcare assistants attempted to help with Mrs A's hygiene cares, but she refused to remove her clothing. She was noted to be lethargic and to require assistance to eat her lunch. Her vital signs were stable. RN C told HDC that when she started work at 3pm, she was made aware of Mrs A's condition at a verbal handover.

48. At 3.30pm, staff were unable to take Mrs A's neurological observations as she was too restless, but at 5pm her observations were recorded as normal. Mrs A refused cares and refused to go to bed. She settled on a chair in the lounge.

49. RN C told HDC that she provided pain relief as Mrs A was complaining of pain in her forehead.

50. A nurse practitioner[28] reviewed Mrs A on 12 Month13. The progress notes from the review record that a registered nurse had reported two falls in the last few evenings, and that Mrs A preferred to sleep in a lounge chair and had been wandering. The nurse practitioner considered that the falls were behaviour related and she trialled furosemide (due to oedema).[29] It was recorded that a voicemail message was left with Mrs A's daughter advising her of the review. Mrs A was also noted to have 'pedal edema[30] with pitting to [her] mid shin'.

51. A FRAT[31] history included the falls on 8 and 11 Month13, but the falls assessment was noted to be 'LOW' risk, with a risk score of 11/20.

[28] Employed by Oceania at the time of these events.
[29] A medication used to treat fluid retention and high blood pressure.
[30] Swollen ankles and/or feet due to accumulation of fluid.
[31] Falls risk assessment tool.

52. In response to the provisional opinion, Mr B told HDC that he believes that the falls were the result of the medication and were not behaviour related, and he queried how Mrs A could have been assessed as a 'LOW' risk for falls when she had had several recent falls.

Care on 13–14 Month13

53. On 13 Month13, a healthcare assistant documented that Mrs A completed her personal cares and ate breakfast and morning tea. It was noted that Mrs A was settled in the mid-morning and that a 'mild weeping of clear fluid' from the scratches on her lower leg was cleaned with Betadine.[32] Her legs were still noted to be red and swollen. She had been wandering and unsettled at lunch time and refused her main lunch meal but ate pudding. She had afternoon tea and again was noted to be wandering.

54. Oceania told HDC that it is unable to provide any of the wound assessment/treatment charts for the skin tear to the right lower leg, and it accepted that this is not up to Oceania standards.

55. The progress notes for the evening shift document that Mrs A was sleepy and asked to go to the bathroom several times but refused to go when staff tried to stand her up.

56. It is recorded that at approximately 5.15am on 14 Month13, Mrs A walked to the resident lounge with assistance as she had been wandering. Mrs A remained in the lounge, and staff tried to sit her up as she was leaning in her chair. She refused to get up and to change her clothes, and she refused to eat or drink.

57. Healthcare assistant (HCA) Ms D said that she had observed Mrs A in the armchair at handover and was informed that the previous shift had been unable to get Mrs A to sit up but that her vital signs had been checked. HCA Ms E attempted to check Mrs A in between providing care to other residents. Ms E noticed bruising on Mrs A's eye and informed the registered nurse, as she considered that Mrs A should not be left like that.

58. During her shift, Ms D unsuccessfully attempted to get Mrs A to sit up and told the registered nurse that Mrs A did not appear to be herself. Ms D said that another healthcare assistant also raised this with RN C, and it was documented that '[b]oth HCA[s] reported to [the] RN on duty[33]'.

59. An entry by RN C at 12.54pm documented that observations were taken at 7am, but there is no recorded entry in the progress notes at 7am.

60. In response to the provisional opinion, Mr B told HDC that he does not believe that staff took their job seriously given his mother's condition, and that no assessment or treatment took place. Mr B said that his mother was clearly unwell as she could not sit up and, given her age and state, a GP or ambulance should have been contacted, and RN C did nothing to assist.

[32] A topical antibacterial solution.
[33] RN C.

RN C's statement

61. RN C[34] told HDC that she had worked as a registered nurse for many years and had looked after dementia, hospital-level, and rest-home-level patients.

62. RN C stated that at 7.15am on 14 Month13 she observed Mrs A in the lounge chair lying on her right-hand side and 'muttering to herself'. RN C said that the night staff had said that they had placed Mrs A in the chair in the lounge rather than in her room so that staff could observe her. RN C said that the night staff did not specifically ask her to monitor Mrs A but, given her schedule, she did this as much as she could anyway. RN C stated that it was the registered nurses' responsibility to document pain issues, medication administered, and neurological observations. RN C recalled that Mrs A's observations taken at 7am were normal and that Mrs A refused to sit up, refused cares, and refused her 8am medication. RN C said that she was unable to obtain Mrs A's pulse or oxygen level measurements as Mrs A was resistant. RN C stated that Mrs A's temperature was recorded as 36.6°C at 10am but she had been unable to take Mrs A's blood pressure or obtain a urine sample as Mrs A had resisted. Throughout the morning, Mrs A continued to refuse to sit up despite attempts by staff. RN C said that she continued to check on Mrs A throughout the morning, but Mrs A's condition remained the same despite efforts to communicate with her. RN C stated that she did notice bruising and redness on Mrs A's right eye, but she thought that this was from Mrs A rubbing it on the chair, and she placed a pillow on the armchair.

63. In response to the provisional opinion, Mr B told HDC that given RN C's previous experience, she should have known how to care for dementia patients, and he is very surprised that RN C could not take Mrs A's vital observations. Mr B does not accept RN C's reasoning that the injury to Mrs A's eye was a result of rubbing it on the chair, and he maintains that this injury was sustained as a result of a previous fall.

64. RN C told HDC that she had been working at Elmswood only since Month12 and was not familiar with Mrs A's habits or behaviour. She therefore relied on the information passed on by the healthcare assistants as to how Mrs A was and what was normal behaviour for her.

65. RN C said that she had intended telephoning Mrs A's family about her concerns, but Mrs A's son, Mr B, arrived at 12.15pm for a visit and noticed that his mother was not well. Mrs A's temperature at that time was recorded as 38.8°C. He requested an ambulance to take his mother to hospital.

66. RN C stated in her initial response to HDC that in addition to Mrs A, she had 29 dementia residents to care for and had to complete three medication rounds and other duties. In a further response to HDC, RN C said that there were 36 residents. There was only one registered nurse and four healthcare assistants during the morning and afternoon shifts, and only three healthcare assistants and no registered nurse during the night shift.

67. RN C told HDC that she was not given proper training. She understood that Oceania had a medication policy, but as this was not available in a printed version, she was unable to read

[34] RN C was a senior registered nurse. RN C told HDC that she no longer works as a nurse.

or study it. She also stated that Elmswood had faulty equipment, namely the iPad and computer. RN C told HDC that on reflection, staff should have sling-hoisted Mrs A to her room. A standing hoist would not have been appropriate given that Mrs A was resistant at the time. RN C said that she should have used her own judgement and telephoned the Acting Clinical Leader about her concerns rather than relying on the healthcare assistants.

68. In response to the provisional opinion, RN C reiterated that she had been at Elmswood for less than three weeks and that she was not provided with adequate training and was expected to learn on the job. RN C accepts that she was 'flustered' and overwhelmed with all that was required in caring for 36 residents, all of whom she was unfamiliar with and therefore relied on the healthcare assistants. While RN C considers herself to be a competent nurse, she was working in a new, stressful, and difficult environment with limited training and support and a very busy workload for one registered nurse.

69. While RN C accepts that she did have previous experience with dementia patients, she was not anticipating being the sole nurse on duty and responsible for the nursing care of 36 residents, all of whom had varying health issues and demands. RN C reiterated that she should not have relied on the healthcare assistants and instead should have undertaken her own assessment of Mrs A earlier than she did, and she should have called the Clinical Nurse Leader.

70. RN C told HDC that while she accepts that she should have undertaken an assessment of Mrs A sooner than she did, Mrs A's behaviour during that morning was consistent with her behaviour previously documented in her progress notes, namely wandering at night, sleeping in the lounge, and refusing cares. RN C said that she did check Mrs A every time she went into the wing and, as she was not familiar with Mrs A's usual behaviour, she obtained assurance from the healthcare assistants that this was normal behaviour for Mrs A.

Subsequent events

71. RN C notified the nurse practitioner, who agreed to Mrs A being transferred to hospital, and an ambulance was called.

72. In response to the provisional opinion, Mr B reiterated that he called the ambulance, as opposed to staff.

73. Observations included that Mrs A was 'hot to touch', appeared to be in pain, and was dehydrated, agitated, and unable to communicate with staff. The primary clinical impression was of septic shock. Mrs A was noted to have faeces between her toes. It is documented that staff at Elmswood said that they had found Mrs A like this at the start of the shift at 7am, and they were unsure how long she had been like this. RN C told HDC that she found out that Mrs A had faeces between her toes only later. RN C said that she had not been informed of this at the time, and that the healthcare assistants may have been aware of it, but they had been unable to perform cares because of Mrs A's resistance.

74. Mrs A was admitted to hospital. Her right leg was noted to be swollen and hot with redness, and she had a small skin tear on her shin. The hospital assessment identified a temperature

of 36.4°C,[35] a high heart rate (98bpm), and blood pressure of 130/59mmHg. Mrs A's Glasgow coma scale (GCS) score was recorded as 10.[36] She was diagnosed with cellulitis of the lower right leg with bacteraemia and associated delirium. Mrs A's condition improved following a course of augmentin,[37] but she continued to be resistive to personal cares and she was transferred to MHSOP on 18 Month13.

75. Sadly, Mrs A passed away on 28 Month13. End-stage dementia was listed as the cause of her death along with cellulitis with Streptococcus bacteraemia.[38]

Internal investigation

76. Following a complaint made by Mrs A's family, Oceania conducted an internal investigation into her care and found that on 13 and 14 Month13 the care provided did not meet expected professional standards. Oceania reached the following conclusions:

- The video footage for the morning of 14 Month13 when Mrs A was sitting in the lounge provides ample evidence that staff, including the registered nurse and healthcare assistants, did not offer basic assistance with food and fluids, repositioning, management of Mrs A's pain, or monitoring of her overall health status.
- RN C failed to address clinical issues promptly and discuss these with the family and other health professionals in accordance with policies. The investigation identified that the healthcare assistants failed to follow through with their requests for the registered nurse and did not provide basic cares. The healthcare assistants should have advised the registered nurse that Mrs A was refusing food and fluid, and that should have prompted action by the registered nurse.
- There was a failure to ensure that a reassessment was undertaken when it became clear that Elmswood could no longer provide the level of care Mrs A required as her condition deteriorated.

77. The internal investigation also found that Mrs A's usual behaviours and refusal to allow cares, coupled with her aggressiveness, created a situation where staff were not able to provide the level of care Mrs A required. Despite MHSOP's recommendation that Mrs A might be better suited to a psychogeriatric environment (D6), staff tried to continue to manage her in their environment rather than unsettle her with a move elsewhere. The availability of D6 beds in the region may have encouraged MHSOP to allow this.

78. Staffing ratios were found to be in line with the Age-Related Residential Care service agreement.[39]

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[35] The recorded temperature in the ambulance was 38.7°C.

[36] The Glasgow coma scale is a tool used to measure decreased consciousness. The highest possible GCS is 15, which reflects an individual who is fully alert, aware, and oriented.

[37] An antibiotic.

[38] A bacterial infection.

[39] Oceania told HDC that as per the Age-Related Residential Care Services agreement, in every facility (D17.3) where there are more than 30 residents, at least two care staff members shall be on duty at all times. A registered nurse must be employed or contracted and is responsible for working with staff. Oceania told HDC

79. Recommendations included a formal apology to Mrs A's family, implementation of the STOP AND WATCH tool, and MHSOP reviews of the residents in Elmswood to be acted upon regardless of the facility staff's agreement to retain the resident. The internal investigation found that the staffing at a D3 facility like Elmswood is insufficient to provide the level of care required for more complex residents with dementia.

80. As a result of the complaint, an audit of a sample of files of residents who had had an acute change in condition was completed to ensure that there is evidence of a short-term care plan. An audit of the files of residents with behaviours of concern was also undertaken to ensure that all acute behavioural changes were documented and followed up.

81. The event and the recommendations following the investigation were presented to the Oceania Clinical Governance Committee, and the Oceania Board of Directors was notified.

Investigation — RN C — 25 Month13

82. Oceania conducted an investigation into the care provided by RN C. As part of the investigation, CCTV footage of the lounge was viewed and showed that Mrs A was in her chair between 5am and 12.21pm.[40] The investigation concluded that RN C's account was inconsistent with her actions captured in the CCTV footage, and that RN C had not provided Mrs A with her diabetes medication and had not carried out observations as she had claimed.

83. The investigation concluded that based on the video footage, RN C had neglected to perform basic nursing observations even when told by the healthcare assistant that Mrs A was not her usual self, and RN C had failed to demonstrate an acceptable standard of nursing care.

84. In response to the provisional opinion, RN C told HDC that she had not seen the CCTV footage and has not had the opportunity to comment on it. She maintains that she observed Mrs A frequently during the morning shift and checked on her every time she went into the wing, and that Mrs A was resistant to cares and medication, which is not disputed by the healthcare assistants.

85. RN C told HDC that as the CCTV footage is no longer available, it should not be relied on to make a finding about the care she provided on 14 Month13.

86. Oceania told HDC that RN C's main place of work was within the rest home/hospital wings at another facility, but she was asked to assist with covering Elmswood's dementia unit on occasion. Oceania said that RN C would not have been as familiar with residents in the dementia unit, but she had declined further orientation to Elmswood when offered.

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that at Elmswood, for the 36 dementia clients, the following staff are rostered, which exceeds base requirements: 30 hours of HCA time every morning (4 HCAs), 28 hours every afternoon (3 HCAs), 24 hours of HCA time every night shift (3 HCAs), 8 hours of RN time every morning (1 RN), 8 hours of RN time every afternoon shift (1 RN). There is a Clinical Manager (an RN) on Monday–Friday morning shifts and one RN on call at all times.

[40] HDC requested the CCTV footage from 14 Month13, but Oceania confirmed that the footage could no longer be located.

Elmswood — audit

87. At the time of the surveillance audit conducted by HealthCERT[41] dated 20 Month8, areas of improvement had been identified relating to complaints management, general practitioner three-monthly reviews, and restraint approval.

88. The most recent audit in 2023 identified that improvements had been made to documentation of interRAI and neurological assessments, addressing those areas requiring improvement at the previous audit (2022). Improvements were required in respect of care planning to document the needs of the resident accurately, activation of enduring powers of attorney as required in secure dementia services, and first aid certification of staff to cover the roster.

Responses to provisional opinion

Mr B

89. Mr B was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion, and his comments have been incorporated throughout the report where relevant.

RN C

90. RN C was provided with an opportunity to comment on the provisional opinion, and her comments have been incorporated throughout the report where relevant. In addition, RN C acknowledged that she should have monitored Mrs A more closely and made herself more familiar with Mrs A's needs. RN C said that she is prepared to accept the finding that she breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

91. RN C told HDC that there were systemic and extensive failures at Elmswood in providing care and treatment for Mrs A, which were already a factor prior to her involvement with Mrs A on 14 Month13. RN C believes that these factors need to be taken into consideration in assessing her culpability, particularly given her obligations to the other dementia residents on 14 Month13.

Oceania Care Company Ltd

92. Oceania was provided with an opportunity to comment on the full provisional opinion. Oceania had no comment regarding the report and the recommendations.

Opinion: Oceania Care Company Ltd — breach

93. First, I acknowledge the distress that this event has caused Mrs A's family, and I offer my condolences for their loss. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. In addition, to help determine whether the care

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

provided by Oceania and RN C was appropriate, I have considered clinical advice from RN Jane Ferreira.

Introduction

94. In accordance with the Code, Elmswood had a responsibility to operate the care home in a manner that provided its residents with services of an appropriate standard.

95. I have several concerns about the care provided to Mrs A from Month7 until Month13 relating to clinical oversight, monitoring, and the standard of documentation. In my view, there were deficiencies in the care provided to Mrs A by multiple staff at Elmswood. These were systemic issues for which Elmswood bears responsibility, as outlined below.

Admission to Elmswood

96. RN Ferreira advised that the interRAI assessment was conducted in the appropriate timeframe as set out by the Age-Related Residential Care (ARRC) contract.[42] Admission nursing assessments were completed on 19 Month1, a nursing care plan was completed on 26 Month1, and an interRAI assessment was completed on 9 Month2, which appears to be consistent with contractual requirements.

97. I accept this advice, and I acknowledge that the admission processes were followed correctly at the time when Mrs A was admitted to Elmswood. However, I have concerns about the oversight of Mrs A following her admission to Elmswood, as discussed below.

Behaviour management

98. As noted above, Mrs A had a complex medical history and had transferred to Elmswood for dementia-level care. She was reviewed by MHSOP on 5 Month3, and it was noted that she had deteriorated since her previous review by MHSOP in Month2, following her admission to Elmswood. Mrs A was seen by MHSOP in Month6 and described as still being resistant to cares, but it was noted that staff were able to manage and that a move to psychogeriatric care was not required at that stage. A further review in Month12 indicated that staff at Elmswood were continuing to find it difficult to assist Mrs A with her personal cares and often this required three staff. Strategies such as guiding Mrs A for toileting and showering and offering alternatives to showering were recommended to staff.

99. On 8 Month13 Mrs A had an unwitnessed fall, which I discuss further below. She was reviewed by MHSOP the following day and it was noted that Mrs A probably did require a psychogeriatric level of care, but staff felt that moving her would make her more unsettled and were keen to continue to try to manage her at Elmswood. Staff were asked to monitor her sedation and mobility, but there is no documentation of this, and staff were noted to have been waiting until Mrs A was sleepy and less resistive before undertaking cares.

[42] The Age-Related Residential Care (ARRC) contract (D16.1) states that each potential resident will be assessed using the most clinically appropriate interRAI assessment tool prior to admission. On admission, the resident's health and personal care needs will be assessed to inform an interim care plan, with an interRAI assessment completed within 21 days of admission to the care home.

Opinion

100. RN Ferreria advised that despite the ongoing concerns raised by MHSOP, this was not reflected in Elmswood's clinical records. RN Ferreria stated:

> 'Progress notes describe some carers stepping away when [Mrs A] was distressed, returning later to complete tasks when she was more accepting of assistance, however file information also indicates that personal cares were being delivered at night when [Mrs A] was "sleepy and less resistive". There is no evidence this was an openly agreed, planned, and documented approach to meeting [Mrs A's] needs, and would not be considered as respectful or person-centred care. File information states that at times [Mrs A] required assistance from up to three carers which raises questions regarding placement suitability, and provider responsibilities regarding delivery of person-centred care in a restraint-free environment, in line with Health and Disability Sector Standards.[43]'

101. While strategies (guiding Mrs A for toileting and showering and offering alternatives to showering) were recommended by MHSOP in Month12, it is unclear whether these were reflected in care planning. RN Ferreira advised that accepted practice would be to commence a short-term care plan to outline agreed interventions using an evidence-based, time-bound approach to guide staff actions and reporting responsibilities, to ensure that the best outcomes occurred for Mrs A.

102. At the review, MHSOP also recommended changes to Mrs A's medication and advised staff that she had an increased risk of sedation and fall events while medications were being adjusted. It does not appear that a short-term care plan was commenced to outline risk management strategies or related nursing responsibilities while Mrs A's medications were under review. RN Ferreira advised that given Mrs A's cardiac and diabetic history, it would have been accepted practice to have monitored her nutritional intake, elimination and sleep patterns, weight, and vital signs, as outlined in the Frailty Care Guides for deprescribing and polypharmacy.[44]

103. Elmswood had a Behaviour that Challenges Management Policy (2019) (Appendix B), which provided guidance regarding nursing assessment, monitoring, and care planning responsibilities. The policy also sets out that a 'Behaviour that Challenges assessment and review management plan' should be in place for those residents who have been identified as having behaviour that challenges. This should include triggers, a description of the behaviour, the effects of the behaviour on the resident and others in the environment, the frequency of occurrence, and management interventions.

104. RN Ferreira noted that while the care plan did set out de-escalation strategies and the use of PRN medication, it did not address medication effectiveness, event reporting, or whether there were criteria for escalation to the senior management team. There is limited

[43] NZS 8134:2021, Part 6.
[44] www.hqsc.govt.nz.

discussion of behaviour chart analysis or reporting of these events in the incident management summary form, which would be considered accepted practice.

105. RN Ferreira also stated that it is unclear whether Mrs A's family were advised of the issues raised at the MHSOP review as to the suitability of Mrs A remaining in dementia-level care, which would be considered part of service provider contractual responsibilities and accepted practice in these circumstances.

106. I accept this advice. Short-term care plans should have been in place with agreed interventions and risk assessments following the reviews by MHSOP. I am concerned that there was a lack of person-centred planning to address Mrs A's needs, and that the concerns raised by MHSOP were not discussed with Mrs A's family (and documented), and nor was a management plan in place, as required by the policy discussed above.

Management of arm injury

107. It is documented that on 8 Month7 Mrs A was grabbed by another resident, and that following this, Mrs A banged her hand against the window. Mrs A sustained an injury to her right arm, but it is unclear which action caused the injury.

108. Staff noted bruising and swelling on Mrs A's arm in the following days, and she was noted to be unsettled and agitated. Mrs A was prescribed paracetamol in addition to her usual medications. Staff noted that Mrs A continued to be unsettled and was indicating that she had a sore arm. Following a review by a nurse practitioner on 10 Month7, Mrs A's family were contacted, and Mrs A was taken to hospital, where it was confirmed that she had a fracture to her right arm. In the weeks that followed, Mrs A was noted to be agitated and frustrated about the cast on her arm, and on 16 Month7 she had to return to hospital to have the cast replaced.

109. The notes of a case conference with Mrs A's family on 10 Month7 indicate that care plans were reviewed and discussed, along with an advanced care plan, but there is no documentation in relation to this.

Opinion

110. I have several concerns about Elmswood's management of this incident on 8 Month7 and the care of Mrs A's injury, including delayed assessments, and poor communication with Mrs A's family.

111. RN Ferreira advised that while progress notes recorded by the Clinical Manager indicate that there was clinical oversight between 8 and 10 Month7, there is no evidence that Mrs A's care and safety needs were addressed, and nor were the contributing factors to the incident, which would have been accepted practice. Expected practice would have been for a short-term care plan to have been commenced on 10 Month7 to outline fracture care and cast monitoring requirements. There is no record of such a plan having been implemented.

112. RN Ferreira was also critical of Mrs A's pain management. She advised that the Abbey pain scale was referred to by staff in Mrs A's pain care plan, which was in line with Oceania's pain management policy (Appendix C), and pain assessments were carried out from 11 Month7

until 27 Month7, which was consistent with the policy. Mrs A's pain care plan was updated to include the fracture to her right arm, but no dates or timeframes of evaluations were included. A statement of evaluation was not in the care plan, which RN Ferreria considers would be accepted practice.

113. I am also concerned about the recording of the incident and the communication with Mrs A's family. RN Ferreira advised that the incident of 8 Month7 should have been recorded as per Oceania's Clinical Incident/Accident, Sentinel Events and Notifications policy (Appendix D). The policy provides timeframes for reporting based on event severity and notes that less serious events should be reported within eight hours, and I consider that the fact that this did not occur was a moderate to serious departure from accepted practice.

114. RN Ferreira stated:

> 'A behavioural event that involved physical contact and resulted in associated harm would be considered a serious event. Accepted practice would be for the on-duty team to follow the care home's escalation and reporting processes, which includes ensuring that nominated representatives were informed, as outlined in the ARRC Services Agreement and Health and Disability Service Standards. Service providers are required to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in a resident's health condition or of any adverse event. Having open communication and a shared understanding of care responsibilities is particularly important for families who are acting on behalf of a resident living with a diagnosis of dementia matewareware.'

115. RN Ferreira acknowledged that a case conference was arranged with Mrs A's family on 10 Month7 but noted that there was no documentation of Mrs A's recent presentation, observed concerns with behaviour and difficulties with delivery of personal care, or MHSOP's recommendation for a higher level of care (discussed below). RN Ferreira considered that given the significance of this content and the recent harm event, it would have been usual practice for the Clinical Manager or Care Home Manager to have been involved at this time.

116. RN Ferreira concluded that the lack of reporting of this incident and the lack of communications with the EPOA constitute a moderate to significant departure from accepted practice.

117. I accept this advice. Regardless of the circumstances in which the injury occurred, Mrs A's family should have been informed in the time specified in the policy, and the incident should have been recorded in eCase along with the implementation of a short-term care plan regarding the management of Mrs A's fracture and cast. Mrs A's pain care plan should have been updated to include dates and timeframes of evaluations. Documentation regarding how Mrs A's care and safety needs were to be addressed should have been completed. Given the concerns regarding Mrs A's behaviour (as discussed below), escalation of these concerns to Elmswood's Clinical Manager should have occurred and should have been discussed with Mrs A's family at the case conference.

Falls management and post-fall care

118. It was documented that Mrs A had been wandering in the days leading up to the unwitnessed fall on 8 Month13, and she had a further unwitnessed fall in the early hours of 11 Month13. She was noted to be lethargic and required assistance to eat lunch, but her vital signs were stable. Staff were to encourage Mrs A to go to bed during the night and conduct regular monitoring and ensure that she was wearing appropriate footwear. The two falls were raised with the nurse practitioner at Mrs A's review, and it was noted that Mrs A preferred to sleep in a lounge chair, and that she had been wandering. The nurse practitioner considered that the falls were behaviour related and trialled furosemide.

119. Over the following days, it was recorded that Mrs A was fatigued and had bilateral lower leg redness and oedema, with weeping of clear fluid. On the morning of 14 Month13, Mrs A walked with assistance to the resident lounge at approximately 5.15am, as she had been wandering. Over the course of the day her condition deteriorated while she was in the lounge, and after the arrival of her son at lunchtime she was transported to hospital.

Opinion

120. I consider that there were several shortcomings in the care provided by Elmswood staff over this time in relation to the clinical oversight and monitoring of Mrs A.

121. Following the unwitnessed fall on 8 Month13, Mrs A's vital signs and observations were recorded as per the Falls Policy (Appendix E), and Mrs A's family were informed. However, RN Ferreira advised that there is no evidence that a wider holistic nursing review occurred, and no supportive measures were offered to Mrs A to rest or elevate her legs after her feet were noted to be swollen on 8 and 10 Month13. On 10 Month13 Mrs A was noted to be walking independently and she had good oral intake. However, there is no evidence that a further nursing assessment or supportive interventions were provided or communicated in a shift handover, and nor were concerns regarding this or the MHSOP review escalated to the Clinical Manager for further guidance on 9 Month13 (as discussed above).

122. Mrs A was noted to be lethargic following the second unwitnessed fall on 11 Month13, and her lower legs were noted to be swollen and red. RN Ferreira advised that it would have been accepted practice for a further nursing assessment to be undertaken at this time. I note that staff were unable to take Mrs A's neurological observations because of her restlessness but were able to take measurements at 5pm. Mrs A refused cares and refused to go to bed and settled on a chair in the lounge. RN Ferreira considered that given the condition of Mrs A's lower legs, it would have been acceptable for staff to have considered a more suitable chair for Mrs A so that she could elevate her lower legs.

123. The two unwitnessed falls were entered into the incident register but there is no evidence that planning was reviewed and updated or that Mrs A's falls management and clinical oversight was prioritised by the nursing team. RN Ferreira considered that given that Mrs A had sustained two falls in recent days, this would have been the accepted practice in the circumstances. The falls risk assessment document that was provided was not dated and referred only to the fall on 11 Month13, with the fall risk assessed as low. The FRAT history

included an entry of the falls on 8 and 11 Month13, but the assessment was recorded as 'LOW', with a risk score of 11/20.

124. Following the GP review on 12 Month13, Mrs A was commenced on a trial of diuretic medication (frusemide) for pedal oedema of her mid-shin. Support strategies were discussed, including skin care, but there is no evidence that a short-term care plan was commenced to guide medication management or specific daily monitoring and care interventions, which RN Ferreira advised would be accepted practice in the circumstances, particularly given the two new medications prescribed at this review and at the MHSOP review on 9 Month13.

125. Mrs A's condition continued to deteriorate on 13 and 14 Month13. RN Ferreira stated that it is unclear whether staff were aware of their monitoring responsibilities, particularly vital signs, urine output, skin, and lower limb presentation, and there was a lack of clinical reasoning applied by staff, with limited recognition of Mrs A's deteriorating condition. RN Ferreira advised that given Mrs A's acute deterioration, it would have been accepted practice to seek paramedic support.

126. Mrs A had an advance directive in place, but it is unclear whether this was reviewed in partnership with her EPOA and medical team during this time.

127. RN Ferreira concluded that the care provided by Elmswood staff over this time in the form of clinical assessment and monitoring was a moderate to severe departure from the accepted standard of care.

128. I accept this advice. I am concerned that there was a lack of critical thinking from staff at Elmswood, and there was a presumption that Mrs A's behaviour was 'usual', which resulted in staff failing to address Mrs A's deteriorating condition, particularly on 14 Month13. Plans for wound care should have been in place, Mrs A's falls risk assessment should have been updated following the unwitnessed falls on 8 and 11 Month13, and short-term care plans for medication management and monitoring should have been in place, with appropriate escalation in response to her deteriorating condition.

Communication with Mrs A's whānau

129. Mrs A was reviewed by MHSOP on multiple occasions following her admission to Elmwsood. On 23 Month12 a referral to MHSOP was completed, as staff at Elmswood were continuing to find it difficult to assist Mrs A with her personal cares, and strategies were recommended to staff. Oceania accepted that progress notes contain no mention of the assessment by MHSOP or of any strategies outlined in the assessment. At the last review by MHSOP on 9 Month13, it was noted that Mrs A continued to be very resistive to personal cares and had periods where she was very distressed. Several psychotropics had been trialled without success, and the addition of sertraline had made Mrs A worse. Mrs A was at risk of falls, and staff were aware that a lot of medication contributed to this in addition to her level of distress and dementia.

130. It was considered by MHSOP that Mrs A likely required a psychogeriatric level of care, but staff at Elmswood felt that moving her would make her more unsettled and they were keen to continue to try to manage her at Elmswood. Mrs A was to be reviewed by MHSOP in a month's time. Zuclopenthixol was to be trialled to see whether this would help with her aggression and agitation, and staff were asked to monitor her sedation and worsening of mobility and to withhold the medication if necessary.

131. Staff advised Mrs A's family about the MHSOP recommendations and the request for staff to monitor Mrs A's sedation and mobility, and the potential for Mrs A to require a transfer.

132. In my view, adequate communication with the family is important in situations where the consumer is cognitively impaired and family are part of the support network, and this is required where the consumer has an activated EPOA. The ability of Elmswood to provide Mrs A with the standard of care she required in addition to the changes in her medication (and the potential risks to her mobility and sedation levels) were significant issues that needed to be discussed with Mrs A's EPOA and whānau. I consider that Mrs A's EPOA and whānau were not adequately informed about the MHSOP reviews and recommendations and did not have input into the decisions, as there is minimal documentation regarding these conversations. Mr B told HDC that the family were not aware of the seriousness of the situation and did not understand the extent of the changes to Mrs A's medication and the potential risks. He said that had they known, they would have requested that Mrs A be transferred. I would have expected Elmswood to hold a case conference with Mrs A's EPOA and whānau to discuss the suitability of Mrs A remaining in dementia-level care, along with the changes to her medication, and for this to be documented fully, and I am critical that this did not occur.

Advance directive form

133. An advance directive form was completed on 25 Month11 by the nurse practitioner. This set out that Mrs A did not have the capacity to make and communicate informed consent about her own medical and mental health treatment. Her daughter was recorded as her EPOA for personal care and welfare, and this had been activated. In the event of an acute medical illness, comfort care was elected, and hospitalisation was indicated in the event of a traumatic injury.

134. The purpose of an advance directive is to set out in advance the treatment wanted (or not wanted) in the event of becoming unwell in the future. It allows for control over treatment and care provided in the event of mental illness where consumers may be unable to communicate their preferences at the time. There is a requirement that consumers must be competent when completing an advance directive.[45]

135. Mrs A did not have capacity to make these decisions at the time the advance directive was signed in Month11, and it was recorded on this form that she did not have the capacity to communicate or make decisions. I do not consider that this was an appropriate document to be completed in these circumstances. An advance directive cannot be completed by an

[45] www.hdc.org.nz

EPOA in situations such as these, and to call this form an advance directive is misleading for the reasons I have outlined.

Staff training

136. Oceania told HDC that RN C's main place of work was within the rest home/hospital wings at another facility, but she was asked to assist with covering Elmswood's dementia unit on occasion. Oceania said that RN C would not have been as familiar with residents in the dementia unit, but she declined further orientation to Elmswood when offered.

137. I am concerned that Oceania was aware that RN C was not familiar with dementia patients and continued to allow her to work in the dementia unit when she had declined further orientation. Oceania had an obligation to ensure that staff were properly trained, and I am critical that Oceania did not ensure that RN C was provided with training and orientation for working at Elmswood.

Conclusion

138. Elmswood had a responsibility to operate the dementia unit in a manner that provided its residents with services of an appropriate standard. The overall deficiencies in care provided to Mrs A demonstrate a pattern of suboptimal care and a lack of critical thinking from staff members. I consider the above shortcomings in relation to clinical oversight and monitoring to be service delivery failures that are directly attributable to Elmswood. In my view, Elmswood failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1)[46] of the Code.

139. In addition, the Health and Disability Services Standards[47] require organisations to ensure that consumer information is 'uniquely identifiable, accurately recorded, current, confidential, and accessible when required'. I consider that there were omissions in record-keeping at Elmswood relating to care plans, incident recording, falls assessment, and clinical notes. Elmswood has accepted that the documentation was not at the expected standard. Accordingly, I find that Elmswood breached Right 4(2)[48] of the Code.

Opinion: RN C — breach

140. RN C had been working at Elmswood since Month12 after having transferred from another facility, where she had worked for many years and had looked after dementia, hospital-level, and rest-home-level patients during her time there. She had a duty to provide services in accordance with the Code and in accordance with the Nursing Council's Code of Conduct.

Accounts of care provided on 14 Month13

141. RN C told HDC that she completed her observations of Mrs A at 7am and 10am but was unable to take Mrs A's blood pressure or obtain a urine sample as she resisted. RN C said that she continued to check on Mrs A throughout the morning, but Mrs A's condition

[46] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[47] NZS 8134.1:2008, Standard 2.9.
[48] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

remained the same despite efforts to communicate with her. RN C stated that she did notice bruising and redness on Mrs A's right eye but thought this was from Mrs A rubbing it on the chair, and she placed a pillow on the armchair. RN C said that she had intended calling Mrs A's family, but they arrived before she could do so.

142. Oceania told HDC that the CCTV footage taken over this time does not support RN C's version of events, and nor do the progress notes. Oceania said that RN C did not assess Mrs A properly while she was in the lounge despite concerns being raised by healthcare assistants, and there is no evidence to suggest that Mrs A was given her diabetic medication.

143. RN C disputes this and maintains that she observed Mrs A frequently during the morning shift and checked on her every time she went into the wing, and that Mrs A was resistant to cares and medication, which is not disputed by the healthcare assistants.

Opinion

144. I acknowledge from the outset that healthcare assistants were also involved in the care provided to Mrs A on 14 Month13. However, RN C was the registered nurse on duty, and she was responsible for documenting pain issues, administering medication, and undertaking neurological observations. I acknowledge that she was not familiar with the residents at Elmswood, having transferred there only recently, but I consider that as an experienced nurse it was her responsibility to familiarise herself with the condition of the residents and seek appropriate support if required. She was familiar with working in aged-care facilities, having transferred from a facility where she had looked after dementia, hospital-level, and rest-home patients. I acknowledge her concerns that she had a very busy workload with complex residents; however, the roster staffing ratios were found to be in line with the Age-Related Residential Care service agreement.

145. I note that Oceania was unable to provide a copy of the CCTV footage, as this had not been retained. However, Oceania conducted its own internal investigation on 25 Month13, which involved viewing the CCTV footage from between 5am and 12.21pm on 14 Month13. Oceania concluded that RN C had not provided Mrs A with her diabetes medication and had not carried out observations as she had claimed. In addition, I note that a healthcare assistant raised concern with RN C that Mrs A was not herself, and the progress notes indicate that both healthcare assistants reported their concerns to RN C. An entry by RN C at 12.54pm documented that observations were taken at 7am, but there is no such entry in the progress notes at 7am.

146. I acknowledge RN C's concern that the CCTV footage is no longer available. However, given the above findings from Oceania's internal investigation, the documented evidence from the healthcare assistants, and the discrepancy in RN C's notes, I find it more likely than not that RN C did not carry out the observations or give Mrs A her medication, as set out in the internal investigation findings. I note that there is also no documentation to support RN C's contention that she undertook observations as required. RN Ferreira stated:

> 'The Nursing Council of New Zealand has clear guidelines regarding the Code of Conduct, competence requirements, and responsibilities to professional, legal, and

> ethical standards of practice for registered nurses [Appendix F]. Additionally, nurses also have a responsibility to advocate for themselves to ensure they are safe, informed, and competent to practise, in line with patient safety principles and regulatory standards. In summary, nurses have a duty of care. I consider that [RN C's] actions on the day in question were below accepted practice standards in the circumstances. This represents a serious departure from professional standards of care and would be viewed similarly by my peers.'

147. I accept this advice, and, despite RN C's submissions, I remain critical of the care provided by RN C. Mrs A was a vulnerable resident and should have been cared for and kept safe. Mrs A's deterioration should have been identified by RN C, and she should have taken appropriate steps to ensure that Mrs A received urgent medical attention. This did not occur, and on 14 Month13 Mrs A was left alone for a substantial period. The lack of monitoring and clinical assessment was sub-standard care. Accordingly, I find that RN C breached Right 4(1) of the Code.

148. I have also considered whether RN C complied with her ethical obligations imposed by the Nursing Council, which are outlined at paragraph 146 above. In response to my provisional opinion, RN C stated that she has not seen the CCTV footage from 14 Month13 and disputes its contents as set out in the Oceania investigation. HDC has also not seen the footage. Whilst I recognise my advisor's opinion, without HDC having the CCTV evidence, and given RN C's opposing perspective on its contents, I am unable to substantiate whether she complied with her ethical obligations.

Changes made since events

149. Oceania told HDC that it took this matter seriously and steps were taken to address the shortfalls in care that were identified as a result of the internal investigation, which included the following:

- The STOP AND WATCH tool has been introduced nationwide through the Regional Cluster Meetings and Clinical Safety Forums. This tool is used to ensure that any acute changes in residents observed by healthcare assistants are documented and provided to the registered nurse for further follow-up.
- The ISBAR[49] communication tool has been introduced to provide better reference when communicating information. This has been integrated into eCase.
- Additional education was provided to Elmswood healthcare assistants on observation and reporting, basic cares, nutrition, and hydration.
- Training was commenced with all Elmswood registered nurses on 'the deteriorating resident' using the information from Frailty Care Guides.

[49] The ISBAR (identification, situation, breakdown, assessment, recommendation) communication framework is used to create a structured and standardised communication format between healthcare workers.

- Review and reflection of the event was provided to Elmswood staff in a 'lesson learned approach' to learn from the mistakes and missed opportunities for timely intervention.
- STOP AND WATCH and ISBAR tools have been added to the annual clinical staff education days.
- A system is to be developed with the clinical management team at Elmswood to ensure that all wounds have a documented treatment plan.
- Audits were completed on resident files to ensure that there was evidence of short-term care plans and ensure that acute behavioural changes were charted and followed up.

Recommendations

Oceania

150. I recommend that Oceania:

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

b) Within three months of the date of this report, provide HDC with an update on whether a system has been implemented to ensure that all wounds have a documented treatment plan.

c) Review its policies and processes relating to resident admissions to dementia-level care, including the management of resident stress and distress, and related responsibilities for open communication and informed consent. Oceania is to report back to HDC on the outcome of the review within six months of the date of this report.

d) Within six months of the date of this report, provide HDC with confirmation that staff at Oceania have completed training related to communication with older people and their family/whānau. This should include strategies for ensuring that changes in resident needs are documented and communicated appropriately. Training should also address the importance of recording all concerns raised by family in the resident's clinical record, and the use of communication tools to better inform clinical assessments, actions, and safe, evidence-based decision-making. Oceania is to provide evidence of this training within six months of the date of this report.

e) Within three months of the date of this report, provide HDC with confirmation that staff at Oceania have completed the HDC online e-learning modules.

RN C

151. RN C told HDC that she no longer works as a registered nurse. I recommend that should RN C return to practice as a nurse, she undertake training on documentation.

152. In the provisional opinion I recommended that RN C provide an apology to Mrs A's family for the breach of the Code identified in this report. This apology was received in response to the provisional opinion and has since been provided to Mrs A's family.

Follow-up actions

153. A copy of this report with details identifying the parties removed, except Oceania Care Company Limited, Elmswood Care Centre and the advisor on this case, will be sent to the Nursing Council, and it will be informed of RN C's name.

154. A copy of this report with details identifying the parties removed, except Oceania Care Company Limited, Elmswood Care Centre and the advisor on this case, will be sent to HealthCERT, Health New Zealand|Te Whatu Ora, and Te Tāhū Hauora|Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Jane Ferreira, PGDipHC, MHlth, Nurse Advisor (Aged Care):

> 'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Elmswood Care Home. 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.
>
> **Documents reviewed**
>
> - Letter of complaint received [2021]
> - Provider response dated [2022]
> - Clinical records including nursing assessments, observation charts, monitoring forms, care plans, progress notes and medical records.
> - Organisational policies including incident management, pressure injury and skin care, behaviours that challenge, medication management, nutrition and hydration, pain management, personal care and grooming and clinical escalation.
> - Additional information received [2023] including response letter, nursing assessments, monitoring forms, progress notes, incident reports, medical records, investigation reports, corrective actions, and staff training records.
>
> **Complaint** [Mrs A's] family have raised concern regarding the care provided to their mother while resident at the care home. Their concerns relate to care delivery, communication, recognition of resident decline, falls management, inadequate monitoring, and failure to escalate care concerns
>
> **Review of clinical records** For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
>
> How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.
>
> In particular, comment on:
>
> - Was Elmswood's admission screening and NASC placement appropriate?
> - Was Elmswood's clinical oversight, pain assessment and monitoring of [Mrs A] between [Month7] and [Month13] adequate?
> - Was it reasonable for the nurses at Elmswood not to load the incident of 8 [Month7] on to the e-case records?

- Were Elmswood's policies and procedures at the time adequate? Please consider if Elmswood's educational and operational improvements adequately address any inadequacies.
- Any other matters that you consider warrant comment.

Background [Mrs A] was admitted to the Dementia community at Elmswood Care Home on 18 [Month1]. Her medical history included dementia with behavioural and psychological symptoms of dementia (BPSD), borderline personality disorder, anxiety and depression, type 2 diabetes, congestive heart failure, hypertension, osteoporosis, mitral and aortic valve disease, and hearing loss. File information indicates that [Mrs A] required a high level of assistance from carers to meet activities of daily living and received support from mental health services for older people due to her complex health needs.

[Mrs A's] family have raised concern regarding a right arm fracture sustained in [Month7], fall events which occurred in [Month13], health decline, delayed care, and communication. On 14 [Month13] [Mrs A] was reportedly sleepy, and reluctant to eat and drink. Following concern expressed by family members during their visit [Mrs A] was transferred to [hospital] via ambulance for further assessment and care. She was diagnosed with septic bacteraemia and right leg cellulitis and passed away on 28 [Month13]. I extend my condolences to [Mrs A's] family at this time.

1) Was Elmswood's admission screening and NASC placement appropriate? According to file information [Mrs A] had been residing at rest home level care with another aged care provider however due to concerns with personal care and safety needs was reassessed to dementia level care on 13 [Month1]. Assessment and transfer information indicates that [Mrs A] required increased supervision and assistance with most activities of daily living and was admitted to the care home's dementia community on 18 [Month1].

The Age-Related Residential Care (ARRC) contract (D16.1) states that each potential resident will be assessed using the most clinically appropriate interRAI assessment tool prior to admission. On admission, the resident's health and personal care needs will be assessed to inform an interim care plan, with an interRAI assessment completed within 21 days of admission to the care home. File information shows that admission nursing assessments were completed on 19 [Month1], a nursing care plan completed on 26 [Month1], and interRAI assessment completed on 9 [Month2] which appears to be in line with contractual requirements.

It is unclear what the care home's pre-admission screening process was regarding admission suitability to the dementia community as the Admission policy was not included in the evidence bundle. Accepted practice would be for the clinical manager or registered nurse (RN) team to review the interRAI assessment report and triggered outcomes in partnership with wider health information to inform admission decisions. The interRAI CAP summary consistently triggers mood and behaviour, with scores and

dialogue indicating a need for further evidence and clinical discussion to ensure the care environment was appropriate to safely meet [Mrs A's] needs, and those of her peers.

Clinical records show that [Mrs A] was under the care of Mental Health Services for Older People (MHSOP) and living with a complex mental health history, which included a diagnosis of dementia matewareware. It is unclear if the care home or clinical manager met with [Mrs A] and her family/whānau prior to admission to discuss goals for care or reviewed clinical assessments and care plans to inform safe admission decisions, which would be considered accepted practice in the circumstances.

Admission progress notes and related communication records discussing admission processes were not included in the evidence bundle so it is difficult to comment on admission suitability decisions. It is unclear what the level of involvement was from Needs Assessors and the MHSOP team in supporting [Mrs A], her family/whānau and care home teams in the reassessment process, or the support plan, as outlined in the ARRC agreement (D16.1A), as she orientated to her new environment.

From the evidence reviewed to respond to this question it appears the recommended admission processes for service providers were followed by the care home team at the time. Health records indicate that [Mrs A] had been regularly assessed and was well supported by regional healthcare teams prior to admission to dementia level care, and it is apparent that COVID-19 pandemic measures influenced usual post-admission processes in the circumstances.

Departure from accepted standards: Nil

2) Was Elmswood's clinical oversight, pain assessment and monitoring of [Mrs A] between [Month7] and [Month13] adequate? The interRAI clinical assessment, 9 Month2, indicated [Mrs A] required assistance with activities of daily living, falls, pain and bowel management, and support with mood and behaviour. Medical and care plan information indicates that [Mrs A] experienced regular episodes of distress, requiring support to de-escalate partnered with as-required (PRN) prescribed medications. [Mrs A] was seen by MHSOP following admission to the care home and described as settling into the new environment. She was seen again on 7 [Month3] with reports of a significant decline in mood, behaviour, and level of function. The provider response advised that the care home had entered [a] lockdown period under the COVID-19 pandemic measures during this timeframe, which had restricted family visits and appeared to have exacerbated [Mrs A's] anxiety and distress.

MHSOP reports reflect collaboration with the RN team regarding [Mrs A's] presentation including RN feedback about daily routines. Clinical information indicates that [Mrs A] experienced high levels of anxiety and distress, with accounts of verbal and physical expression surrounding toileting and personal care. It is unclear if the use of masks, gowns, and gloves worn during COVID-19 was a barrier to effective communication for [Mrs A] or contributed to misunderstanding about care interventions.

The Behaviour that Challenges Management policy (2020) provides guidance regarding nursing assessment, monitoring, and care planning responsibilities, aligned to contractual requirements for service providers. The nursing care plan in place at the time provides discussion of de-escalation strategies and the use of PRN medication but does not provide guidance regarding assessment of medication effectiveness, event reporting or criteria for escalation to the senior clinical team. There is limited discussion of behaviour chart analysis, or reporting of these events in the incident management summary form which would be considered accepted practice in this setting.

Consultation reports 9 [Month4] and 4 [Month6] reflect concern with [Mrs A's] levels of anxiety and displays of distress, particularly surrounding personal care, noting that [Mrs A] may require specialist dementia (psychogeriatric) level care. The provider has stated that the care team felt they could support [Mrs A] with her needs at the time and were reluctant to consider transferring her. It is unclear if meetings were held with [Mrs A's] EPOA regarding suitability to remain at Dementia-level care, which would be considered part of service provider contractual responsibilities and accepted practice in the circumstances.

File information shows [Mrs A] sustained a right arm injury on 8 [Month7] with an ulna fracture confirmed two days later. Progress note entries outline the event history and related actions, however there are apparent departures with incident management processes, and delayed assessment, care, and communication. [Mrs A] was taken by family to hospital for treatment on 10 [Month7] which confirmed a fracture and returned to the care home with a cast in place. It does not appear that a short-term care plan was commenced to outline fracture care and cast monitoring requirements at this time. The care record reflects pain assessments were commenced on 11 [Month7] and continued regularly until 27 [Month7] using the Abbey pain scale which is in line with the organisation's Pain Management policy (2020).

The policy states that pain management strategies will be reflected in the resident's care plans, evaluated, and reviewed six monthly or as required, and refers to the use of short-term care plans. Nursing information indicated that [Mrs A] experienced chronic lower back pain, which is reflected in her care plan, 26 [Month1] and reviewed 7 [Month8], however there is no evidence of a statement of evaluation which would be accepted practice. Medication records show [Mrs A] was prescribed regular doses of Paracetamol, which administration records show she received. The care plan had been updated to record the right arm fracture with a goal to be free from pain, but no dates, timeframes or evaluation were included, which presents an improvement opportunity.

Progress note entries between 8–10 [Month7] describe general care occurring with regular comments of daily activities including oral intake, limb movement, sleep patterns and personal care delivery. There are regular entries in the care record from the clinical manager which indicates clinical oversight, however there is no evidence that [Mrs A's] falls risk, care and safety needs were reviewed or that contributing factors and corrective actions to the altercation event were considered which would be accepted practice.

File evidence reflects a case conference was held on 10 [Month7] between an RN and [Mrs A's] EPOA. There does not appear to be any discussion recorded in the meeting minutes regarding [Mrs A's] recent presentation, observed concerns with behaviour and difficulties with delivery of personal care, or MHSOP recommendation for a higher level of care. Given the significance of this content and recent harm event it would be usual practice for the clinical manager or care home manager to be involved at this time. The resident review process is acknowledged as an important opportunity to review health, safety, and wellbeing data to determine if the documented care plan interventions remain appropriate, or reassessment of need indicated, in line with service provider contractual requirements. Accepted practice would be to establish a family meeting in partnership with the care home's clinical team to discuss the clinical concerns, goals for care and care pathway.

MHSOP records reflect ongoing concern with [Mrs A's] health and wellbeing, however this information does not appear to be consistently reflected within the reviewed nursing record. Progress notes describe some carers stepping away when [Mrs A] was distressed, returning later to complete tasks when she was more accepting of assistance, however file information also indicates that personal cares were being delivered at night when [Mrs A] was 'sleepy and less resistive'. There is no evidence this was an openly agreed, planned, and documented approach to meeting [Mrs A's] needs, and would not be considered as respectful or person-centred care. File information states that at times [Mrs A] required assistance from up to three carers which raises questions regarding placement suitability, and provider responsibilities regarding delivery of person-centred care in a restraint-free environment, in line with Health and Disability Sector Standards.

It appears additional strategies for personal care interventions were shared by MHSOP with the care home team in [Month12], however this information is not reflected in care planning or progress note documentation. Accepted practice would be to commence a short-term care plan to outline agreed interventions using an evidence-based, time-bound approach to guide staff actions and reporting responsibilities to ensure the best outcomes occurred for [Mrs A].

Care plan information shows [Mrs A] was independently mobile, able to transfer or reposition herself without staff assistance and was assessed as low falls risk. MHSOP information has discussed changes to prescribed medications, commenting that [Mrs A] was at increased risk of sedation and fall events while medications were adjusted. It does not appear that a short-term care plan was commenced to outline risk management strategies or related nursing responsibilities while medications were under review. Given [Mrs A's] cardiac and diabetic history it would be accepted practice to monitor nutritional intake, elimination and sleep patterns, weight and vital signs as outlined in the Frailty Care Guides for deprescribing and polypharmacy (HQSC, 2019).

On 8 [Month13] the duty RN reported that both [Mrs A's] feet appeared "a bit swollen" but there is no evidence that further nursing assessment occurred or that supportive measures were offered to rest or elevate her legs. PM shift progress notes and the

incident record reflect that [Mrs A] experienced an unwitnessed fall at 2120hrs in the dining room and sustained a contusion to the left side of her head. Vital signs were recorded, and neurological observations commenced per accepted falls protocol. The incident record refers to positioning as a contributing factor, noting that [Mrs A] walked with her head down. The clinical manager has stated in the care record that [Mrs A's] family were informed of the fall event on 9 [Month13], but there is no evidence that a wider holistic nursing review occurred.

On 9 [Month13] [Mrs A] was seen by MHSOP and RN progress notes refer to a review of behaviour chart data and trial of a new medication (Zuclopenthixol). The RN provided instructions to observe for signs of sleepiness and declining mobility, and the entry reflects communication with [Mrs A's] EPOA, however there is no evidence that a short-term care plan was commenced to guide care, safety and reporting responsibilities which would be accepted nursing practice at this time.

On 10 [Month13] the RN entry has reported that [Mrs A's] feet appeared a bit swollen, was walking independently with good oral intake but there is no evidence of further nursing assessment or supportive interventions provided, communication in a shift handover record nor escalation of concerns to the clinical manager for further guidance.

On 11 [Month13] [Mrs A] experienced an unwitnessed fall at 0325hrs while sleeping on a chair in the lounge and was found lying face down on the floor with bruising to her forehead. Progress notes describe the assessment process and documentation indicates that neurological observations were commenced. RN progress notes on the next shift discuss nursing observations and commencement of a pain chart. The entry described [Mrs A's] lower legs as "swollen and red", tubigrip support was offered and [Mrs A] was booked for GP review the next day. An entry by carers stated that [Mrs A] appeared "very lethargic" throughout the shift, requiring assistance with eating her lunch. It is unclear whether further nursing assessment occurred at this time or if clinical information was communicated to the incoming shift which would be considered accepted practice. Entries on the PM shift state [Mrs A] was sleeping in the lounge, but it is unclear whether staff considered a more suitable chair for [Mrs A] to rest in that could elevate her lower legs given the identified concern.

The care record reflects incident review occurred by the clinical manager on 9 and 11 [Month13] in line with the organisation's incident management policy, and comments provided regarding care and safety needs, however it is unclear if the documentation discrepancies in neurological observations were addressed. It is also unclear if care planning was reviewed and updated in response to these instructions or if [Mrs A's] falls management and clinical oversight was prioritised by the RN team given, she had sustained two falls in recent days which would be accepted practice in the circumstances.

On 12 [Month13] [Mrs A] was assessed by the nurse practitioner (NP). Consultation notes indicate falls occurred either side of the new MHSOP medication, and report stable vital signs, weight, and blood glucose levels. [Mrs A] was commenced on a trial

of diuretic medication (Frusemide) for assessed pedal oedema present to mid-shin. Support strategies were discussed including skin care however there is no evidence that a short-term care plan was commenced to guide medication management, specific daily monitoring and care interventions which would be accepted practice in the circumstances, particularly given the two new medications.

File information on 13 and 14 [Month13] describe [Mrs A] as fatigued, with bilateral lower leg redness and oedema, and weeping of clear fluid. An RN entry refers to delivery of wound care, but the provider has advised there is no evidence of supporting documentation, and acknowledged this is below their organisational practice standards. It appears [Mrs A] was assisted with food and fluids however it is unclear if staff were aware of their monitoring responsibilities, particularly vital signs, urine output, skin, and lower limb presentation. There appears to be a lack of clinical reasoning applied by the nursing team with limited recognition of decline and precautionary care prioritisation. [Mrs A] had an advance directive in place, but it is unclear if this was reviewed in partnership with her EPOA and medical team.

As outlined in Frailty Care Guides, Sepsis is classed as a medical emergency (HQSC, 2019). Given [Mrs A's] acute deterioration, seeking paramedic support is considered accepted practice for a medical emergency in an aged residential care setting. The Sepsis Screening tool provides guidance about signs of acute deterioration to inform clinical decision making, partnered with the STOP AND WATCH tool and ISBAR communication tool, which the provider has now implemented. The provider investigation report has identified contributing factors to delayed communication and clinical actions which they have addressed in their corrective action plan.

The provider has discussed a shortage of specialist dementia (psychogeriatric level beds) in the region, which may have influenced reassessment processes at the time. Given the expressed view from MHSOP regarding reassessment, it is unclear whether the care home team sought additional support to allow [Mrs A] to remain safely in her current environment until a bed was available in a more appropriate health setting.

From the evidence reviewed to respond to this question it appears there are identified areas of concern regarding clinical oversight and timely nursing assessment, recognition of resident decline, clinical decision-making, and care escalation, including departures in communication processes and documentation standards which would be viewed similarly by my peers.

Departures from accepted practice: Moderate to significant

3) Was it reasonable for the nurses at Elmswood not to load the incident of 8 [Month7] on to the e-case records?

The organisation's Clinical Incident/Accident, Sentinel Events and Notifications policy (Jan 2020) provides very clear guidance regarding actions and expectations for event management, documentation, and reporting responsibilities, aligned to contractual requirements for service providers. The policy states that "*all resident incident/ accidents will be reported in the electronic management system (eCase) in the relevant*

incident register and entered into progress notes. Documentation will be objective, factual, and accurate … with discussion of contributary causes and actions taken … and events reported as soon as possible to the most senior person on duty". The policy states that "*the resident's family will be notified as soon as possible after the event that affected their care or treatment … and advised of actions taken to remedy any harm suffered by the resident".* The policy provides timeframes for reporting based on event severity, noting "*less serious events prior to end of shift (within 8 hours) and serious risk events reported as soon as is practicable to the one-up manager".* A behavioural event that involved physical contact and resulted in associated harm would be considered a serious event. Accepted practice would be for the on-duty team to follow the care home's escalation and reporting processes, which includes ensuring that nominated representatives were informed, as outlined in the ARRC Services Agreement and Health and Disability Service Standards. Service providers are required to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in a resident's health condition or of any adverse event. Having open communication and a shared understanding of care responsibilities is particularly important for families who are acting on behalf of a resident living with a diagnosis of dementia matewareware. From the evidence reviewed to respond to this question, I believe the lack of event reporting and related communication with the EPOA to be below the level of accepted practice and this would be viewed similarly by my peers. Departure from accepted practice: Moderate to significant.

4) Were Elmswood's policies and procedures at the time adequate? Please consider if Elmswood's educational and operational improvements adequately address any inadequacies. From the information provided it appears that the policies and procedures in place at the time of [Mrs A's] admission were adequate, as evidenced through the Manatū Hauora|Ministry of Health external health certification process, under the Health and Disability Services (Safety) Act 2001. Evidence of updated policies has been provided which reflects the health and practice requirements aligned to the new Nga Paerewa standards. While the organisation's falls prevention and management policy and neurological observations policy were not provided, the provider has stated that the Frailty Care Guides are used to inform and support nursing practice. This suite of tools is a well-respected, healthcare resource and widely used in the aged care sector. As outlined in the provider response a new clinical escalation policy (May 2022) was introduced which provides guidance steps to support decision-making regarding signs of acute deterioration, and education records indicate steps have been taken to address the identified practice gaps. There may be opportunities for the care home team to review policies and processes relating to resident admissions to dementia level care, including the management of resident stress and distress, and related responsibilities to open communication and informed consent.

Clinical advice I note that the events occurred during the COVID-19 pandemic period and would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams and health service providers during this time. Based on this review I recommend the care home team complete additional education on

communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the family in the resident's clinical record, and the use of communication tools to better inform clinical assessments, actions, and safe, evidence-based decision-making. To support this approach, I recommend that the care home team complete the new HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

References Health and Disability Commissioner. (2022). Online Learning. https://www.hdc.org.nz/education/online-learning/

Health Quality and Safety Commission. (2019). Frailty Care Guides. http://www.hqsc.govt.nz/'

'**Addendum — CLINICAL ADVICE — AGED CARE**

CONSUMER	**:**	[Mrs A]
PROVIDER	**:**	Oceania Healthcare: Elmswood Care Home
FILE NUMBER	**:**	C21HDC01877
DATE	**:**	21 February 2024

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Elmswood Care Home. 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.

2. **Complaint**
[Mrs A's] family have raised concern regarding the care provided to their mother while resident at the care home. Their concerns relate to care delivery, communication, recognition of resident decline, falls management, inadequate monitoring, and failure to escalate care concerns.

3. Request for review of additional information.
Thank you for the opportunity to review the additional information received from the Provider. I have been asked to comment on whether the responses received change any of my initial advice, and to consider whether there were any departures regarding the care provided by the duty RN during the timeframe in question.

On review of the submitted information which has included the Provider's investigation reports and related statements, education and training records, I consider that my initial advice remains appropriate in the circumstances. As discussed in my response, while the organisation had recognised systems and processes in place there appear to be concerns with appropriate nursing assessments, timely nursing interventions, care leadership, communication and clinical decision making, which contributed to delayed resident care. Partnered with this is a lack of recognition of resident decline, and responsibilities to resident care, safety, wellbeing, dignity, and respect.

The Provider has shared their event investigation which identified a range of contributing factors, which included RN and Carer practice gaps that I concur with. The report discusses relevant areas for improvement, as evidenced in the supporting training records. The provider's investigation report states that from their review … *the RN and HCAs, did not provide adequate care for [Mrs A] …*

The event report observed that there were minimal points of contact and care provided by the RN and carers during the timeframe in question. File information indicates that while the duty RN was experienced, they were working in an unfamiliar setting which may have contributed to practice delays.

The Nursing Council of New Zealand has clear guidelines regarding the Code of Conduct, competence requirements, and responsibilities to professional, legal, and ethical standards of practice for registered nurses. Additionally, nurses also have a responsibility to advocate for themselves to ensure they are safe, informed, and competent to practise, in line with patient safety principles and regulatory standards. In summary, nurses have a duty of care. I consider that [RN C's] actions on the day in question were below accepted practice standards in the circumstances. This represents a serious departure from professional standards of care and would be viewed similarly by my peers.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner'

Appendix B: Behaviour that Challenges Policy

‘1 PURPOSE

This policy aims to ensure that the needs of residents with behaviours that challenge are met and managed effectively by Oceania Healthcare staff while avoiding injury to staff and others.

2 ORGANISATIONAL SCOPE

The ‘Behaviour that Challenges Policy’ applies to all staff involved in care and communication with residents and/or their support person.

3 LEGISLATION

This policy is based on Ngā Paerewa Health and Disability Services Standard NZS 8134:2021

4 DEFINITIONS

For the purposes of this policy, unless otherwise stated, the following definitions shall apply:

Behaviour that Challenges	Behaviour that Challenges is defined as “culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary facilities.” Reference: Emerson, Eric (2001) — Challenging Behaviour: Analysis and Intervention in People with Severe Learning Disabilities.

5 PROCEDURE

5.1 BEHAVIOUR THAT CHALLENGES OVERVIEW

All steps are taken to minimise the risks associated with behaviour that challenges. Oceania Healthcare will ensure the safety of residents, staff and visitors is maintained. This will include:

- Providing a safe environment with minimal restrictions
- Avoiding the use of restraint
- Providing an interesting, structured environment
- Contemporary education will be delivered annually to staff about behaviour that challenges, de-escalation and keeping themselves safe

Oceania Healthcare management of behaviour that challenges reflect the emphasis it places on the rights of the individual to freedom of choice, dignity and privacy. However, when a resident's behaviour is likely to cause major disruption and/or injury to themselves or others, appropriate action will be taken.

Suggested strategies:
Distraction or Diversion — if a resident's behaviour is escalating or antecedents are present, distract them with something else e.g. resident becoming agitated because they want to go home. Try engaging them in an activity that has been identified as a possible distraction.

- Provide a low stimulus, soothing environment
- Involve family in the planning and implementation of care and activity delivery
- Seek multi-disciplinary/medical interventions
- Review the interventions on the Behaviour chart in charting and ensure interventions are described in personal strategies within the care plan (ensure this covers the 24-hour period).
- Consider whether the current care environment and level is appropriate for this resident as their condition and Behavioural and Psychological Symptoms of Dementia (BPSD) changes

NOTE: Restraint can only be implemented in an emergency by a Registered Nurse. Oceania Healthcare Restraint Documentation and Consent should be obtained ASAP following application of emergency restraint and followed up with the EPOA/GP & Restraint coordinator

5.2 ASSESSMENT AND PLANNING

Each resident who is identified as having behaviour that challenges is to be assessed on admission and a behaviour charting plan commenced. The behaviour assessment is completed as part of the admission assessments and charting commenced if behaviours are identified.

The Behaviour charting will include the following: -

- Known antecedents or triggers of the behaviour and any unmet needs
- A description of the behaviour
- The effects of the behaviour to the resident, others, and the environment
- Patterns of occurrence
- Management interventions

All residents in Dementia Units are to be assessed on admission with ongoing behaviour charting and a care plan that instructs a 24-hour plan of care within the care plan, based on triggers identified and personal strategies that may resolve identified behaviours.

If the resident's behaviour is unable to be successfully managed then the GP or NP may need to refer the resident for specialist assessment and treatment.

The administration of medications to manage behaviour will only be used following full consultation with the Multi-Disciplinary Team, the resident and EPA.

6 APPROVAL AGENCY This policy is approved by the Group General Manager, Clinical & Care Services.'

Appendix C: Pain Management Policy

'1 PURPOSE

This policy sets out how a resident's pain will be managed and minimised in order to ensure the resident's comfort.

2 ORGANISATIONAL SCOPE

This Policy is to be followed by all staff throughout Oceania Healthcare.

3 LEGISLATION

This policy is based on HDSS NZS 8134:2008.

4 DEFINITIONS

For the purposes of this policy, unless otherwise stated, the following definitions shall apply:

Pain Management	"Pain management encompasses pharmacological, non-pharmacological and other approaches to prevent, reduce or stop pain sensations"

5 PROCEDURE

- All staff effectively recognise and report pain, particularly in cognitively impaired residents. They also recognise that all residents have a different level of pain threshold and different abilities to cope with pain.
- A resident with pain who is able to participate in the process is assessed by a Registered Nurse using the Oceania Healthcare approved tools. The onset of the pain, its location, duration, type, aggravating and, relieving factors and treatments already tried are included in the assessment.
- Residents with cognitive or sensory impairment and those with special language, cultural or educational needs are assessed and monitored by observing pain indicators, such as facial grimaces, vocal complaints, body language, reduced mobility, aggression and resistive response to care. The *Abbey* assessment tool is used for these residents.
- A multi-disciplinary approach to managing the pain is planned and implemented, which may include a comprehensive nursing assessment, a pain management specialists opinion, and a General/Nurse Practitioner review.
- Methods other than medications are considered when managing pain, i.e. repositioning, massage, approved heat treatments, mobilisation, passive exercise, music, relaxation or calming and reassurance.
- While an on-going pain management plan is being developed, the short term care plan is reviewed at least weekly, or more frequently if the resident's condition deteriorates.

- The effectiveness of the treatment is evaluated after each dosage or treatment is given. This is to be recorded in the resident's progress notes and on MediMap.
- When the pain is being effectively managed, the pain management strategies are documented in the residents Person Centred Care Plan, evaluated and reviewed six monthly or as necessary.

6 ASSOCIATED DOCUMENTS

Type	Title / description
PCCP	Pain Assessment (including Abbey Pain Scale) Pain Monitoring Tool Short Term Care Plan'

Appendix D: Clinical Incident/Accident, Sentinel Events and Notifications Policy

CLINICAL INCIDENT/ ACCIDENT, SENTINEL EVENTS AND NOTIFICATIONS POLICY

1 PURPOSE

The policy objectives are to:

- Focus attention on improving care to residents
- Facilitate quality improvement and risk reduction
- Ensure that the systems for identifying, reporting, and managing incidents/ accidents and sentinel events are robust and consistent with a quality improvement approach
- Ensure systems for identifying, reporting, and managing incidents/ accidents and sentinel events are appropriate to people's culture, values, and behaviours.

This will be achieved by:

- providing a standardized approach to investigate, analyse, and report on clinical incident/ accidents and sentinel events.
- encouraging a culture of learning- not one of blame
- providing a system for communicating lessons learnt from events so that others may benefit from the learnings
- ensuring that systems and processes change because of lessons learnt and these are evaluated.
- Having a reporting system in place for incidents/ accidents which provides an accountability mechanism, evidence of standardised root cause analysis investigation, and evidence of a standardised approach to implementation of safety practices.

2 ORGANISATIONAL SCOPE

This policy affects all staff and is aligned to the Oceania Healthcare Health & Safety policy (Section 05) and Food safety reporting system, but excludes events reported by the consumers (events reported by consumers are managed within in the Complaints policy)

NB – Visitors, contractors, property incidents etc are covered in the Health & Safety policy.

3 LEGISLATION

This policy is based on the following legislation:

- Health & Disability Sector Standards SNZ 8134:2020
- Health and Safety at Work Act 2015 (Associated Regulation and amendments)

- Health & Disability Act 2000(and amendments)
- Health Act 1956 (and amendments)
- Retirement Village Code of Practice 2008 (and amendments)
- Coroners Act 1988

4 DEFINITIONS

For the purpose of this policy and unless otherwise stated, the following definitions shall apply:

Incident	An undesired event, which under different circumstances could have resulted in harm to people, property, or loss of process
Accident	An undesired event that results in harm to people, damage to property or loss of process
Sentinel Event	An undesired event that signals something serious or "sentinel" has occurred and that warrants in -depth investigation to determine the root cause of the event.

5 CLINICAL INCIDENT/ACCIDENT MANAGEMENT

- All resident incident / accidents will be reported in eCase into the relevant resident incident register and in the eCase progress notes. Documentation will be objective, factual, and accurate.
- All entries into the incident/ accident register will indicate contributory causes to the incident/ accident, any immediate and other actions taken. The Clinical manager's review will give an overview of the incident/ accident and confirm that all necessary changes have been documented in the resident care plan as part of any corrective actions.
- Incidents/Accidents must be reported as soon as possible to the most senior person on duty to expedite investigation and increase likelihood of finding the cause of the event. The sooner the cause or details of the event are identified, the sooner preventative measures can be established.
- Any incidents/ accidents of a serious nature will be reported as a Sentinel event (see below).
- All witnesses to the event will be recorded

Village residents only- incidents will be notified to the relevant Village Manager and go through the reporting system used for Independent Living Units.

Food safety incidents/ accidents

- Any food safety incident/ accident involving a resident will be reported in eCase under Resident incident register

- Any other food safety incident/ accident (non-resident specific) will be reported in the relevant food safety reporting system

INCIDENT CLASSIFICATION TABLE – examples

What type of incident or event has occurred?		Examples
No Resident Involved (But potential for resident harm)	An incident occurred that had the potential to cause harm to a resident but was discovered before resident was involved	A meal was served up for a resident that contained a food item that the resident was allergic to. The error was noticed before the meal was placed in front of the resident – you must follow food incident reporting procedure
Resident Involved	If an injury occurs to a Resident only, you must complete the resident incident register in eCase	The Resident has fallen over and sustained a skin tear etc.
Resident Involved	If an injury incident where both Resident and Staff are involved – complete both the resident incident form in eCase and follow Health and Safety (HS) reporting procedures.	Staff member is hit by an aggressive resident causing minor injury.

6 EDUCATION

- All staff working in the care centres are provided annual education to identify risks and learn how to report incident/ accidents and Sentinel events. This will be completed during orientation and then via annual study days.
- BCMs/ CMs are provided with education on how to complete a root cause analysis investigation, along with how to write robust corrective action plans. Education will include the escalation process for serious/ sentinel events.

7 REPORTABLE EVENTS

- Any Serious/ Sentinel events involving residents are reported immediately by the BCM/CM to the staff outlined below.

- Reportable events are notified to the following persons in the following order:
  A) The person responsible for the supervision of the facility (i.e., RN on duty, Duty HCA)
  B) The person responsible for the oversight of the facility (on call manager e.g., CM/BCM)
  C) Regional Clinical manager/ Regional operations manager, who will escalate higher if necessary.
  D) Appropriate others e.g., Infection control national advisor

- It is the responsibility of the CM and BCM to ensure that sentinel events are followed up in a timely manner e.g., Immediate actions are taken, and then preventative measures and corrective actions are identified. The investigation process should commence within 24 hours and the process completed with 20 working days.

- It is the responsibility of the BCM/CM to send in and advanced sentinel event notification via IRENE within 24 hours after the event.

- It is the responsibility of the QCAM office to notify external agencies as required. Copies of notifications will be sent to individual facilities by the QCAM office for their own records.

- Sentinel Incidents/ accidents are reported monthly at staff meetings.

- Sentinel events are reported monthly, and relevant presentations reviewed at Clinical governance committee meetings. Lessons learnt and recommendations are presented at regional cluster meetings, Clinical Safety Forum meetings and other Oceania forums held throughout the year.

TIMEFRAMES FOR REPORTING

- Less serious events must be reported within 8 hours (prior to shift finishing).
- Serious risk must be reported as soon as is practicable to the one-up manager
- Clinical Sentinel event reports will be escalated to Group General Manager Clinical and Care Services as soon as possible after the event and will be escalated forward as required

8 INFORMATION TO RESIDENTS

- Residents/ families are notified as soon as possible after the event that affected their care/ treatment.
- Resident/ families will be advised of the actions that will be taken or have been taken to remedy any harm suffered by the resident.
- If an incident/ accident is reportable the resident/ EPOA will be informed.

NOTIFICATIONS TO EXTERNAL AGENCIES (see MOH notification table below taken from MOH website)

Examples of notifications

- Unexpected death of a resident not signed off by the GP/NP and referred to the coroner
- Nursing council notifications of nurses deemed to have deviated from Oceania policy where their practice is deemed to be unsafe (usually following on from an HR process)
- Any event that must be reported to regulatory bodies under statute or to the Oceania Healthcare insurer (see attached list for MOH section 31 notifications)

CONFIDENTIALITY

- Documentation is securely stored with approved access.
- The process complies with the Privacy Act 2020 and Health Information Privacy code 2020.

9 RELATED POLICIES, DOCUMENTATION AND REFERENCES

Type	Title / description
Policy / Procedures	Food Safety reporting (non-resident related) HS 05a Staff Incident Reporting, Recording Procedures HS 05b Serious Incident Escalation Process HS 05e Staff Incident Investigation Procedures Missing/ absconding resident policy
Register	Resident incident register(eCase) Medication incident register (eCase) Food safety online register
Online form	Advanced Sentinel event notification (IRENE online portal) HS 05f Notifiable Events Reporting to WorkSafe - Website link Food safety online reporting (via IRENE)

Type	Title / description
Form	HS 05c Staff Incident Reporting and Investigation Form HS 05d Incident Classification Table HS 05g Root Cause Investigation Form

10 APPROVAL AGENCY

This policy is approved by the Group General Manager, Clinical and Care Services.

11 APPENDICES

APPENDIX 1. Section 31 reporting guidelines for MOH

APPENDIX 2. Notifications and responses to external agencies

APPENDIX 3. Flow chart for Incidents/ Accidents/ Sentinel events

APPENDIX 4. Event Follow up and Investigation Process

APPENDIX 1. Section 31 reporting guidelines

Buildings and Governance **Notified by Group General Manager Clinical and Care Services**	**The Elements** **(which pose H&S risk to the safety of the residents)** **Notified by QCAM office**	**People** **Notified by QCAM office**	**Viral Outbreaks *** **Notified to PHU in local DHB by BCM/CM** **NB: Reoccurrence of outbreak will be notified to MoH by QCAM office**
Changes in the facility contact name, address, or telephone numbers Changes in the governing body, partners, or trustees Any new fixed building New clinical manager	Power outage over 4 hours Earthquake damage Flood damage Wind damage Fire damage Call bell failure over 4 hours No services available	Assault of any kind Intruders, trespassers, or harassment Missing medication Theft of any kind A missing resident (over 3 hours) A sudden or suspicious death A police investigation A coroner's investigation Pressure Injury Grade 3/4/ Unstageable/ SDTI	Norovirus Gastroenteritis (non-defined) Respiratory (RSV) Influenza TB Other

Note:

* All viral outbreaks should be reported to Public Health and the DHB Planning and Funding Manager.

Exceptions:

- Complex fractures should be reported to ACC.
- Falls witnessed/unwitnessed, and fractures should be reported via internal quality and risk management systems. These events do not require reporting under a Section 31.

2. APPENDIX 2- Notifications and response to external agencies

This communication sets out an overview of the process to be followed for notifications and communications with external agencies that are made on behalf of Oceania, in relation to our care health & safety and clinical areas. It covers all communications and notifications to the Ministry of Health (MOH) HealthCERT (including Section 31 notifications), DHBs, Health and Safety notifications to WorkSafe New Zealand, Ombudsman, regulatory bodies (for health professionals etc), Health and Disability Commission (HDC), Coroners, and the NZ Police. The CEO, the Board, and the Clinical Governance Committee (CGC) are made aware of these notifications through various monthly reports.

We have recently appointed a Quality, Compliance and Audit Manager (QCAM) who has the key responsibility for responding, co-ordinating, monitoring, and ensuring we meet our reporting requirements to these agencies. The QCAM is supported by the Clinical Administrator who maintains registers and files of the communications at Support Office. This new team is now the repository of **all** compliance, auditing, clinical, quality, health, and safety policies.

If any contact is received from any of the external agencies named above, the CM/BCM should immediately forward this to the Clinical Administrator and copy in the relevant RCM (for clinical-related matters), or Health & Safety Manager (for Health & Safety related matters) and ROM. The Clinical Administrator will inform the QCAM who will notify and brief the Group General Manager, Clinical and Care Services (GGMCCS). The GGMCCS is ultimately responsible for collating information on notifications to the agencies and reporting those to the CEO and Board.

Issues relating to communications with external agencies will be discussed at regular meetings between RCMs and ROMs and the GM Ops and GGMCCS to ensure that everyone is kept updated.

Your primary contact point for clarification as to notifications and responses to external agencies is the RCM and the QCAM.

Please also note that any HR investigations/concerns with regards to the clinical care and practice of a regulated health professional and HCA (who function under delegation and supervision of RN), need to be notified to the RCM and they need to be involved in the investigation and disciplinary processes. The RCM is responsible for escalating to GGMCCS. It is the GGMCCS who will notify the relevant regulatory body. Regulated health professionals who meet the requirements for notification under s34 of the Health Practitioners Competence Assurance Act 2003 will be reported to the relevant regulatory body by GGMCCS.

Please refer to the table below for further guidance, all of which is reflected into our current policies:

	Issue	Process to follow
1.	Death referred to Coroner	All communications regarding unexpected deaths that need to be referred to the coroner, or where the coroner has taken jurisdiction associated with a sudden or suspicious death, should be forwarded to the Clinical Administrator and the RCM and ROM copied in.
2.	Health and Disability Commission complaints	Any correspondence from the HDC Office needs to be forwarded to the Clinical Administrator and the RCM and ROM copied in. The QCAM will advise RCM and BCM on the type of investigation and required response to meet the requirements outlined by the HDC. The RCM will lead the investigation, ensuring that we have the information prior

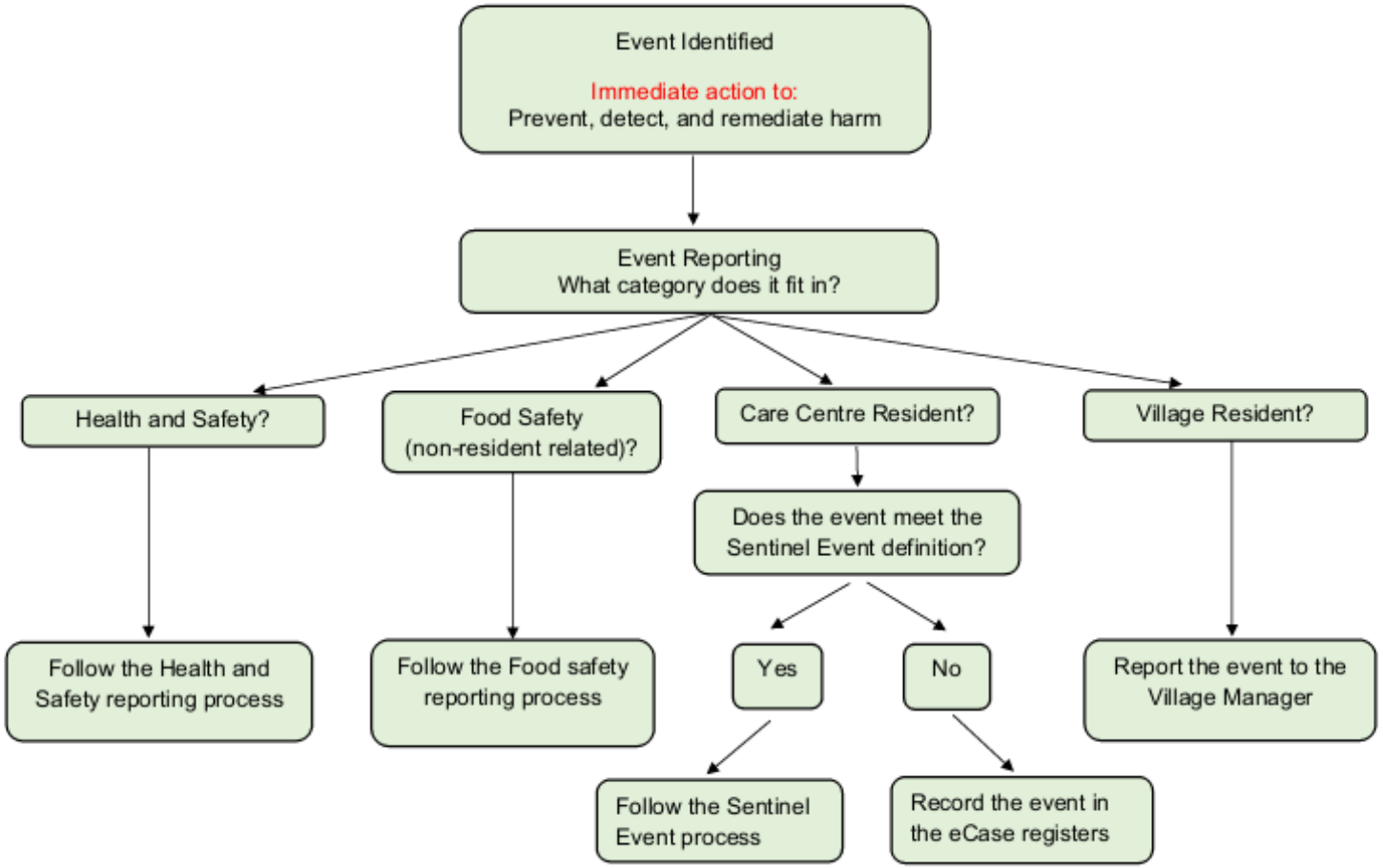
		to response deadline. All requests for time extensions for responses to HDC will be approved by GGMCCS. All documents and files are maintained by the Clinical Administrator.
3.	Ministry of Health- HealthCERT	**Sentinel events**- Please complete the Sentinel Advanced Notification as soon as possible after the event. The QCAM will receive this Notification and complete **a section 31 notification** if required. This notification will be forwarded to MoH and the relevant DHB by the Clinical Administrator. The BCM/ CM commences the investigation, overseen by the RCM, and once completed to the root cause stage, forwards to the QCAM who will work with the RCM/ BCM/ CM to address the root cause. All clinical indicators meeting the criteria of a Sentinel Event need to have a Sentinel Event notification completed, as well as completing the relevant register in eCase. Medication errors will be entered into the medication register but also separately highlighted as a Sentinel Event. **Changes of BCM/CM** will be notified to MoH/ HealthCERT by the Clinical Administrator after approved by GGMCCS. **Certification**- all correspondence, register and relationship management with auditors and HealthCERT, including changes in bed numbers or categories, will be managed by the QCAM and Clinical Administrator. Please advise the Clinical Administrator of any changes to bed numbers or categories.
4.	Police investigations	Please escalate all police investigations to the RCM and ROM will work with you. Please also inform the Clinical Administrator and QCAM. An Advanced Sentinel Event notification needs to be completed for police investigations.
5.	Ombudsman requests	Any correspondence received from Ombudsman's office needs to be referred to RCM and ROM and forwarded to Oceania's General Counsel.
6.	Notifiable Events (WorkSafe)	Any Notifiable Events or potentially Notifiable Events are to be escalated immediately to the ROM and Health & Safety Manager who will work with you to freeze the scene of the event. The HS Administrator should also be informed. H&S can assist with the investigation if required and will prepare the notification to WorkSafe. Please use the following email address for HSE matters- safety@oceaniahealthcare.co.nz

Once received, the Quality Audit and Compliance Manager will work on a response to these external agencies with the GGMCCS.

The CEO and/or GGMCCS must approve and sign off all communications sent to the organisations listed above.

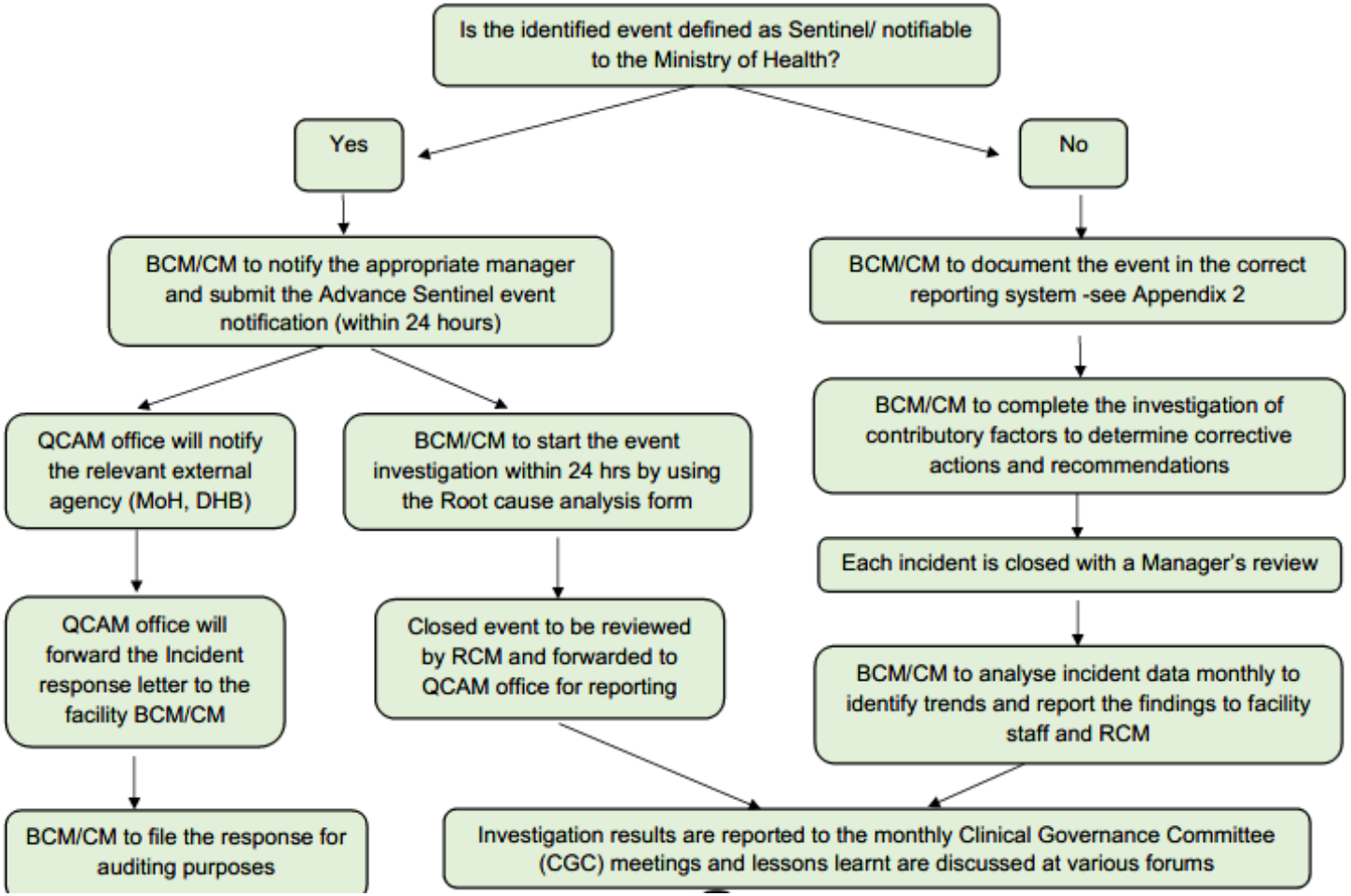
If you have any questions related to this process, please do not hesitate to contact your RCM or ROM.

Appendix 3. Flow chart for Incidents/ Accidents/ Sentinel events



Page 11 of 11

Appendix 4. Event Follow up and Investigation Process.



Appendix E: Falls Management Policy

‘1 PURPOSE

This policy sets out to guide staff to minimise the occurrence of falls by identifying the risk of a resident falling and then managing that risk.

2 ORGANISATIONAL SCOPE

This Policy applies to all staff employed by Oceania Healthcare.

3 LEGISLATION

This policy is based on the Health and Disability Services Standard NZS 8134.1 2008.

4 DEFINITIONS

For the purposes of this policy, unless otherwise stated, the following definitions shall apply:

A Fall	An unintentional change in position where the person ends up on the floor or other lower level; includes falls when assisted by others (InterRAI)

5 POLICY GUIDELINES AND PROCEDURE

5.1 Assessment and measurement of falls risk

All residents are assessed using interRAI and eCase assessment. Falls risk is determined by a triggered CAP and/or Registered Nurse observation of risk. Successful interventions will be indicated if Falls in interRAI assessment summary are no longer triggered on assessment and/or if frequent fallers are no longer falling.

5.2 Falls Risk Management Plan

A personalised fall management plan is developed following assessment and this is documented in the resident eCase care plan.

Nursing interventions for those identified with a fall risk may include, although not exclusively:

- Orientating the resident to the facility on admission
- Ensuring appropriate mobility aids are used.
- Ensuring footwear is appropriate, safe and fits properly.
- Continually assess the environment to reduce number of hazards, uneven surfaces and slippery surfaces
- Supervising activities

- Maintaining bed at low level Assisting with toileting at regular intervals
- Reminding residents to ask for assistance to transfer.
- Assisting residents to transfer
- Regularly assessing what tasks the resident can safely undertake. Ensuring call bell is within reach at all times.
- Ensuring seating height is suited to the resident need/ability.
- Close monitoring at regular intervals — intentional rounding
- Ensuring essential items are within reach.
- Use hip protectors where appropriate and acceptable to the resident (to prevent injury)

The use of equipment e.g. specialised beds, sensor mats and chair alarms where assessment indicates.

5.3 Resident Falls

All residents who fall must be assessed for injury by the most senior health professional on duty prior to moving their position.

If a resident is assessed post fall by an RN who is still in orientation period or is part of a new grad programme, a senior RN must oversee the assessment. Please refer to the APPENDIX 1: Post Fall flow diagram at end of policy for guidelines on process to follow post fall.

The senior staff member notifies:

- Family/EPA (adhering to Oceania Health Care Open Disclosure Policy)
- GP/NP whether there is an obvious injury or not. (This may not be required immediately Post Fall but should form part of the prevention follow up plan)
- An ambulance may need to be called and the resident transferred to hospital. If no RN is on duty the on-call nurse must be notified.
- Complete an Incident/Accident Reporting Form in eCase.
- Complete the Falls Risk Assessment Tool (FRAT) in eCase under charting. This is to identify contributing factors of the fall and further corrective actions to be taken. If the falls risk rating has changed following the FRAT being completed the RN updates the falls alert accordingly.
- Regional Clinical Manager must be notified for all residents who have a fall which results in an admission to hospital. This can be notified via email or immediately if injury is deemed serious in nature (i.e. life threatening)

Any **unwitnessed fall** or a fall that involves injury to the residents' head must have: -

- Documents fall in eCase progress notes and handover documentation.
- Commence a workflow in eCase for neurological observations for 24 hours (RN should have annual training to identify any unusual observations)
- Pain assessment should be completed for the following 48 hours post fall using the pain monitoring form under charting. Any increase in pain, especially with decrease in limb function should be highlighted to GP/NP to rule out potential fracture injury.

Other assessments that may be considered as relevant to the fall should be considered e.g.:

- Recent changes to medication
- Footwear assessment
- Vision screening
- Continence assessment
- Cardio-vascular assessment
- Depression screening
- Cognitive assessment (looking for wandering, agitation and impulsive behaviour)
- Syncope syndrome

5.4 Residents Who Fall Frequently

Residents who have fallen more than twice in one month must have a thorough reassessment of their health status. This may include:

- A medical review to exclude physiological causes, i.e. Delirium.
- A medication review (aim to maximise health benefits whilst reducing side effects)
- A nursing review of resident care plan
- A physiotherapy review (may benefit from strength and balance exercise programme)

Following the reviews, the resident care plan will be evaluated and updated accordingly. The resident will be entered on the Frequent Fallers Register by the Clinical Manager.

The residents on the register will be reviewed after each fall as per policy and will be removed from the register if falls decrease below 2 falls per month.

Injuries are to be photographed if permission is obtained from resident / EPA.

5.5 Sensor Mats

- Where a resident's care plan includes a sensor mat, the Registered Nurse needs to test the sensor mat's functionality with the call bell prior to it being used.

- For the sensor mats in situ, the Registered Nurse needs to check the sensor mat recording and this needs to be documented in the resident's eCase notes to show that the mat is present and working.
- If the regular sensor mat is not working, then a replacement needs to be arranged by a Registered Nurse.
- If a sensor mat replacement is not readily available, then the registered nurse should consider the steps required for resident's mobilization/care and these need to be reported to the care team/CM.
- Any faulty sensor mats need to be reported to the care centre maintenance.
- Maintenance staff are responsible for ensuring tag and testing occur on a regular cycle as per maintenance plan.

5.6 Falls Analysis

All falls are analysed monthly to identify trends and possible corrective actions.

Results are communicated to the staff via monthly facility Quality Meetings/RN meetings and entered into the eCase resident register. This register is reviewed by the Clinical manager monthly and a manager review completed. This data may be shared at Clinical Manager forums quarterly.

Oceania participates in Benchmarking data analysis with other aged care providers in some regions. Data analysis may be fed back to these regions.

6 REFERENCES

Frailty Care Guides — HQSC 2019

interRAI Long-Term Care Facilities Assessment Form and **User's Manual Version 9.1** Australian Edition 2011

7 ASSOCIATED DOCUMENTS

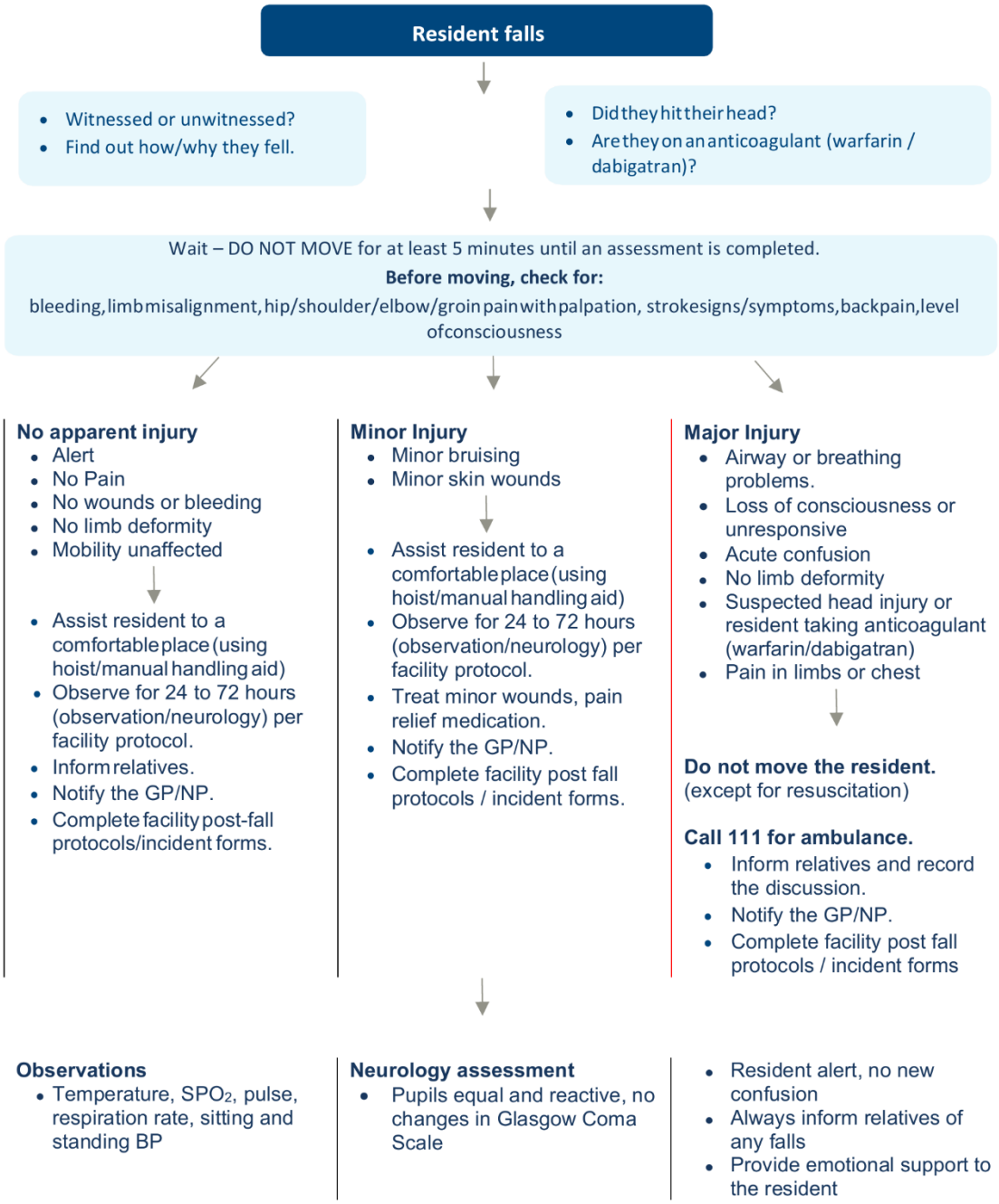
Type	Title / description
eCase	Incident Form
	Falls Risk Assessment Tool (FRAT)
	Neurological Observations Chart'

APPENDIX 1: Post Falls Assessment

FRAILTYCAREGUIDES | NGĀARATOHUMAIMOAHAUWAREA

Post-fall assessment

https://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/publications-and-resources/publication/2876/



Names have been removed to protect privacy (except Oceania Care Company Ltd, Elmswood Care Centre and the advisor). Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix F: Nursing Council of New Zealand Code of Conduct for Nurses

'PRINCIPLE 4.

Maintain health consumer trust by providing safe and competent care

4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

4.2 Be readily accessible to health consumers and colleagues when you are on duty.

4.5 Ask for advice and assistance from colleagues especially when care may be compromised by your lack of knowledge or skill.

4.8 Keep clear and accurate records.

4.9 Administer medicines and health care intervention in accordance with legislation, your scope of practice and established standards or guidelines.

4.10 Practice in accordance with professional standards relating to safety and quality health care.

Guidance: Documentation

- 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.
- Do not tamper with original records in any way.
- Ensure any entries you make in health consumers' records are clearly and legibly signed, dated and timed.'