Registered Nurse, Mr B

An Aged Care Facility

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC00477)

Overview

On 17 December 2007, a resident of an aged care facility[1] had an altercation with a registered nurse which resulted in the registered nurse pushing the man in the sternum, causing him to fall to the floor. The man developed severe bruising. This report considers not only this event, and what preceded it, but also the response.

Complaint and investigation

On 15 January 2008, the Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Mr B to her father, Mr J. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr J by Mr B. In particular, in relation to care provided on 6 and 17 December 2007.*
- *The appropriateness of the care provided to Mr J by an aged care facility.*

The investigation was delegated to the Deputy Commissioner, Rae Lamb. The parties involved with the investigation were:

Ms A	Complainant
Mr B	Provider/Nurse Manager/Registered Nurse
Ms C	Provider/Director of Nursing
Ms L	Manager
Ms D	Registered Nurse
Ms E	Cleaner
Ms F	Careworker
Ms G	Careworker
Ms H	Careworker
Dr I	General Practitioner
Mr J	Consumer
Mr K	Mr J's son

Independent expert advice was obtained from nursing advisor Wendy Rowe (see Appendix A).

[1] Any reference to the aged care facility includes the owner of the facility.

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Information gathered during investigation

Background

Mr J was 83 at the time of the incident. He had previously lived with his son, Mr K. However, Mr K felt that his father was no longer able to cope and had become increasingly unsafe at home. As a result, Mr J was admitted to a public hospital for a needs assessment. Mr J had been diagnosed with fronto-temporal dementia and was noted to be paranoid, argumentative and lacking insight.

The needs assessment was completed on 14 November 2007 and Mr J was assessed as requiring level 4 secure dementia level care.[2] He was subsequently admitted to a 20-bed specialised dementia unit in an aged care facility.

The aged care facility is funded according to a contract with the DHB. It has a 20-bed specialised dementia unit which, at the time of this incident, was divided into two separate wings. The first wing had 10 beds of D3 (dementia rest home level) patients. The other wing had 10 beds of D6 level (dementia private hospital level) patients.[3]

In late 2007 the dementia unit was normally staffed by one registered nurse who covered the whole unit, and three caregivers (generally one would cover the D3 side, with the other two on the D6 side). Mr B had been the nurse manager of the dementia unit since February 2006.[4] He had been a registered nurse since 1988 and was studying towards a postgraduate certificate in nursing. Mr B also has qualifications in teaching and with the New Zealand Police, and has experience in conflict management and caring for patients with psychiatric illnesses. Mr B generally worked the day shift from Monday to Friday. He advised that one day a month was allocated to administration and paperwork, but he was not always able to use that day owing to staff shortages.

3 December 2007

On 3 December 2007, Mr J was admitted to the D3 wing. Mr B, the registered nurse on duty, documented that Mr J was agitated and paranoid on arrival. The nursing progress notes state:

> "This 83 [year] old man was admitted today from [the public Hospital]. He is very angry and does not want to be here. He believes there is nothing wrong with him and is currently refusing all cares."

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[2] Level 4 on the support needs level assessment is described as, "There is a change in health/social situation and a higher level supervision/assistance is required due to increasing needs. Health professional supervision/care is needed regularly."

[3] The dementia unit has since been restructured and now has 20 D3 beds.

[4] Mr B resigned from his position at the aged care facility in February 2008.

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He was also noted to be "quite paranoid at beginning of shift", but settled throughout the day. At 2pm, Mr B documented that Mr J responded well to discussions about New Zealand history and geography as a form of distraction.

The care plan, completed by Mr B at the time of admission, documents that Mr J was independently mobile, requiring some assistance with cares. Mr B also noted that Mr J lacked insight and could be "accusatory to [his] son and staff".

Mr B has suggested that Ms D had primary responsibility for Mr J and was therefore responsible for updating Mr J's care plan. However, Ms D and the aged care facility both advised that Mr B had a responsibility for completing the residents' care plan when they were first admitted. The rostered registered nurse on duty then had a responsibility to update the care plan if and when it was necessary.

4 and 5 December 2007

Over the next few days Mr J appeared to be quite settled and nothing significant was recorded in the clinical records.

6 December 2007

On 6 December at 2am, the progress notes document that Mr J "had rolled out of bed on the pm shift". No injuries were noted and no incident form was completed. It was noted that Mr J had an unsettled night and his voice had kept other residents awake. This information was subsequently handed over to Mr B when he started the morning shift.

Mr B recalls that at approximately 7am, after he had taken a verbal handover from the night nurse and read the progress notes, he went into Mr J's room to check on him. Mr B found Mr J half out of his bed and tangled in a sheet. He then assisted Mr J to untangle himself and put him back to bed. Mr B recalls that Mr J was quite confused and disorientated. When he asked Mr J what was wrong, Mr J told him that he had fallen out of bed the previous night. Mr B noted some blood on the floor. After he established that Mr J was not injured, Mr B left him to sleep.

Mr B recalls that later that morning, at breakfast time, Mr J was upset and stated that he wanted to go home. Mr B explained to Mr J that this was not possible. He recalls that Mr J became quite upset, accusing Mr B of throwing him around the room. Mr B advised that he spent some time talking to Mr J, who eventually calmed down. Mr B recalls that Mr J then shook his hand and stated that he would try to be good and do what he was told. At 2.30pm, Mr B documented in the progress notes:

> "Not a good morning this shift, quite confused and paranoid and accusatory, also would not listen to staff and constantly trying to speak over the top of them."

He recorded that Mr J had "a lot of unresolved grief and personal issues" which were contributing to his "paranoia and underlying aggression". He also stated that the dementia

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was compounding Mr J's problems of "rationalisation" and therefore making it difficult for staff to explain things to him. Mr B then noted that Mr J had calmed down after lunch. He requested that the night staff carry out a thorough check of Mr J's body when showering him as he had found "blood on the floor where he had allegedly fallen".

At 9pm, Ms D, the registered nurse working the afternoon shift, documented that Mr J was "very upset re altercation with [charge nurse manager] this morning". She noted that Mr J was very upset and had begun crying when telling her what had occurred. Ms D asked Mr J if he wanted to document his concerns on a complaint form. However, Mr J declined.

Ms D also documented that a bruise and a small skin tear, which was clean and dry, was noted on Mr J's left shoulder while showering him. Ms D noted that this was "obviously the cause of blood on floor last evening". No further concerns were noted.

Later that night the progress notes note that "bruising ++" was noted on Mr J's left shoulder.

7 December 2007

The following day Mr B was again the duty nurse. The records state that Mr J was cooperative with cares, but became agitated when questioned about why he was wearing the same clothes as the previous day.

Mr J was reviewed by the rest home's general practitioner (GP), Dr I. Dr I advised that at the time of admission Mr J was upset about being admitted to the dementia unit and did not believe that he needed to be there. He blamed his son for admitting him. Dr I advised that Mr J had become increasingly paranoid and had not been sleeping well. Dr I subsequently increased Mr J's prescription of haloperidol.[5]

8/9 December 2007

On the morning of 8 December 2007, Mr J approached Ms D and advised that he had thought about their conversation on 6 December and he did wish to lodge a complaint. Ms D documented in the progress notes:

> "[Mr J] came to me this morning and told me that he did wish to put in a complaint/incident form in regarding Thursday morning's (6/12/07) incident with [the Nurse Manager]."

Ms D subsequently completed an incident form on behalf of Mr J on which she documented Mr J's complaint. In section one of the form Ms D documented:[6]

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[5] Haloperidol is used for the treatment of acute psychosis and delirium.

[6] The incident form in place has three sections to be completed. Section 1 — "to be completed by staff member reporting incident". Section 2 — "Registered Nurse in charge at time of incident to complete". Section 3 — "To be completed by [Registered Nurse] in charge of unit".

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> "Getting out of bed, [Mr B] asked me what happened last night, next thing he grabbed me 'like a sack of potatoes' out of bed, pulled me to the side of the bed and started dressing me 'pretty roughly'.
>
> [Mr B] shut the bedroom door 'he is the boss' told me 'I was paranoid' pointing his finger at me, told me also I was going to be locked up on the other side 'I felt frightened [and] scared' (patient then began to cry) would not let me talk, [Mr B] asked me to forget it and we then shook hands."

Section three of the form was completed by Mr B on 13 December. Under "assessment" Mr B documented:

> "Totally misjudged by patient who has diagnosed dementia (frontal/temporal). He lacks insight and his emotions are impaired. He is often accusatory and paranoid. Spoke to son re father's comments and son said he used to 'do this to me as well' and when things did not go his way he would start crying and getting attention from other people. These accusations did not occur."

At the bottom of section three, Mr B noted "for the attention of [Director of Nursing]". He has subsequently denied that an incident occurred.

While acknowledging that Mr J was quite paranoid as a result of his dementia, Ms D recalls that Mr J appeared to be genuinely upset about what happened. She believes there was a personality clash between Mr B and Mr J, which stemmed from Mr J believing that Mr B and his son were conspiring to keep him in the rest home.

The aged care facility advised that, following this incident being reported, the Director of Nursing, Ms C, "did not visit the patient to follow up on the accusations, as she did not consider it appropriate or warranted for her to interview a demented paranoid patient". Ms C commented that she reviewed the incident and concluded that Mr B had managed this incident appropriately by requesting a review by the GP. Ms C did not believe there were any unresolved issues in relation to Mr J's care and well-being at that time.

Over the next few days Mr J remained settled and no significant concerns were reported in the progress notes.

10 December 2007

On 10 December, Mr J was noted to be quite paranoid and agitated. The progress notes document that he was very loud and invasive towards the women in the dining room during breakfast time and had to be asked to leave them alone. Later that day, the progress notes state that Mr J had become "very paranoid and hostile" and refused input from staff. An incident report was completed by one of the nurses, which states:

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> "Whilst I was discussing with caregiver … re her roster/duties [Mr J] interrupted so I said please wait for a couple of minutes till I finished. He was annoyed and refused shower and put himself to bed. He accused me of asking him to shut up."

Mr B later completed section three of this incident report. He noted that Mr J had dementia and lacked insight and as a result became accusatory towards staff. He documented that no further action would be taken.

11–16 December 2007
The progress notes from 11 until 16 December show that Mr J was generally cooperative, although he was reported to become angry at times when he did not get his own way.

17 December 2007
On the morning of 17 December, Mr B, who was on an administrative day, was working in the staff office completing some paperwork. Mr B recalls that the registered nurse on duty, Ms D, was not present at 6.45am so he took handover from the night staff.

Ms C has confirmed that Ms D was rostered on that day and was present for her shift. However, she is unable to be sure what time she started her duty. Ms C said that she would have expected Ms D to have taken handover as she was the registered nurse on duty for that day, but commented that Mr B was generally at work early, so may have taken the handover on this day.

Mr B reported that at approximately 7am, while he was sitting in the nurses' office doing some paperwork, he saw Mr J pacing up and down the corridor. He recalls that Mr J walked up to the front entrance and began banging on the door yelling to be let out. He then walked back towards the office and started banging on the office window. Mr B stated: "He was banging and yelling and demanding that I let him out for approximately ten (10) minutes and I felt quite scared and upset by his behaviour."

Mr B stated that while Mr J had displayed aggressive and paranoid behaviour in the past, "on the morning of the 17th December he was the worst that I had seen him".

Mr B recalls that he initially tried to ignore Mr J in the hope that he would calm down and go away. However, Mr J continued to bang on the window. Mr B advised that he felt "frightened and intimidated". The progress notes written by Mr B describing the incident state:

> "[Mr J] [w]as up and dressed at the start of the shift. Aggressive, banging on glass window in office and demanding for the front door to be opened so he could go out. Started yelling and swearing and becoming more and more aggressive. Left for 10 minutes and ignored. When staff member went to go out office door [Mr J] was stood there and approached staff member with fists raised and right hand pulled back ready to punch, he said 'come on you want some' staff member trapped with partially closed

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> door behind and no where to retreat. So patient pushed out the way in a defensive manner. Patient fell to floor but lowered himself as he was falling."

Mr B was the "staff member". He explained that when he opened the door it closed behind him. Because the door has a keypad lock on it he was then unable to easily open the door and return to the office when Mr J confronted him.

Mr B advised that he pushed Mr J in the centre of his chest once with a clenched fist, explaining, "I have weak wrists and am not able to push very well with an open hand without causing pain and discomfort to my wrists." Mr B stated that he pushed Mr J firmly, but that this "definitely was not a punch". Mr J consequently "stumbled back and fell to the floor". Mr B described Mr J as falling onto his front with his hands bunched up underneath him.

Mr B advised that there were no witnesses present during this incident. The incident report records 7.30am as the time of these events.

No other staff member recalls hearing anything unusual. During subsequent interviews, both Ms D (who was working on the D6 wing) and Ms F (the caregiver who was working on the D3 side at the time of this incident) commented that, while the office is a short distance from the patient rooms on both wings, they believe that they would have heard Mr J if he had been making a lot of noise. Ms D stated that, because of the nature of the work, staff are very alert to unusual sounds.

In contrast, Ms C said that other staff were probably in bedrooms assisting other patients and it would "be easy for staff to be unaware that anything was happening". Mr B's lawyer subsequently added that while there are two rooms situated fairly close to the office, the other rooms are situated some distance from it. The lawyer considered that if a staff member was in either a patient room or the shower area, "they would be unlikely to hear anything else going on in the unit".

The aged care facility's policy for managing patients with disturbed behaviours states that in handling aggression the staff member must protect themselves and other residents. It also states that the staff member should leave a situation "when you are by yourself and feel you are in danger". The manager of the aged care facility, Ms L, advised that in an emergency situation a "three bell" system is used which summons assistance from another staff member. However, Ms L advised that in this situation there were no bells in the immediate vicinity.

The cleaner, Ms E, recalls finding Mr J lying on the ground when she arrived at work at approximately 7.40am. Mr J was lying on his side with his hands held up to his chest. There was no one else around at this time. She recalls Mr J calling out to her to "ring [Dr I], I have been punched". However, she told Mr J that she was only the cleaner and could not call Dr I. She then recalls that Mr B appeared from another room and walked right past Mr J without saying a word. Ms E felt that Mr B appeared quite "wound up". Ms E advised that she continued with her work as she did not think it was her place to interfere.

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Ms F recalls Mr B advising her of the incident immediately after it had occurred. Ms F stated that, at the time (approximately 7.45am), she was in the shower room[7] with another patient when Mr B came down the corridor calling out her name. Mr B advised her that something had happened with Mr J and he had put his hand out and that Mr J was now on the ground, but gave her no more information. Ms F asked whether everything was all right and whether he needed a hand, but Mr B said that everything was fine.

Ms F advised that after she had finished showering the other patient (about 10 minutes later) she saw that Mr J was still lying on the floor. Ms F recalls that Mr B then came out of the staff office and told her that he had put his hand out with a closed fist and Mr J came running at him and ended up falling on the ground. Ms F recalls this explanation clearly because she remembers thinking that it was odd that Mr B's explanation had changed. Mr B told her that Mr J was fine and that she should carry on with what she was doing, which she did.

Ms D recalls that after she had finished her medication round on the D6 wing sometime between 8am and 8.30am and was putting away the medication trolley, she saw Mr B sitting in the nurses' office and Mr J lying on the ground. Mr B has questioned whether Ms D had arrived at work by this time, but the rosters confirm that Ms D worked a full shift that day. Therefore, while Ms D may not have been present during handover, I believe that Ms D was present at 8.30am. Ms C also advised that it is not unusual for the medication rounds on the D6 side to be finished by 8.30am.

Ms D recalls that as she was returning from the D6 side she saw Mr B come out of the office, and he stated that Mr J had run into his fist and had fallen on the ground. She recalls that Mr J was then assisted to sit up in a chair.

In contrast, Mr B advised that after the fall, Mr J remained on the floor for approximately five minutes. He stated that "during which time I kept checking on him in between attending to other patients who required my urgent attention and who had been ringing their bells during this time". Mr B's lawyer has since added that after Mr J fell Mr B asked Mr J if he wanted to be helped up but he was verbally abused. Mr B therefore decided that it was best to leave Mr J where he was to give him time to calm down, but to continue to monitor him. Mr B felt that continuing to talk to Mr J would aggravate the situation. Mr B stated that "[Mr J] looked comfortable so I thought it appropriate in the circumstances that I left him on the floor and give him time to calm down".

Mr B advised that after a further five minutes he offered Mr J a chair to sit on. However, Mr J responded aggressively to this, stating that he wanted Mr B to leave him alone. Consequently, Mr B left Mr J alone for a further 5–10 minutes, during which time he advised that he continued to check him. Mr J subsequently allowed Mr B to get him a chair.

[7] The shower room is situated in an alcove around the corner, approximately 20 metres from the staff office.

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Mr B then contacted Dr I and asked him to come in to assess Mr J. Mr B stated that Dr I arrived at approximately 8.30am. However, Dr I recalls being called at his practice just after 9am. He did not document what time he arrived at the aged care facility. However, because the progress notes indicate that Mr J returned from having an X-ray at 10.50am we can conclude that he must have seen Mr J sometime that morning. In the medical records Dr I recorded:

> "[very] aggressive towards staff and has staff member bailed up against door. Staff member pushed him [and] he fell …"

Dr I arranged for a chest X-ray. He also made a referral to the DHB for a psychiatric review. Dr I's letter to the DHB stated that Mr J's presenting problem was "Paranoia aggression". Further to this he documented:

> "Since [arriving at the dementia unit] [Mr J] has been over intrusive with other patients, very paranoid, initially centered on charge nurse [Mr B] and his son but has spread to other family members. He has been more aggressive over the weekend and cornered [Mr B] this morning forcing [Mr B] to push him and he fell to the floor."

The X-ray showed no evidence of any fractures. However, Mr J was left with significant bruising around his sternum. Ms D advised that she accompanied Mr J for his X-ray, travelling by taxi. During this trip, Mr J told her that he had been punched in the chest. Ms D recalls that when assisting Mr J to get ready for the X-ray she was able to see a large bruise starting to develop in the middle of Mr J's chest.

Mr B advised that, following the incident, he also called Mr K to advise him what had happened. Mr B recalls that Mr K was very apologetic and said that this was not unusual behaviour for his father. This conversation is not documented in the progress notes.

Mr B later completed an incident form reporting the incident. In section one, Mr B outlined what had occurred. In section two, Mr B stated that he had notified the doctor and Mr K, that Mr J had been put in a chair and given reassurance, and that an X-ray had been taken. Mr B also completed section three. In this section, completed on 28 December, Mr B recorded that no fractures had been reported on X-ray and that a referral had been sent to the DHB for reassessment and "?D6 care".

Ms A, Mr J's daughter, advised that sometime on 17 December her brother called to advise that there had been an incident between their father and Mr B. Ms A subsequently called Mr B and recalls that Mr B explained to her that Mr J had become agitated and angry and had started banging on the window of the staff office. Mr B explained that he went out to talk to Mr J and some sort of incident took place between them. Ms A said that what she understood from Mr B's explanation was that Mr J had fallen onto the floor with his hands against his sternum resulting in him needing an X-ray.

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Ms A said that after she had spoken to Mr B she started to think about his explanation, and wondered how, from Mr B's explanation, her father could have hurt himself badly enough to need an X-ray. Ms A felt that something was wrong with the story. When she called the following day to follow up the results of the X-ray, she asked Mr B again about the incident. This was when she discovered that Mr B had hit her father using a closed fist. Her letter of complaint was subsequently written using the information provided to her by Mr B.

Mr B advised that in the days following the incident Mr J became preoccupied with it and kept telling people that Mr B had hit him.

Mr B recalls that a few days after the incident he telephoned Mr K to update him on Mr J's care. Ms A was visiting from overseas and answered the telephone. Mr B advised that as a courtesy he discussed Mr J's current state with Ms A.

On 24 December 2007, Ms A made a complaint about the incident of 17 December to the Director of Nursing.

On 16 January 2008, in response to Ms A's complaint, Ms C, Director of Nursing, wrote to Ms A. In conclusion, Ms C stated:

> "It appears to me that [Mr B] was threatened by your father and he took appropriate defensive action to safely de-escalate and manage your father's aggression. There was no intention to harm or injure your father, [the dementia unit] is a safe and caring environment and it is my intention to keep it so."

Ms C subsequently advised HDC that it was her responsibility, as the Director of Nursing, to follow up any major incident. However, she does not recall ever being informed of this incident at the time. Ms C advised that she was not aware of the details of the incident until she returned from a holiday in January 2008, at which time she commenced an investigation and met with the family to advise them of the action she was taking. Ms C advised that following her review she considered that Mr B had followed the appropriate process after the incident. She did not consider that any further action was warranted.

Ongoing care

Mr B advised that after the incident Mr J became quiet and settled. He advised that "there have been no further aggressive outbursts. [Mr J] did warm to me over the next few weeks and his behaviour and overall condition improved."

However, subsequent incident forms completed on the evening of 17 December and on 23 December report Mr J becoming unsettled at night and falling out of his bed.

On 14 February, an incident report completed by Mr B recorded an occasion in which Mr J accused Mr B of not allowing him to attend a family meeting. The progress notes written by Ms D document that Mr J had become quite "feisty" and was accusing Mr B of telling him things that were not true. Ms D signed the incident form as a witness. Mr B completed all

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sections of the form. In section three Mr B noted that "medications and reassurance and time away from stimulus are helpful for him".

Policy and procedures

The aged care facility incident reporting process requires that the details of an incident are described in section one of the incident form. The registered nurse in charge at the time is then required to review the incident and record in section two the details of what action would be taken. The Unit Manager should then review the incident, take any additional action if required, and complete section three of the form. The policy states that the Director of Nursing will review incident reports monthly and report any trends. If the incident involves serious harm, the incident reporting policy states that the incident must be investigated immediately. The investigation should be carried out by the Director of Nursing.

The policy for the "Management of Disturbed Behaviour" states that "it is essential for accurate records to be kept, this will enable nursing and medical staff to establish the cause and develop a plan of care in order to minimize re-occurrence". Accordingly, it has a "disturbing behaviour assessment and monitoring form" to ensure that all the necessary information is recorded to assist in identifying successful interventions and identifying behavioural trends. However, the policy does not state who is responsible for implementing the monitoring form.

Furthermore, the policy for hazard identification requires that, in a situation where patient behaviour due to illness may result in "attacks, assault, falls, injury", a nursing plan is developed to "reflect details of successful care approach. Staff education on the same". Ms C explained that staff would commence monitoring a patient's behaviour when it became clear that there was an ongoing problem. She considered this to be the responsibility of whichever staff member identified that there was an issue. Ms C advised, however, that the first step was to contact the GP. When the behaviour continued, staff would then commence monitoring the patient's behaviour to identify any strategies not already implemented to help address the problem. Ms C did not believe that there were any concerns in relation to Mr J's behaviour.

Mr B has suggested that Ms D was the primary nurse responsible for Mr J. However, as previously stated, Mr B was responsible for completing Mr J's care plan. Furthermore, Ms L, Manager of Aged Care Services, advised that following the incident on 17 December, because Mr J appears to respond better to female staff members, Mr J's care was transferred to registered nurse Ms D as his primary nurse responsible for care planning. Mr J's medications were also reviewed and changes made to his regime, including adding two sedative drugs to help him settle.

Ms L advised that Mr J is now much more settled, but still has occasional unpredictable episodes of paranoia and aggression.

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Further comment from staff

Ms D advised that, when Mr J first arrived at the dementia unit, he was unsettled. However, she does not recall any issues in relation to difficulty managing his behaviour. Similarly, all the carers interviewed agreed that while Mr J could be a bit difficult at times, he generally just wanted attention. None of the staff interviewed felt that Mr J was aggressive, or had heard of any situations in which he had been prior to the incident on 17 December. However, both Ms F and Ms D commented that they felt that there was a personality clash between Mr J and Mr B. Ms D believed that this was simply because Mr J felt that Mr B was conspiring with Mr J's son to keep him there when he did not believe that he needed to be there. Ms D also commented that while Mr B and Mr J did not necessarily get on very well, she had never observed any situations where she was concerned about the care Mr B provided. Furthermore, no staff had ever observed any concerns about the way Mr B dealt with any other patients. Ms C stated:

> "I have never had a problem with the nursing care that [Mr B] has provided to the residents and have always found him to be honest and forthcoming about anything that occurs in the unit to do with the residents. I have never had a complaint about his care of the residents from any of the other families."

Mr B

Mr B advised that he has previously worked as a constable in the Police, as well as a teacher, and has a lot of experience dealing with people with disturbed and challenging behaviour. Staff education records shows that Mr B completed a total of 11 hours in-service training between May 2006 and February 2007. The aged care facility advised that Mr B's most recent education in managing patients with difficult behaviours was a three-day course on "Nursing Management of Dementia, Delirium and Depression" in 2007.

Mr B stated that he is "very upset about the allegations and judgmental words used by [Ms A] in her letter of complaint". He believes that he is being unfairly accused of assaulting Mr J based on what Mr J has said.

Ms A

Ms A acknowledged that Mr J can be difficult to manage at times because of his dementia. However, it was her understanding that staff are trained to manage these types of situation. Ms A believes that Mr B failed to manage this situation appropriately. She is concerned that he may have an anger management problem.

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Ms A has since advised that Mr J is now much happier and settled at the dementia unit and she is happy with the care being provided.

Response to provisional opinion

Mr B

Mr B responded to the provisional opinion during an interview with HDC staff. On behalf of Mr B, Mr B's lawyer, has also provided a written response. In light of these responses, some amendments have been made to the previous section.

In her submission the lawyer stated:

> "It is also curious that the version of a man with dementia who is confused and is noted to be suffering increasing paranoia (see doctors notes of 8 December) is favoured over that of [Mr B]. This man is also known to dwell on incidents and to expand and confuse them as time goes on. His transfer notes from [the] DHB state that he 'has cognitive impairment and lacks insight'. It should also be remembered that he had fallen out of bed on the evening of the 6th and could well have the two incidents muddled and mixed up."

In relation to why he did not contact another staff member when he saw Mr J banging on the front door on 17 December, Mr B explained that he had seen Mr J exhibit similar behaviour in the past and he thought that if he left Mr J he would calm down as he had done previously. However, instead Mr J re-focused his anger towards Mr B, who he saw in the nurses' office. Mr B explained that Mr J started to bang on the window with such force that he thought the window would break. He therefore responded by opening the door to ask Mr J what he wanted. In her written statement, the lawyer stated: "At the time that [Mr J] was banging on the office window there was no opportunity to contact anyone." She explained that there is no emergency bell in the office and at that time of the morning the telephone in the office only rings in the hospital or the main office. In any case, because Ms D had not been at handover Mr B was unsure if she had arrived yet. Mr B considered that this situation was unavoidable.

The lawyer reiterated that when Mr B became trapped and felt threatened by Mr J, Mr B "pushed" him with a "closed fist" so that he stumbled backwards and fell slowly to the ground. The lawyer submitted that this could be verified by the fact that Mr J had no bruising on his buttocks or hips. Mr B denies that he punched Mr J. Mr B stated: "I could have punched or kicked him, which probably would have been justified in the circumstances, but I didn't, I did what I thought was safe and effective."

The lawyer stated that Mr B "cannot explain or understand why the bruising was so significant on this occasion and he is surprised that [it] was the extent it was given the degree

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of force he believes was exerted in pushing Mr J away". The lawyer submitted that elderly people are more susceptible to bruising. She stated: "It is common knowledge that older people with thinner skin bruise more easily and that therefore less force is required to sustain what can look like a substantial bruise." To support this statement the lawyer provided a copy of a page copied from a website that provides assistance in placing people in rest homes. The lawyer highlighted that bruising had been noted in Mr J's progress notes on other occasions following previous incidents such as a fall out of bed on 6 December.

The lawyer advised that Mr B left Mr J where he had fallen on the floor because Mr J continued to be verbally abusive and he was concerned that Mr J might hit or kick him if he got too close. The lawyer stated that "[Mr B] could tell by the way he had fallen that Mr J had not been injured and so left him to cool down". Mr B then attended call bells that had gone off in the interim. However, the lawyer advised that Mr B does not believe that Mr J was left on the floor for longer than 20 minutes, during which time he regularly checked him. The lawyer stated that Mr B's decision to leave Mr J on the ground "was a professional decision based on his experience with dealing with confused people who were agitated, angry and aggressive". Mr B disputes that Ms D ever saw Mr J on the floor.

The lawyer advised that Ms F's recollection that he told her that Mr J was "fine", was in relation to the fact that Mr B had left Mr J to calm down, which he considered was working.

In relation to why he filled out all three sections of the incident form, the lawyer acknowledged that it was "unwise practice for [Mr B] to complete all three sections of the incident report however as has been explained he did so because all 3 sections related to him at the time". She pointed out that Mr B was the person reporting the incident, the registered nurse in charge at the time, as well as the unit manager. Mr B advised that he had never been told that the form should not be completed in this way. The lawyer also explained that the reason that Mr B wrote in the third person was because he did not have strong writing skills and he believed that this was the best way of being objective in his writing. She stated that there was no intention to confuse or deceive by writing in this manner.

Mr B advised that following an incident, it would be his normal practice to notify Ms C immediately. However, he cannot remember whether he did on this occasion. The lawyer submitted that "[t]he fact that neither can recall whether this was done is not evidence that it did not occur".

The lawyer submitted that "[Mr B] did take adequate action to de-escalate the situation and that he did respond appropriately to Mr J's behaviour. He initially believed that if left Mr J would calm down at the front door. He acted promptly to Mr J's aggression at the window, fearing that the window would shatter and used force that he considered to be appropriate and effective to make Mr J stand away from him and to stop a potentially very real attack on himself. He then left the situation allowing Mr J to calm down whilst continuing to monitor him to ensure that he was safe."

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The lawyer also stated that "[Mr B] is a good nurse and has provided the Commissioner with letters of support from patient's families that attest to this. The Director of Nursing in her letter to [Mr J's] daughter describes [Mr B] as being patient, gentle, caring, defensive, considerate and a very good advocate for the elderly. She believed that he took defensive action that was appropriate to de-escalate and manage [Mr J's] aggression and that he had no intention to harm or injure [Mr J]."

Mr B stated: "I swear on my grandmother's grave that I have told the truth. I didn't do anything wrong. … I am a good nurse."

The aged care facility

Ms L responded on behalf of the aged care facility. In relation to the management of the alleged incident on 6 December, Ms L reiterated the aged care facility's view that there was "every reason not to accept the statements of a demented and paranoid patient". Ms L advised that she also considered that Ms D's comment that she had no reason to disbelieve Mr J's account of the incident was "naïve". Furthermore, Ms L commented that Ms D's statement that Mr J did not seem to have a problem with any other staff member was incorrect, highlighting an incident between another staff member in which Mr J became annoyed and accused her of asking him to "shut up".

In relation to the incident on 17 December, Ms L advised that she considered it very unlikely that any other staff member would have heard Mr J, even if he had been making a lot of noise. She advised that she and another staff member did an experiment in which one staff member banged and shouted in the nurses' office, while another staff member stood in the shower area. Ms L advised that no noise could be heard in the shower area. When they repeated this with someone standing in the dinning room on the other side of the unit a very faint thud was heard.

In relation to the technique Mr B used to push Mr J away, Ms L stated that they were "surprised" to learn that Mr B had used a clenched fist, commenting that the bruising appeared to be consistent with Mr B using an open palm. She stated:

> "[Mr B] had spoken to [Ms C], our Quality Manager and myself on separate occasions, and had demonstrated using an open palm. If the bruising did relate to this incident and not to subsequent falls out of bed … then it appears to us to be consistent with an open palm."

Ms L also stated that she did not believe that it was "abusive for [Mr B] to leave [Mr J] for a cooling period", given that he did offer Mr J a chair after about five minutes. However, she agrees that in "hindsight it would have been wiser to call [Ms D] to assist him at this stage". However, she also commented that "there is evidence [Mr J] when upset did in fact refuse assistance eg on admission and in the progress notes dated 10 December".

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In relation to the incident reporting forms, Ms L advised that this has now been reviewed. She also advised that the reporting of incidents is regularly discussed during staff meetings.

In relation to how the aged care facility records staff training, Ms L advised that it only records courses that it has provided or paid for. Ms L explained that the course attended by Mr B referred to in its previous statement had not been recorded on his training record because he had paid for it himself.

Ms L also advised that in the last 18 months the aged care facility has offered four courses relating to staff training on issues of patient abuse.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Opinion: Breach — Mr B

Standard of care

Mr B was the nurse manager for the dementia unit. He worked the day shift Monday to Friday. One day a month was allocated to administrative duties. On these days, another registered nurse was rostered on duty.

On 17 December 2007, Mr B was meant to be doing administrative work and Ms D was the registered nurse on duty. However, Mr B recalls that Ms D was not present for the early morning handover and he took it in her absence. Mr B advised that at approximately 7am, he was in the office completing some paperwork. He recalls seeing Mr J walk past and start banging on the front door demanding to be let out of the unit. Mr J then walked back to Mr B's office and began banging on the office window. Mr B stated that Mr J continued to bang on the window for approximately 10 minutes. No other staff members recall hearing

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anything unusual and Mr B and Ms L have advised that it would have been difficult for them to do so. Mr B described feeling "frightened and intimidated" when Mr J began banging on the window. He said Mr J was yelling, swearing and becoming increasingly aggressive. Because Mr B was concerned Mr J would break the window he decided to open the office door and ask what was wrong.

After he opened the office door, Mr B advised that he became trapped, unable to move back into the office. He felt threatened by Mr J and concerned that he would punch him. Mr B then "pushed [Mr J] in the centre of his chest once" with a "closed fist". Consequently, Mr J stumbled backwards and fell to the floor. Mr B advised that he left Mr J for approximately five minutes while he went to attend a number of calls bells that had gone off in the interim. He had to answer these bells because no one else was around to do so. Mr B explained that Mr J "looked comfortable so I thought it appropriate in the circumstances that I left him on the floor and give him time to calm down". Mr B then left Mr J on the ground for a further 5–10 minutes after Mr J refused a chair that was offered to him. Mr B advised that he checked on Mr J a number of times during this time.

In contrast, while no one can recall the exact time that Mr J remained on the floor, the accounts provided by staff members who arrived at the scene following the incident suggest that Mr B made little attempt to check or help Mr J. The cleaner, Ms E, stated that when she arrived at the scene, Mr B walked straight past Mr J, making no attempt to check him. She commented that Mr B appeared quite "wound up". Furthermore, both Ms F and Ms D recall seeing Mr B in the office during this time.

The policy for managing patients with disturbed behaviours states that in handling aggression the staff member must protect themselves and other residents. It also states that the staff member should leave a situation "when you are by yourself and feel you are in danger". Equally, principle 2 of the Nursing Council *Code of Conduct* (2004) requires that the "nurse acts ethically and maintains standards of practice". It specifically notes that professional misconduct could include "inappropriate use of force; or intimidation causing injury or bodily harm".

It is my view that Mr B did not comply with these requirements or respond appropriately to Mr J's behaviour. Several aspects concern me. In response to the provisional opinion, the lawyer submitted that Mr B initially thought Mr J would calm down and it was not until Mr J started to bang on the office window that he took action. The lawyer stated that "[a]t the time that [Mr J] was banging on the office window there was no opportunity to contact anyone". However, in his initial statement to this Office Mr B stated that Mr J was "banging and yelling and demanding that I let him out for approximately ten (10) minutes …" In my view that was plenty of time to contact another staff member for assistance, particularly since Mr B, in his own account, described feeling frightened and scared by Mr J's behaviour.

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Even if I accept that Mr B did not have time to respond once Mr J started banging on the window, he had 10–15 minutes prior to this when Mr J was behaving, in Mr B's words, "the worst that I had seen him", when he could have contacted someone. There were clear alternatives open to Mr B if he felt unsafe, and there was time to apply them. Even if he could not contact a staff member directly, it would have been wise to at least call through to the main hospital to notify someone else what was occurring.

The extent of Mr J's bruising is also of concern. In response to the provisional opinion, the lawyer submitted that elderly people bruise easily and therefore, it could not be proven that Mr B used force to push Mr J. To support this Mr B's lawyer provided a copy of a page copied from a website that provides assistance in placing people in rest homes. I have obtained further advice from my expert, Ms Rowe, who advised that sometimes medications, such as prednisone or warfarin, can lead to the patient bruising more easily.

Mr J was on 100mg/day of enteric coated aspirin.[8] I accept that this may have resulted in Mr J bruising more easily than someone not taking aspirin. Regardless of this, I note Ms Rowe's advice that, in her view, Mr J would not have experienced the amount of bruising he did if he had been gently pushed. I acknowledge that there is evidence that Mr J had experienced bruising on previous occasions. However, these were related to specific incidents such as Mr J falling out of his bed.

Furthermore, when Mr B was interviewed during this investigation, he stated: "I could have punched or kicked [Mr J], which probably would have been justified in the circumstances, but I didn't, I did what I thought was safe and effective." These comments lead me to have serious concerns about Mr B's insight.

Adding to my concern is the fact that Mr B has provided somewhat differing accounts about the incident. Both Ms F and Ms D recall Mr B advising them that "Mr J ran into my fist". In his statement to this Office, Mr B stated that he pushed Mr J with a clenched fist. Yet, Ms L advised that Mr B had demonstrated using an open palm to both herself and Ms C on separate occasions. This raises questions about Mr B's credibility and the degree of force used.

It is my view that this incident could have been avoided and Mr B did not respond appropriately.

While I acknowledge that at times Mr J was difficult to manage, I do not accept that Mr B's decision to leave Mr J lying where he fell for some time was professional. Even if I accept that Mr B felt unsafe getting too close to Mr J before he cooled down, Mr B should have, at the very least, asked another staff member to assist with Mr J, and checked him to see if he was injured. Instead he answered other residents' call bells. Clearly, there were other staff who could have assisted him with Mr J, particularly as it was common knowledge that Mr J

[8] This is a low dose of aspirin used as a prophylactic for stroke.

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responded better to females. I am also concerned by Ms F's comment that after she saw Mr J lying on the floor, Mr B told her that Mr J was fine and to continue with her work. Similarly, I note Ms E's recollection that Mr B ignored Mr J, walking straight past him. Neither of these comments suggest that Mr B was responding appropriately to the situation.

Incident reporting

Despite being directly involved, Mr B reviewed and evaluated the incidents on 6 and 17 December himself. He completed section three of the incident form for 6 December, and all three sections for the incident on 17 December. In the form for 17 December he did not indicate that he was the staff member involved. He simply referred to the "staff member". Furthermore, while I acknowledge that Mr B did inform Ms C of the incident on 6 December, there is no evidence that he promptly and formally notified anyone of the incident on 17 December, and sought their review. I do not accept the lawyer's submission that "[t]he fact that neither party can recall whether this was done is not evidence that it did not occur". Certainly no action was taken to investigate the incident by the aged care facility at that time. This would suggest that even if Mr B did inform Ms C that an incident had occurred, he did not clearly state the seriousness of it.

Incident reporting is an essential part of patient safety. Accurate and prompt reporting and analysis of each incident to determine the underlying factors are central to reducing the risk of similar incidents occurring in the future. Fundamental to this process is having the incident reviewed and evaluated by a person not directly involved in the incident. This is why there are three different sections on the incident forms, requiring sign-off by people in different roles. While I acknowledge that Mr B was fulfilling all three roles on 17 December, I am astonished that Mr B, an experienced nurse, considered that it was appropriate for him to be in charge of reviewing incidents that he was himself directly involved in. This is common sense. As noted by my expert advisor, Ms Rowe, in relation to the 17 December incident:

> "… the incident form is written in the third person. It is not completed in full. Not all questions are answered in sequence. All three sections are completed by [Mr B]. This is inappropriate given that he was the person involved directly in this incident."

It is my view that, in a situation such as this, the Director of Nursing should have been notified immediately and a review commenced. Not doing so demonstrated very poor judgement by an experienced nurse.

Conclusion

Mr B failed to take adequate action to de-escalate the situation on 17 December despite there being opportunity to do so. He also failed to appropriately respond to Mr J's fall and left him lying where he landed for some time. I am not convinced that Mr B made any attempt to check or assist Mr J. Certainly, accounts from staff suggest that Mr B was angry and "wound up", telling other staff to leave Mr J alone.

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In my view Mr B used unreasonable force when he felt trapped by Mr J and therefore failed to provide services in accordance with the relevant professional standards. He also failed to take reasonable steps to check Mr J for injuries or to call another staff member for assistance. Whether he thought Mr J was calming down or not, this was unacceptable. Furthermore, Mr B should not have reviewed the incident himself and he should have notified the Director of Nursing immediately that a serious incident had occurred. I conclude that by failing to provide services with reasonable care and skill Mr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). By failing to comply with the relevant standards Mr B also breached Right 4(2) of the Code.

Referral to Director of Proceedings

I accept that Mr B did not deliberately strike Mr J, and that Mr J's behaviour could be extremely difficult to manage at times. I also note that the aged care facility and others have found Mr B to be a good nurse.

However, the use of unreasonable force is completely unacceptable — whatever the circumstances. Furthermore, there was a marked imbalance of power. Mr J is a vulnerable, elderly, dementia patient, while Mr B is an experienced nurse with a background, training and experience, in managing conflict and difficult behaviour. I also note Ms Rowe's advice that Mr B's behaviour would be viewed with severe disapproval by his peers.

For these reasons, I have decided to refer Mr B to the Director of Proceedings who will consider whether disciplinary proceedings are warranted.

Opinion: No breach — The aged care facility

Under section 72 of the Health and Disability Commissioner Act 1994 (the Act) an employer is liable for acts or omissions by an employee unless they prove that they took such steps as were reasonably practicable to prevent the employee from breaching the Code.

As Mr B was an employee of the aged care facility at the time of these incidents, consideration must therefore be given as to whether it is vicariously liable for his breaches of the Code. Under section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

The aged care facility has provided evidence of Mr B's experience and training, which included training in the Police force and as a teacher. Mr B also advised in his statement to HDC that he has "several years dealing with patients who have challenging behaviours and who are afflicted with psychiatric illnesses". In 2007, Mr B attended a three-day course on

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Nursing Management of Dementia, Delirium and Depression. I am satisfied that Mr B was adequately trained in restraint management and de-escalation and the management of patients with dementia.

Part 4.2 of the *Health and Disability Sector Standards* (2001) requires that residents receive services that meet their individual assessed needs. Clause E4.4 of the *Aged Related Residential Care Services Agreement* requires that care planning must include "strategies for minimising episodes of challenging behaviours based on assessment and prevention".

Ms Rowe advised that when patients are admitted to a rest home it normally takes a few days for them to settle in. It is her expectation that a rest home would have a monitoring system in place that is available to staff if the patient begins to display difficult or challenging behaviours. Ms Rowe advised that implementing patient monitoring is the responsibility of nursing staff.

The aged care facility has provided a copy of its behaviour monitoring form. I am satisfied that this was available to all staff had they had any concerns about Mr J's behaviour.

I am satisfied that the aged care facility had adequate policies and procedures in place and provided adequate training to its staff. Overall, I accept that the aged care facility could not reasonably have been expected to prevent Mr B's actions and therefore is not vicariously liable for Mr B's breaches of the Code.

Other comment

Two matters in relation to the management of these events merit further comment.

Response to incident on 6 December
Ms C was notified of the incident on 6 December and discussed the allegations with Mr B. She did not speak to Mr J, and concluded that no further action was warranted because the GP had been asked to review him. I acknowledge that Mr J has dementia and was known to be paranoid and lacking insight. I also understand that at this time Mr J was very unsettled and unhappy about being there. However, I consider that it would have been wise for Ms C to take further steps to try to address Mr J's concerns. She should have spoken to Mr J and to other staff. Simply dismissing Mr J's allegations on the basis of his dementia, and accepting Mr B's opinion, was not sufficient in the circumstances. Closer review of the situation may have highlighted emerging difficulties in Mr J's relationship with Mr B and provided an opportunity to adjust his care so that other nurses were more involved.

Incident reporting
As discussed earlier, the reporting, analysis and follow-up of incidents is an important part of patient safety. The incident reporting forms required input from the person reporting the

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incident, the registered nurse in charge at the time of the incident, and the registered nurse in charge of the unit, plus subsequent review by the Director of Nursing. However, on 6 and 17 December Mr B was both involved in the incidents and the registered nurse in charge. My expert advisor, Wendy Rowe, has indicated that in these circumstances, common sense should dictate that someone else should review the incident. However, this did not occur. In my view this has highlighted a flaw in the incident reporting forms.

While I have concluded that it was Mr B's responsibility to appropriately report the incident and identify that the matter required review by another staff member, I am also concerned by some of the actions of other staff members during these events. Everyone involved in aged care has a responsibility to protect residents and report incidents, including auxiliary staff. Despite seeing Mr J on the floor, neither the cleaner, caregiver, nor the other registered nurse on duty reported the incident or took action to assist Mr J. It appears that all responsibility was deferred to Mr B. While I accept that he, as the senior nurse, indicated he was in control of the situation, I am left with a feeling that the response of other staff may be in part a reflection of the culture in place at the aged care facility.

I am pleased to see that the aged care facility has offered staff four different seminars on patient rights and abuse over the last 18 months and that incident reporting is regularly discussed at staff meetings. However, I hope that the aged care facility will use this as an opportunity to reinforce to all staff their role and responsibilities in responding to incidents, in particular the importance of ensuring residents are safe and well, incidents are reported, and that the incident review and analysis is carried out by someone not directly involved.

Recommendations

Mr B:

- Mr B should provide Mr J with a written apology for his breach of the Code. This should be sent to this Office to be forwarded to Mr J's family by **15 December 2008**.

The aged care facility

- The aged care facility should review their incident reporting forms and take steps to ensure that all staff are educated on incident reporting and the requirements for incidents to be reviewed by someone not directly involved.

The aged care facility should report back to this Office on action taken on these recommendations by **31 January 2009**.

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Follow-up actions

- Mr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report will be sent to the Nursing Council of New Zealand with the recommendation that it consider whether a review of Mr B's competence is warranted.
- A copy of this report, with details identifying the parties removed, except the names of my expert advisor and the aged care facility, will be sent to the District Health Board and the Ministry of Health (HealthCert).
- An anonymised copy of this report will be sent to HealthCare Providers New Zealand and the Association of Residential Care Homes, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings considered the matter and laid a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal found the nurse guilty of professional misconduct, and he was suspended for eight weeks, fined $500 and ordered to pay 25% of costs. The Tribunal imposed conditions on the nurse's practice that required him to undergo further study and supervision, and precluded him from practising in a sole charge or supervisory position for two years after the suspension. He was also required to undergo a competence assessment after he completed the prescribed study.

Link to HPDT decision:
http://www.hpdt.org.nz/portals/0/nur09115ddecdp070(anon).pdf

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Appendix A

Independent Advisor's Report

"I have been asked to provide an opinion to the Commissioner on case number 08/00477. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am a registered nurse with 23 years of nursing experience. I spent the first 15 years of my career working in a hospital in a variety of settings, mainly medical and rehabilitation. I then worked for seven years in the private sector mainly in the aged care environment. I now work as a senior academic staff member at a polytechnic and as a casual registered nurse for an agency, which includes Aged Care Facilities with Dementia Units. I have a Bachelor of Nursing, a Master of Arts and a Certificate in Adult Teaching and Education."

Expert Advice

[At this stage Ms Rowe refers to the information provided by this Office. This information has been removed for the sake of brevity.]

…

Additional information presented by the independent advisor:

"Videheck, S (2001) Psychiatric Mental Health nursing Lippmcott Philadelphia (p 221–229).

Elder, R, Evans, K, & Nizette, D, (2005) Psychiatric and Mental Health Nursing Elsevier Mosby: Sydney

Please comment generally on the standard of care provide to [Mr J] by [Mr B] and [the aged care facility]

The care provided by [Mr B] on 6 December is described in his statement clearly. However the clinical progress notes are written in the third person [Mr J's progress notes] entry for 06/12/07, 14 30 where it states "would not listen to staff and constantly trying to talk over the top them."

[Mr B's] conversation in his statement with [Mr J's] son [Mr K] about his abusive behaviour is not documented in the clinical records [Mr J's progress notes].

The incident form pertaining to this event is written by staff nurse [Ms D]. Although section three is completed by [Mr B] he does not explain what actually happened during this situation but that "these actions did not occur".

Also it indicates that this incident form needs to be brought to the attention of the [Director of Nursing], however there is no documented evidence of this happening. [Ms

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L], Manager Aged Care Services, indicates in her letter [dated 22 February 2008] that [Ms C] did not deem it appropriate or warranted to interview a "demented paranoid patient". This is not documented.

The Director of Nursing does not mention this event occurring in her letter to [Mr J's daughter], written in response to the complaint dated 16 January 2007.

On the 17 of December 2007 [Mr B] indicates that [Mr J] tried to get his attention for 10 minutes to let him out of the unit by banging on the door and window and yelling at him [in his statement to this Office]. During this period of time, [Mr B] ignored this behaviour hoping [Mr J] would go away. [Mr B] describes this behaviour as upsetting, frightening, scary and intimidating [in his statement to this Office]. When [Mr B] eventually opened the door he stood in the doorway with the door partially open and felt [Mr J] was about to punch him so he pushed [Mr J] with a close fist in the centre of his chest to protect himself. [Mr J] then fell to the floor. It appears from the statement that [Mr B] did not speak to [Mr J] at any stage, until five minutes later when he returned to offer [Mr J] a chair.

The clinical progress notes of the 17/12/07 [Mr J's nursing progress notes] written by [Mr B] state this event in the third person. Nowhere does it indicate that the [Charge Nurse Manager] was the person [Mr J] was being aggressive towards. The time is also incorrect as this entry would have been written some time after the event. There is no documentation that indicates that [Mr J's son] had been notified of this event or what was spoken about during this conversation. Although this is stated on the incident form [completed on 17 December 2007].

The incident form is also written in the third person by [Mr B]. It does state who was involved. This incident form does not indicate that the client fell to the floor after being pushed. The form [incident report] also does not indicate what was being X rayed. The entire incident form is completed by [Mr B], all three sections even though the incident only involved him and a client. There is no indication that the incident form would be forwarded to the Director of Nursing.

In the Director of Nursing's letter to [Mr J's] daughter, [Ms A] re the complaint [Ms C] indicates that [Mr B] was threatened by your father and he took "appropriate defensive action to safely de-escalate and manage your father's aggression." How this was done is not explained.

[Ms L], Manager Aged Care Services, indicated in her letter [dated 22 February 2008] that the police were notified of this event. This is not documented any where else.

Other staff caring for [Mr J] managed his behaviour appropriately. [Mr J] obviously liked and trusted Staff Nurse [Ms D]. During the time in mention the clinical progress notes indicate that [Mr J's] moods fluctuated and his behaviour was abusive at times.

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There are no issues with the care provided by the other staff members at [the aged care facility].

What standards apply in this case?

Documentation: Neither the clinical progress notes, nor incident forms are adequately completed for such a serious event. Follow up of the incident form is not evidenced, nor clear. The clinical progress notes are hard to read and should be written by [Mr B] in the first person, stating the facts in sequence. The time written needs to be correct for the event. A plan of action would have supported staff to care for [Mr J] following this incident.

Initial assessment and care plan: This assessment and care plan is not adequately completed so other staff members can know or understand how to manage [Mr J].

Once it was obvious that [Mr J] was experiencing fluctuations in moods and behaviours a behavioural assessment monitoring chart should have been instigated to show patterns of behaviour. This would be standard practice.

Were those standards complied with?

No.

Please comment on whether [Mr J's] anger and aggression, as described on 17 December 2007, was appropriately managed.

There were no attempts made by [Mr B] to talk to [Mr J].

No other staff member was contacted to diffuse the situation and/or distract [Mr J] before he left the office area.

Do you consider any alternative action could have been taken to de escalate the situation.

Yes.

Action should have been taken by [Mr B] immediately it became obvious to him that [Mr J] was not going to stop until someone took some notice of him. This could have been in the first minutes.

There was another registered nurse working in the unit at the same time as this event occurred. If this nurse could have been notified by phone, call bell, emergency bell or pager this would have been beneficial as [Mr J] liked this staff member. There may also have been other staff members who could have been notified to assist. There were two other hospital aids on duty that could have assisted.

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As [Mr J] was in no immediate danger [Mr B] could have stayed in the office.

I find it hard to believe that no one else in the unit heard [Mr J] banging on the glass and door and yelling over a period of ten minutes.

Please comment on whether the action taken by [Mr B] following the incident on 17 December was adequate.

When [Mr J] was pushed and fell to the floor [Mr B] did not talk to him at this point to ensure he was alright, instead he was left for five minutes before being approached. As this was [Mr B's] administrative day why was he answering the bells of other clients when there were adequate staff members on duty.

Although Staff Nurse [Ms C] was on duty and [Mr B] knew that [Mr J] had a good relationship with her he did not seek her out to assist him with [Mr J]. Instead he continued to manage the event in isolation of any other staff members.

The incident forms completed following the incidents on 6 and 17 December have been signed off by [Mr B] as the unit manager. Please comment on whether this was appropriate given [Mr B's] involvement in the incidents.

As stated previously, the incident form is written in the third person. It is not completed in full. Not all questions are answered in sequence. All three sections are completed by [Mr B]. This is inappropriate given that he was the person involved directly in this incident. There was another registered nurse on duty who could have commented directly following the event about [Mr J's] condition, and outlined follow up taken. The form should then have been forwarded to the Director of Nursing for her to complete section three.

Please comment on whether the policies provided by [the aged care facility] are adequate for a dementia unit housing residents such as [Mr J].

Restraint policy indicates staff training to occur annually for all staff [the aged care facility Restraint Policy]. This is not evidenced.

Management of Disturbing Behaviour Policy indicates under the heading of handling the aggression: if you feel you are at risk, then leave. A disturbing behaviour assessment and monitoring form would have been beneficial for this client.

Any other comments you wish to make.

[Mr B's] staff education record does not indicate that three day course attended [in 2007] as stated by [Ms L], Manager Aged Care Services. This record shows approximately 11 hours of in-service education attended between May 06 and February 07, not including the three day course ([in 2007]) which may have included 21 hours of

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teaching (and additional time to complete assignment which has not been completed in the four months following this course by [Mr B]). In total this would mean [Mr B] has attended approximately 32 hours of clinical in-service education between May 06 and February 08. If audited by Nursing Council, based on this information and not knowing of any additional clinical studies [Mr B] may have completed he would not meet minimum standards of sixty hours in the last three years.

I am surprised by [Mr B's] comments that he found [Mr J's] behaviour to be as upsetting and frightening. And that he was scared and intimidating considering [Mr J's] age and [Mr B's] previous occupations and experiences. [Mr J] was obviously a complex and complicated client to manage. During the time in question he exhibited a variety of behaviours towards staff and other residents. As stated by Elder, Evans and Nizette (2005, p. 57) "Violence rarely erupts suddenly. Frequently, aggression follows a period of mounting tension". They go on to explain "to decrease the likelihood of a situation escalating means recognising this possibility in its infancy, not its adolescence, violent episodes never occur as isolated acts, but as part of a process" (p. 58 & 356).

Overall Comment

The Clinical Nurse Manager failed to meet the standard of care and skill reasonably expected during this incident, and following documentation. I believe that [Mr B] did not provide an appropriate standard of care for [Mr J] on the 17 of December 2007. I believe he should have [sought] out help from other staff members during this event as he knew [Mr J] had paranoid thoughts about him. By opening the door of the office I believe [Mr B] reacted to the situation before thinking about alternative options. Following the event [Mr B's] documentation and follow up is inadequate. I believe that [Mr B's] peers would view the conduct with severe disapproval, taking into consideration his level of experience in this area of nursing. [The aged care facility] did not follow up or manage this incident effectively and may choose to review policies on documentation, emergency systems and incident reporting."

Further advice — care planning and monitoring

In relation to care planning, Ms Rowe advised that she considered that she would expect a rest home, particularly a dementia unit, to have adequate behaviour monitoring systems in place, such as a behaviour monitoring form available to all staff. Ms Rowe advised that it is not essential for the care plan to have a specific area for documenting how to manage a patient's difficult behaviour. It is the registered nurse's responsibility to identify any problems and document ways it could be managed.

Ms Rowe advised that when patients are first admitted it can be difficult to know much about the patient's behaviour and how it should be managed. It generally takes a few days for a patient to settle in. Ms Rowe advised that she would expect staff to implement a monitoring system if they considered there to be any issue with the patient's behaviour.

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Therefore Ms Rowe said that the rest home's responsibility was to ensure there were adequate monitoring forms in place.

Ms Rowe commented that in this case, if the other staff did not have a problem with [Mr J's] behaviour, but [Mr B] did [Mr B] had a responsibility to identify the problem and put in place something to manage this. Ms Rowe stated that it is her view that [Mr B] had sufficient experience to do this.

Furthermore, Ms Rowe considered that [Mr B] appeared to have sufficient qualifications and experience for his role.

In relation to the review of an incident when a staff member was involved in the incident, Ms Rowe advised that it would be her expectation that the staff member would not review the incident themselves. Ms Rowe advised that she did not necessarily think that the rest home had a responsibility to have this written into policy, this was simply common sense. Ms Rowe stated that it was not appropriate for [Mr B] to review the incident on 6 or 17 December.

Specifically, in relation to the incident on 17 December, Ms Rowe stated that if the Director of Nursing was away whoever was second in charge had a responsibility to review the incident. If the incident was reviewed by another staff member this should have been documented.

Further advice — bruising

In relation to whether elderly people have a higher predisposition for bruising, Ms Rowe advised that some medications, such as prednisone or warfarin, can cause a person to bruise more easily. However, Ms Rowe advised that while bruising is often seen in elderly patients, this is generally the result of them bumping into things and falling more often.

In relation to the article provided by the lawyer, Ms Rowe said that this is an article from the internet. While she had not seen the article, she said that for it to be considered as supportive evidence it would need to be edited and published in a reputable peer reviewed journal/website.

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