Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 23HDC01644)

Introduction

1. On 23 June 2023, this Office received a referral from the Coroner about the care provided to the late Mrs A (in her eighties at the time of events) while she was a resident at Heritage Lifecare Limited (trading as Hodgson House Lifecare and Village).

2. The following issue was identified for investigation:

- *Whether Heritage Lifecare Limited provided Mrs A with an appropriate standard of care between 29 Month1[1] and 6 Month2 (inclusive).*

3. Sadly, on 16 Month2, Mrs A passed away in hospital.

4. This report is the opinion of Carolyn Cooper, Aged Care Commissioner.

Background

5. Mrs A's medical history included end-stage lung cancer with a long-standing productive cough, a left breast lumpectomy[2] in 1995, COPD,[3] chronic low blood pressure, lower back pain, and constant chest pain from a non-union fracture[4] of her rib.

6. Mrs A's daughter, Mrs B, was noted as her next of kin and, at the time of these events, she held an enduring power of attorney (EPOA)[5] for Mrs A's personal care and welfare.

7. Mrs A was in hospice[6] from 10 Month1 to 28 Month1. On 29 Month1, she was admitted to Hodgson House[7] for palliative[8] care owing to difficulty managing her pain and essential needs at home because of end-stage lung cancer. It was documented that Mrs A was '[q]uite aware' that she was on a palliative pathway.

[1] Relevant months are referred to as Month1–Month2 to protect privacy.
[2] Surgery to remove cancer or other abnormal tissue from the breast.
[3] Chronic obstructive pulmonary disease (lung disease that restricts airflow and causes breathing problems).
[4] A fracture that persists for a minimum of nine months without signs of healing for three months.
[5] A legal document in which a person (the donor, in this case Mrs A) appoints another person (the attorney — Mrs B) to make decisions on their behalf if the donor becomes incompetent.
[6] A hospice provides palliative care.
[7] Hodgson House provides palliative, hospital, and rest-home levels of care.
[8] An approach that focuses on providing relief from the symptoms of stress of a condition, such as cancer.

8. This report considers the adequacy of the initial assessments undertaken when Mrs A was admitted to Hodgson House, the management of Mrs A's wounds and falls risk, and an incident in which Mrs A left the facility unnoticed and suffered a fall.

Documentation, assessments, and admission to Hodgson House

Policies and agreements

Care planning policy and procedure

9. The purpose of the care planning policy is to 'develop and document a resident-centred care plan using a collaborative approach …' The policy documents that registered nurses are 'responsible for [the] development and review' of care plans. In terms of timeframes, initial care plans are to be developed within 24 hours of a resident's admission; short-term care plans are to be developed in response to acute care needs of the resident and evaluated at least weekly; and long-term care plans are to be developed within three weeks of admission. It is documented that care plans are to be 'comprehensive' based on the resident's individual needs to ensure that care is provided 'continuously and collaboratively in line with their diagnoses [and] agreed goals of care …'.

Pain Assessment and Management policy and procedure

10. The purpose of the Pain Assessment and Management Policy is to provide each resident with an 'individualised pain relief [plan] with the aim of preventing unrelieved pain in relation to acute and chronic pain'. The policy outlines the responsibilities of the registered nurse, such as ensuring that residents receive regular and PRN (as required) pain relief, and that pain assessments are completed for residents on admission. The information from the pain assessment is then recorded into the resident's initial care plan along with interventions to guide staff on how to alleviate the resident's pain. It is also documented in the policy that the registered nurse documents the effectiveness of pain-relief medication in the resident's progress notes. The policy documents that in the case of chronic pain, this is to be recorded in the resident's long-term care plan.

Age-Related Residential Care Services Agreement

11. Health NZ contracts with aged residential care providers for delivery of services to older people via the Age-Related Residential Care Services Agreement. This agreement requires that registered nurses are responsible for creating care plans, and each resident's health and personal care needs are assessed on admission in order to establish an initial care plan to cover a period of up to 21 days.

12. The following subsections set out the information in the hospice's transfer documents, as against that in the admission assessments at Hodgson House, with respect to Mrs A's skin integrity, pain management, and falls risk.

Skin integrity

Hospice — transfer paperwork

- Mrs A's Waterlow[9] score was 19, which meant that Mrs A was at high risk[10] of developing pressure injuries. Mrs A's high score would have accounted for her existing pressure injuries (noted below).
- Mrs A had two stage 2 pressure injuries[11] on her sacrum,[12] which required protective dressings and daily monitoring, and for her to have regular time off her sacrum as much as possible, along with the use of pressure-relieving aids.
- Mrs A was at a high risk of developing cellulitis[13] on her legs, so she required daily monitoring for any redness, heat, or complaints of pain (in relation to her legs).

Hodgson House — initial assessments and care plans on admission

- It was documented that Mrs A had grade 2 pressure injuries on her sacrum. However, although she was assessed as having a high risk of further pressure wounds, there was no information on how to monitor and manage her pressure injuries and no short-term care plans were developed.
- It was documented that Mrs A had recurring cellulitis. However, there was no further information on this form as to the location of the cellulitis or how to monitor and treat her cellulitis, and no short-term care plan was developed.

Pain management

Hospice — transfer paperwork

- Mrs A required regular and PRN pain relief for a non-union rib fracture, chronic back pain, and neck and left arm pain, and therefore was prescribed regular paracetamol and fentanyl[14] patches and PRN oxycodone for breakthrough pain.[15] It was noted in the hospice notes that Mrs A's main concern was the management of her pain.

Hodgson House — initial assessments and care plans on admission

- It was documented that Mrs A had no pain on admission, and that she was prescribed regular and PRN pain relief. A pain assessment tool (which described the location, severity, and quality of pain) was not completed for Mrs A on admission.

[9] A Waterlow score is an interdisciplinary assessment that determines an individual's risk of developing pressure injuries.
[10] The Waterlow scores are as follows: at-risk patients, a score of 10–14; high-risk patients, a score of 15–10; and very high-risk patients, a score of 20 and above.
[11] Stage 2 pressure injuries present as an ulcer or open wound.
[12] The area of the lower back just above the buttocks.
[13] A bacterial infection of the skin and tissues beneath the skin, most commonly affecting the legs.
[14] A strong synthetic opioid painkiller.
[15] A strong opioid painkiller.

Falls risk

Hospice — transfer paperwork

- Mrs A was assessed as having a high risk of falling, due to previous falls (in 2020 and in Month1).
- Mrs A needed to be supervised when transferring, as her co-ordination was 'fluctuating/poor'.
- Mrs A required a seated walking frame so that she could rest when she was short of breath. Occasionally she would mobilise outside using a scooter, but currently she was not using this.
- Mrs A had to be encouraged to use the call bell for assistance to ensure that she had appropriate support when mobilising, due to her high falls risk.
- Mrs A required a sensor mat[16] overnight so that staff could be alerted to her movements and offer their assistance if she required it.

Hodgson House — initial assessments and care plans on admission

- It was documented on Mrs A's initial assessment on 29 Month1 that she was not at risk of falling. A COOMBE falls assessment[17] completed two days later noted that Mrs A was at a medium risk of falling. However, Mrs A's risk assessment summary form was not updated with this new information, nor was a short-term care plan created to direct staff on how to manage her falls risk.
- It was documented that Mrs A required a walking frame to mobilise. However, the assessment did not specify whether she required specific assistance.

Hodgson House — other admission records

- Mrs A's baseline vital observations were recorded on admission (they were within her normal limits). However, no further vital or neurological observations were recorded for Mrs A during her stay.
- It was documented that Mrs A had allergies to grapefruit and a 'severe' allergy to atracarium,[18] but there was no further information about how the allergy manifested, or the signs and symptoms of the allergy response and the intervention required, and a short-term care plan was not developed.
- It was documented that Mrs A wore hearing aids and glasses. However, the assessment did not note that she did not like wearing her hearing aids (as was recorded in the hospice's transfer paperwork).

[16] A device used to detect a person's movements.
[17] Assessment of a person's risk of falling.
[18] A medication used in general anaesthesia.

- It was documented that Mrs A was 'extremely thin, emaciated'. However, no further assessments were made in relation to her weight management or nutrition, and no short-term care plan was developed.

13. There is no evidence that collaboration with Mrs A and her family occurred during these initial assessments to ensure that all her needs were expressed and noted by the admitting registered nurse.

14. Although Mrs A's assessment paperwork appears incomplete and lacking in detail, as outlined above, Mrs A's progress notes on the day of her admission relating to her skin integrity appear comprehensive. The progress notes document that Mrs A had a pressure injury on her sacrum and note the size and grade of the injury. The nurse documented that Mrs A required regular repositioning when in bed. The notes document that Mrs A was at a high risk of cellulitis in her left lower leg. The progress notes also document that Mrs A had a grapefruit allergy, but no further information was included. It is unclear why this information was not incorporated into short-term care plans.

15. Heritage Lifecare told HDC that it accepts that there should have been 'some short term care plan documentation to address matters such as the pressure injury, and that is not present'.

Management of Mrs A's pressure injuries

Policy

Wound Assessment and Management Policy

16. The purpose of the Wound Assessment and Management Policy is to provide guidance to staff on the 'key elements of effective Wound Management in order to optimise healing in acute, chronic and complex wounds'. The policy outlines that registered nurses are responsible for '[m]aintaining accurate and comprehensive wound management documentation including photographing wounds weekly' and are responsible for completing a wound assessment as soon as possible after the wound has been identified, along with developing a short-term care plan. The policy also outlines that it is the registered nurse's responsibility to ensure that new wounds are entered into the Wound Register. The registered nurses are also responsible for developing and reviewing wound management care plans.

17. As noted above, Mrs A was admitted to Hodgson House with compromised skin integrity related to her two sacral pressure injuries, lower leg oedema,[19] and history of lower leg cellulitis.

18. Although on admission it was noted that Mrs A had pressure injuries and she was assessed as a high risk of further pressure injuries, the assessment was incomplete and there was no short-term care plan to direct staff on how to monitor and manage her pressure injuries.

[19] Swelling.

19. It was documented in Mrs A's progress notes on 30 Month1 that the staff were aware of her pressure injuries, and on 5 Month2 it was documented that she was 'repositioned regularly' and a barrier spray was applied to her sacrum.

20. Heritage Lifecare told HDC that Mrs A's pressure injuries were 'not managed in the way that Heritage would expect such … pressure [injuries] to be managed. [They were] not added to the wound register and there were no photos taken of the pressure [injuries] upon admission [nor] a short-term care plan put in place.'

Pain management

21. As noted above, in relation to pain management Mrs A was prescribed regular paracetamol[20] and fentanyl patches. To manage breakthrough pain ,[21] she was prescribed PRN oxycodone.

22. It was documented in Mrs A's progress notes on 30 Month1 and 1 Month2 that Mrs A had complained of pain in her sacral area and was given liquid oxycodone. It is recorded in the electronic medication record that at both times she described her pain as 9/10 on the pain scale,[22] and the nurses recorded that the oxycodone worked with '[g]ood effect' in relieving her discomfort.

23. As noted previously, Mrs A's Pain Assessment Tool dated 31 Month1 (which discussed the location, severity, and quality of the pain) was not completed on admission, and a short-term care plan to manage her pain was not developed, even though Mrs A was on regular and PRN pain relief.

Mrs A's falls risk assessment and management

Policy

Falls Prevention and Management Policy

24. The purpose of the Falls Prevention and Management Policy is to 'provide guidance to [staff] about minimising falls and reducing harm from falls'. The policy notes that those at the highest risk of falling are residents who are new to the facility. The policy documents that registered nurses are responsible for identifying the falls risk for individual residents and are 'to ensure prevention strategies are documented in the [long-term care plan] and interim care plans' and that these plans are reviewed as required. They also have the responsibility to ensure that the Physiotherapist Support Plan is identified in a short-term care plan or a long-term care plan. The policy also notes that the falls risk assessment factors are to be entered into the resident's progress notes within 24 hours of admission. This policy documents that the FRAT (Falls Risk Assessment Tool[23]) or the COOMBE assessment tool is to be used when assessing new residents on admission and can be used at any other time

[20] Non-opioid pain relief for mild to moderate pain.
[21] A sudden increase in pain that may occur for people who already have chronic pain.
[22] An assessment tool used to determine a person's level of pain.
[23] A FRAT is used to assess a person's risk of falling and categorises the person into low, moderate, or high risk of falls. This assessment then forms the basis of the falls risk care plan.

the registered nurse considers appropriate. The falls risk is to be documented as part of the resident's initial assessment and a care plan developed within 24 hours of admission.

25. It was documented that prior to her admission to Hodgson House, Mrs A had fallen at her home on 22 Month1 and had 'sustained 3 or more falls in a one-month period over the past six months'. Her COOMBE falls assessment form (completed on 31 Month1) noted that overall she had a medium risk of falling.

26. Heritage Lifecare told HDC that Mrs A's COOMBE assessment was filled out incorrectly, and it noted a score of four for mobility status. In the COOMBE assessment, under the area of 'mobility status', a score of four indicates that the resident requires the assistance of another person(s) to walk and is known to try to walk unassisted. However, Heritage Lifecare advised that as Mrs A was independent with her walking frame, its view is that the score should have been two, which would have made her overall score a low risk of falling.

27. Heritage Lifecare told HDC that an observation chart was in place to document Mrs A's mobility. However, Heritage Lifecare stated: 'We have not been able to locate that chart. In that situation there were [no] specific measures in place to prevent [Mrs A] suffering a fall.'

Environmental safety considerations

28. When Mrs A was admitted into Hodgson House, her room was located next to an exit door. Heritage Lifecare told HDC that the room Mrs A was initially planned to occupy was occupied by another resident 'whose needs were greater than Mrs A's at the time'. Heritage Lifecare told HDC that therefore Mrs A was not in an actual palliative bed but in the 'geographical area where those palliative beds were located'.

29. Heritage Lifecare said that this new location was discussed with Mrs A's family, who were 'happy' with that room, and a physical orientation 'is understood to have occurred'.

30. Regarding Mrs A's room being located next to an exit door, Heritage Lifecare noted that on assessment, Mrs A was identified as being 'cognitively aware of her surroundings and her limitations', and therefore it was not anticipated that she would leave the facility without telling someone', and intentional rounding[24] and regular visual checks on Mrs A 'were not required'. It was also documented that Mrs A could use her call bell if required.

Call bells, CCTV[25] surveillance, and door alarms

31. In an undated internal six-monthly audit regarding maintaining the call-bell system, it was documented that the call bells had not been tested 'within the past six months, and any faults remedied'. No corrective action plan was put in place to remedy this. In a maintenance audit report dated approximately six months prior, it was noted that there were concerns

[24] Checking of a resident, usually hourly, to ensure that the resident is settled and does not need any assistance.
[25] Closed-circuit television.

that the fire doors were not in 'good repair', but again no corrective actions were identified to remedy this.

32. Hodgson House had CCTV surveillance cameras to monitor residents' movements should they leave the care home, but Heritage Lifecare told HDC that it could not provide HDC with any CCTV footage due to an electrical fault.

33. In a statement to the Police, the care home manager of Hodgson House explained that there were switches above the exit doors, similar to light switches, that when turned on at night have an alarm that sounds when the door is opened.

34. It was documented that Mrs A's family were told that Hodgson House was a 'non secured unit' in which the residents were 'free to open doors to go outside' and that Hodgson House 'cannot watch residents 24/7'.

Sentinel event 6 Month2 — management of Mrs A following fall

Policies

First Aid policy — Heritage Lifecare

35. The purpose of the First Aid policy is to ensure that 'appropriate first aid is provided as quickly as possible for any injured … resident'. The policy discusses first aid officers' responsibilities but does not provide instructions on the actions to take if an event occurs.

Falls Prevention and Management Policy

36. In terms of post-fall management, an incident form is to be completed 'as soon as possible or at the latest by the end of the shift after the event including as much information as possible about the fall, potential or known causes, any assessment of treatment given post fall'. It is documented that the registered nurse is to check the resident for injuries, pain, and bleeding and take baseline vital signs and neurological observations (especially if it is an unwitnessed fall). Regarding neurological observations, the policy states: '[The] [f]all must have been witnessed in order to rule out [the] need for neurological obs.' If it is a serious injury, the policy directs staff to stay with the resident keeping them warm, and to call an ambulance and notify the GP, on-call senior staff, and the next of kin/EPOA.

37. In the early hours of 6 Month2 Mrs A was seen out of her room and appeared 'a bit confused and agitated' as she was wandering around the care home. She was redirected back to her room.

38. It was documented that Mrs A was last seen in her bed around 6.10am. At 6.45am Mrs A was discovered outside the care home, approximately 25 metres away from her room.

39. It was documented by the registered nurse on duty, RN C, that she was approached by a carer 'stating there was a lady lying in the garden in the driveway outside in her nightgown'. RN C attended to Mrs A and noted that some succulents had been ripped out of the garden and that initially Mrs A was 'unresponsive and cold to the touch'. The carer provided blankets to warm up Mrs A and noted that Mrs A was 'mumbling nonsense'. RN C then asked

the oncoming nurse to call for an ambulance and to inform Mrs A's family and the clinical nurse specialist. Mrs A's vital and neurological observations were not recorded.

40. Mrs A's Incident/Accident Investigation form completed by the clinical manager recorded that Mrs A was found 'outside the building … lying on her right side by staff coming on duty … [and that she] was cold with multiple bruising and abrasions'. However, there were no details about what Mrs A was wearing, the position of her body, the area in which she was found, or further details about the injuries she had sustained, and no discussion regarding factors that may have contributed to her fall. In addition, although several areas for improvement (such as alarm monitoring systems) were identified on the incident form, it appears that the corrective action plan was not updated to show that these improvements were made following Mrs A's fall.

41. An ambulance arrived at Hodgson House around 7.10am to transport Mrs A to the public hospital. According to the ambulance service, the primary clinical impression was that Mrs A had acute confusion, concussion,[26] and hypothermia.[27] The ambulance care summary documents: '[C]are staff state [Mrs A] has been acutely confused since last night.'

42. Progress notes on 6 Month2 document that 'upon rolling [Mrs A] to transfer onto the [ambulance] stretcher, multiple abrasions and bruising [were] seen from head to toe [and her] [r]ight hip [was a] very dark purple [colour]'. The records do not show that Mrs A was checked for injuries at the time of her fall, and instead it appears that she was checked for injuries when she was transferred to the ambulance stretcher.

43. RN C documented that she did not 'recall seeing any alarms for doors going off or noticing any doors open'. The clinical services manager spoke to Mrs A's daughter, Mrs B, and explained that 'the building is not secured and that residents can get outside for emergency exits and that doors are alarmed to indicate one being open'. However, Heritage Lifecare told HDC that Mrs A's door alarm had an 'unidentified intermittent fault that meant it did not trigger when [Mrs] A exited out the door'.

44. There is no evidence that following this incident, feedback and communication was shared with Mrs A's family about a review of the event or any improvements made as a result of the event.

Emergency Department (ED) admission — 6 Month2

45. The ED doctors considered that Mrs A was confused secondary to delirium and that there was no clear reason for her fall. Mrs A told the doctors that she remembered going into the garden to 'save someone's life' and that she had not been herself in the last few days.

[26] Injury to the brain caused by a blow to the head.
[27] A significant and potentially dangerous drop in body temperature usually caused by prolonged exposure to cold.

46. Initially it was anticipated that Mrs A could be discharged from the hospital when she was comfortable. However, on 14 Month2, Mrs A tested positive for COVID-19 and, sadly, she died from complications of this on 16 Month2.

Further information

47. In relation to the sentinel event on 6 Month2, when Mrs A was found on the ground in the garden, Heritage Lifecare told HDC that the 'act of intentionally pulling weeds out of [the] garden would seem inconsistent with her being confused' but added that she did not use her walking frame or scooter, and this was 'unusual and unexplained'. The Hodgson House manager added that Mrs A 'was not alerted as a "wanderer" and [Hodgson House] never had any issues around [Mrs A] wandering, so her leaving the facility was out of character'.

48. In a statement to the Police, Mrs B said that her mother had been wearing only a nightie and no shoes and had left her walking frame in her room, which was unusual, as 'she could only walk a few metres without her walker before she would be out of breath because of her lungs'.

49. Heritage Lifecare told HDC that no serious event investigation was initiated in response to this event and that '[t]he only investigation or analysis that has been found is the incident form'.

50. Heritage Lifecare confirmed that 'no neurological observations were completed at the time of [Mrs] A's fall'. When asked about the actions of the staff who first attended Mrs A, Heritage Lifecare told HDC that none of the staff now work at Hodgson House.

51. Heritage Lifecare told HDC: 'We do accept that there are some things that could have been done better, for instance the short-term care planning, and documentation about the incident.' Heritage Lifecare said that there was 'lack of clinical leadership' at Hodgson House at the time Mrs A was a resident, so this may have contributed to the oversights.

52. Heritage Lifecare stated:

> '[Although] there were some absences of documentation and steps that we would have expected to have occurred … [Mrs A's] exit out of the facility and being found was totally unanticipated. She was at all times considered to be competent and was also mobile.'

Responses to provisional opinion

Heritage Lifecare

53. Heritage Lifecare was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. Heritage Lifecare accepted the Aged Care Commissioner's provisional decision and had no further comments.

Mrs B

54. Mrs B was given the opportunity to respond to the 'information gathered' section of the provisional opinion. Mrs B told HDC:

> 'There seems to be some inconsistencies regarding the security from Hodgson House. When I first asked about the camera footage, I was told they were looking into it. I was constantly told this. Then in one of the reports from [a national clinical assurance lead] a cord was missing, then another report it was a CCTV electrical fault. Also one person saying the door was locked then another saying it is never locked from the inside. It doesn't give me any confidence in what they say … It seems to me strange that all of their security and safety measures were not working.'

55. Mrs B added: 'I would hope that the safety and security of future residents has been prioritised, and all the issues that have been highlighted fixed.'

Opinion: Hodgson House — breach

56. First, I acknowledge the distress that these events have caused Mrs A's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Heritage Lifecare Limited (trading as Hodgson House Lifecare and Village) was appropriate, I considered in-house clinical advice from registered nurse (RN) Jane Ferreira (Appendix A).

Documentation, assessments, and admission to Hodgson House

57. Mrs A was admitted to Hodgson House with a complex medical background that included end-stage lung cancer, COPD, and chronic low blood pressure. Prior to her admission to Hodgson House on 29 Month1, she was supported by the hospice, which provided Hodgson House with a comprehensive handover and care plan that identified several areas of Mrs A's health that required monitoring via short-term care plans, such as pain management, falls/mobility management, and management of her pressure injuries.

58. Prior to admission to Hodgson House, Mrs A had been prescribed regular and PRN pain relief. However, Mrs A's Pain Assessment Tool was not completed on admission, and no short-term care plan for managing her pain was developed.

59. RN Ferreira advised that Mrs A's admission paperwork appears incomplete and lacking in detail, and there is no evidence that any short-term care plans or monitoring forms were commenced for Mrs A. RN Ferreira stated:

> 'Given Mrs A's complex history and reason for admission it would be considered accepted nursing practice to ensure that all risk factors were identified on admission so suitable care and safety interventions could be planned and implemented.'

60. In particular, RN Ferreira noted Mrs A's admission documentation and advised:

> 'The initial assessment states that Mrs A had no pain on admission however further prompts regarding type, signs and location of pain, and related care instructions were incomplete. The mobility section states that Mrs A required a walking frame however her level of mobility is not discussed and falls risk was not reflected. The tool reported

> a stage 2 sacral pressure injury, however related wound care responsibilities are not discussed … The related Nutritional Risk Assessment assessed Mrs A as (1) "extremely thin, emaciated, [cachexic]", however there is no consideration of care or dietary monitoring requirements to support quality of life measures and principles of wound healing.'

61. RN Ferreira stated that Mrs A's Risk Assessment Summary form (completed on 30 Month1, the day after she was admitted) noted that she did not have a risk of falling. However, the COOMBE Falls Assessment form completed on 31 Month1 assessed Mrs A as a medium risk of falling.

62. Heritage Lifecare told HDC that it accepts that there should have been 'some short-term care plan documentation to address matters such as the pressure injury, and that [these short-term care plans are] not present'.

63. RN Ferreira also advised that it is 'unclear from the submitted information if Mrs A or her whānau participated in the nursing assessment and interim care plan process'.

64. Heritage Lifecare submitted that although Mrs A had an EPOA, it was not enacted, as she was 'cognitively able to make her decisions regarding her care'.

65. Taking the above into account, RN Ferreira advised that due to incomplete admission assessments and missing information, which contributed to a lack of comprehensive care planning and no short-term care plans, this amounted to a moderate to serious departure from the accepted standard of care.

66. I accept RN Ferreira's advice. In my view, accurate comprehensive health assessments are the foundation of good nursing practice and clinical decision-making. Mrs A's assessments were inadequate and incomplete and did not reflect or record her condition accurately. I am unsure why the staff did not take into consideration the information in the pre-admission documentation provided by the hospice, at least for the initial assessments and care plans on admission, which, in my view, were comprehensive and identified Mrs A's needs.

67. Mrs A's pain assessment on admission to Hodgson House noted that she had no pain on admission. I question the accuracy of this assessment, as prior to Mrs A's admission to Hodgson House she had been prescribed regular pain relief and had several co-morbidities that would have caused her pain (a non-union rib fracture, chronic back pain, and neck and left arm pain). In addition, the hospice's notes record that Mrs A's main concern was the management of her pain.

68. By not undertaking comprehensive and complete assessments, appropriate short-term care plans were not developed, which meant that staff were not guided in meeting the complex health needs of a vulnerable resident.

69. In my opinion, the cumulative effects of missed, incomplete, or incorrect nursing assessments in this case were detrimental to Mrs A's care.

70. I have also considered the relevant policies in place at the time Mrs A was a resident at Hodgson House. There is no evidence that Mrs A or her family were encouraged to be involved in the care planning process, even though the care planning policy encourages a collaborative approach to care planning to ensure that comprehensive assessments are completed. It is disappointing that it appears staff did not encourage more whānau involvement in Mrs A's care planning and assessments.

71. In addition to the admission assessments being insufficient, I have further concerns about the ongoing management of Mrs A's pressure injuries and falls risk.

Management of Mrs A's pressure injuries

72. Mrs A was admitted to Hodgson House with compromised skin integrity related to her two sacral pressure injuries, lower leg oedema, and history of lower leg cellulitis. Although these were noted on admission, the assessments were incomplete, and no short-term care plan was developed to guide staff on how to monitor and manage Mrs A's pressure injuries on an ongoing basis.

73. RN Ferreira advised:

> 'Given that Mrs A presented with compromised skin integrity, frailty and other health conditions, it would be considered accepted practice to complete skin and wound assessments, commence a wound management plan, with a supporting [short-term care plan], and manage related event reporting responsibilities in line with policy guidance …'

74. RN Ferreira considered that the Wound Assessment and Management policy that was in place at the time of these events provided clear guidance and expectations for nursing assessment and management of pressure injuries.

75. RN Ferreira also noted that the nursing progress notes contain reports of Mrs A requesting pain relief in relation to her pressure injuries and being given pain relief, but 'there is no evidence that pain assessments were completed'.

76. Heritage Lifecare told HDC:

> '[Mrs A's pressure injuries were] not managed in the way that Heritage would expect such pressure [injuries are] to be managed. [They were] not added to the wound register and there were no photos taken of the pressure [injuries] upon admission [nor] a short-term care plan put in place.'

77. In response to this statement, RN Ferreira noted:

> 'The provider has acknowledged that the care of Mrs A's pressure injury was below their practice standards which I concur with in the circumstances. It is unclear from the

> submitted evidence what improvements have been made by the provider in response to learnings from this complaint.'

78. Taking the above into account, RN Ferreira advised that the lack of wound documentation, including a wound assessment, wound photos, a short-term care plan, and a lack of communication with the nursing team regarding Mrs A's specific wound care needs, amounted to a moderate to serious departure from the accepted standard of care.

79. I accept RN Ferreira's advice. Pressure injury wounds require monitoring and correct management. Mrs A's pressure injuries were causing her pain and could have deteriorated. I am unsure whether staff referred to the hospice's pre-admission paperwork, which included how it managed Mrs A's pressure injuries via a care plan and noted the wound dressings used, the body repositioning needed, and her pain relief.

80. I have considered the relevant policies in place at the time of events and note, as RN Ferreira has observed, that the Wound Assessment and Management policy provided clear guidance to staff on how to manage 'acute, chronic and complex wounds' such as pressure injuries, and noted that it was the nurses' responsibility to complete a wound assessment on admission and to complete a short-term care plan. I am critical that Mrs A's pressure injuries were not managed in a satisfactory manner, although there was existing policy to guide staff.

Falls risk management

81. Mrs A had fallen at least four times over the past six months prior to her admission to Hodgson House, including her recent fall on 22 Month1 just prior to her admission. Hodgson House assessed Mrs A as a medium risk of falling.

82. RN Ferreira observed that, conversely, preadmission information from the hospice noted that Mrs A had instead been identified as a high falls risk and needed to use a walker or motorised scooter to assist her to mobilise.

83. RN Ferreira stated:

> '[Mrs A] had a history of falls with recent injury, lower leg oedema, pain, and infections, with declining health and was receiving a comprehensive list of prescribed medications, including opiates [and was] motivated to maintain her mobility and reluctant to ask for assistance. Consideration of these factors would suggest that Mrs A was at high risk of falls.'

84. RN Ferreira advised:

> 'There does not appear to be evidence of a mobility assessment or review completed by a physiotherapist (PT) during Mrs A's admission. Given her falls history, pressure injury and health comorbidities, a referral for [physiotherapist] assessment would be considered indicated in the circumstances.'

85. Heritage Lifecare told HDC that an observation chart was in place to document Mrs A's mobility. However, Heritage Lifecare was unable to locate the chart and stated: '[I]n that situation there were [no] specific measures in place to prevent [Mrs A] suffering a fall.'

86. Taking the above into account, RN Ferreira advised that the deficient falls assessment process, including the apparent lack of consideration of Mrs A's previous falls history, her complex medical background, and her use of opiate medication, with no evidence of a mobility assessment on admission, amounted to a moderate to serious departure from the accepted standard of care.

87. I accept RN Ferreira's advice. I am very concerned that Hodgson House staff apparently did not consider the pre-admission paperwork from the hospice, which noted that Mrs A required a sensor mat overnight, she was at a high risk of falls, she required a seated walking frame, and she was to be supervised when transferring, as her co-ordination was poor. I am also concerned that despite Mrs A having a history of falls, Heritage commented that her COOMBE assessment was filled out incorrectly, and that she should have had a score of two for mobility rather than four, which would have given her an overall 'low risk' of falls. This contrasts with RN Ferreira's assessment of Mrs A's likely falls risk, and, in my view, seems inconsistent with Mrs A's multiple risk factors and the fact that the hospice had assessed Mrs A as a high falls risk.

88. I have also considered the relevant policy that was in place at the time of events and note that the Falls Prevention and Management policy documented that the nurses were responsible for identifying the falls risk of new residents and were required to ensure that a falls risk assessment and care plan was developed within 24 hours of admission. This did not occur for Mrs A, for which I am critical given that this policy provides appropriate direction to staff relating to falls management.

Environmental safety needs/considerations

89. Mrs A was admitted to Hodgson House under a palliative care contract, but her intended room was occupied and she was given a room next to an exit door. It was noted that Mrs A could use a call bell if she needed assistance. Heritage Lifecare told HDC that this change in location was discussed with Mrs A's family, but it had no documentation to show that this conversation occurred. Heritage Lifecare also told HDC that Mrs A was 'alert/well orientated' with no safety concerns.

90. In an undated six-monthly audit regarding maintaining the call-bell system, it was documented that the call bells had not been tested 'within the past six months, and any faults remedied'. No corrective action plan was put in place. In a maintenance audit report dated approximately six months prior it was noted that there were concerns that the fire doors were not in 'good repair', but again no corrective actions were identified to remedy this. Heritage Lifecare told HDC that the door that Mrs A used to exit the facility had an unidentified fault at the time, which meant that the alarm did not sound when she opened the door.

91. Hodgson House had CCTV surveillance cameras to monitor residents' movements if they left the care home, but Heritage Lifecare was unable to provide HDC with any CCTV footage due to an electrical fault.

92. RN Ferreira advised:

> 'The provider advised that an intermittent fault was identified with the alarm system during Mrs A's admission. It appears from the event timeline that the alarm system interfaced with the nurse-call system, with documentation stating, "*checked exit doors and noticed issues with lack of alarming/nil notification of call bell panel*". This would indicate that communication tools within the safety systems (such as pagers and visual displays) in addition to the door sounders, were not triggered to alert the duty team.
>
> While residents rely on call bells to communicate with the care team, the duty teams rely on functioning safety systems as risk mitigation tools to enable them to respond promptly and appropriately to resident needs … Creating a safe environment for residents requires clinical and operational systems to be collaborative, with oversight of systems and processes provided by care home leaders.'

93. RN Ferreira noted:

> 'It appears there were system and practice concerns at the time. There does not appear to be evidence of communication with [Mrs A], her whānau/family and the care team regarding environmental safety needs, with no evidence of clinical leadership or a risk management plan to ensure resident and staff health and safety needs were addressed.'

94. Taking the above into account, RN Ferreira advised that this amounted to a moderate to severe departure from the accepted standard of care. I accept RN Ferreira's advice. There were environmental safety issues in that the fire doors were not in good repair and the call bell system had not been tested for at least six months. I acknowledge that staff performed routine visual checks of Mrs A on the morning of 6 Month2 (when she left the facility), but I am concerned that several faults contributed to an unsafe environment. As RN Ferreira pointed out, staff are reliant on safety systems functioning properly in order for them to maintain the safety of residents in their care.

95. In addition, Mrs A was a new resident and still settling in and orientating to the care home, and she was placed next to an exit door without a documented discussion with Mrs A or her family about whether they had any safety concerns. Although Heritage Lifecare maintains that Hodgson House is not a locked facility, in my opinion there still needed to be consideration of the safety of residents, and in particular a new resident who had been placed next to an exit door.

96. I also note that Mrs A was encouraged to use her call bell. However, given that the call bell system had not been tested in the preceding six months, it is unclear whether there were any faults with the bell, and it may not have worked. Ultimately, I cannot determine whether

there were any faults with the call bell system, or whether Mrs A attempted to use the call bell while she was at Hodgson House, but I remain concerned that the call-bell system had not been tested appropriately.

97. Finally, it is unfortunate that Heritage Lifecare was unable to provide HDC with its CCTV surveillance footage due to an electrical fault.

Sentinel event 6 Month2 — management of Mrs A following her fall

98. In relation to the actions of the staff who first attended to Mrs A after finding her on the ground outside Hodgson House, RN Ferreira advised:

> 'It would be considered accepted practice for the attending RN to provide a detailed event description outlining the assessment process and related nursing actions in the care record and incident management system. It does not appear that pain, vital signs or neurological assessments were completed by the RN as part of the primary assessment, in line with post-fall policy guidance, or rationale provided otherwise if a major injury was suspected which required urgent paramedic support.'

99. RN Ferreira noted that the incident form (which was completed by the clinical manager) lacked detail and some sections were not completed. RN Ferreira advised:

> 'There is no discussion of event location, resident position including distance from the exit point, clothing, footwear or mobility aid, identification of hazards, or discussion of contributing factors to the missing resident with fall event. The pictorial diagram does not indicate where observed injuries were sustained, per event details, with limited evidence of nursing assessment, care and reporting provided by the primary RN.'

100. RN Ferreira also considered the entries in the nursing notes following Mrs A's fall and noted:

> 'A late RN entry in progress notes completed 18 [Month2] referred to Mrs A being found outside in winter temperatures in nightwear on 6 [Month2]. Plants were found on a ramp with suggestions that Mrs A lost her balance, but there is no evidence of further enquiry, such as consideration of where her walking aid was positioned, potential hazards, or reference to known health conditions such as fatigue, shortness of breath or postural hypotension.'

101. RN Ferreira also noted that following Mrs A's fall and transfer to hospital, a serious event was recognised, as the operations manager was informed. However, RN Ferreira advised:

> 'The incident form identified several areas for improvement, including operational issues with alarm monitoring systems and clinical delays in nursing assessment and care planning processes, however the corrective action plan does not appear to have been updated to evidence completion of the agreed interventions. The documentation is incomplete, lacking dates and signatures, with no evidence of feedback and communication shared with Mrs A's whānau/family.'

102. Taking the above into account, RN Ferreira advised that although staff ensured that Mrs A was transferred to the hospital quickly following her fall, there were 'identified concerns with care home leadership regarding event investigation responsibilities, including communication, documentation and reporting standards' and, due to poor nursing documentation and incident reporting, an adverse event investigation was not conducted, which amounted to a moderate to serious departure from the accepted standard of care.

103. I accept RN Ferreira's advice and have concerns about how Mrs A was managed after her fall. Documentation indicates that Mrs A was found on the ground at around 6.45am, after which a head-to-toe assessment should have been completed immediately. However, Mrs A's progress notes record that it was only when Mrs A was moved on to the ambulance stretcher that the nurse commented on the injuries to her body and documented this at 10.27am. I find this concerning and am unsure why a head-to-toe assessment of Mrs A was not done by the nurse as soon as possible after Mrs A was found on the ground at 6.45am.

104. I have considered the relevant policy in place at the time of this event and note that it includes that 'appropriate first aid is provided as quickly as possible' and that the attending nurse is to check the resident for injuries and take baseline vital and neurological observations (especially in the case of unwitnessed falls to rule out head injury). In my opinion, the policy in place was appropriate to guide staff in the management of Mrs A when she was found on the ground, but it is unclear why these policies were not followed. This lack of compliance is concerning.

105. In addition, I considered Heritage Lifecare's feedback. Heritage Lifecare noted that 'the act of intentionally pulling weeds out of the garden would seem inconsistent with [Mrs A] being confused'. I disagree. Mrs A's fall occurred in Month2, and, in my opinion, it is unusual for a person to walk outside with no shoes and only a nightie at around 6.15am on a winter's morning, even if the intention is to attend to the garden. Mrs A's daughter also noted this in her statement to the Police and said that it was unusual for her mother to leave her walking frame in her room given that she needed it to rest, or she would get very out of breath. I also note that it was documented that Mrs A was a little confused and agitated in the early hours of 6 Month2 and, when she arrived at the hospital, she was diagnosed with delirium.

106. I am very concerned about the lack of detail in the incident form regarding Mrs A's fall, and that although this incident was flagged as an adverse/serious event, a serious event investigation did not occur, and therefore no appropriate feedback was given to Mrs A's family about the incident and assurances of corrective actions to prevent this from happening again.

Conclusion

107. In summary, I find that Heritage Lifecare Limited (trading as Hodgson House Lifecare and Village) did not provide Mrs A with an appropriate standard of care between 29 Month1 and 6 Month2, for the following reasons:

a) The admission assessments were incomplete, which contributed to a lack of comprehensive care planning, and no short-term care plans were created for Mrs A.

b) There was a lack of essential wound documentation, which meant that Mrs A's specific wound care needs in relation to her pressure injuries were not identified, and no short-term care plan was created to guide staff.

c) Mrs A's previous falls history and assessment from the hospice was not considered, nor was her complex medical background or use of opiate medication, which may have affected her balance.

d) Mrs A's safety as a new resident was not considered adequately, as she was placed in a room next to an exit door that had not been tested to ensure that it was in good condition, and the call-bell system had not been tested within the preceding six months, which meant there may have been unknown faults with the system.

e) On 6 Month2 when Mrs A was found on the ground outside the care home, there was a lack of nursing assessments, including neurological and vital observations and a head-to-toe assessment of her injuries, the incident reporting and nursing documentation were poor, and no serious event investigation was initiated by Hodgson House.

108. Although individual staff members were responsible for some of the issues identified, overall, I consider that the issues represent a pattern of poor care and non-compliance with policies, for which ultimately Heritage Lifecare is responsible. Accordingly, I consider that Heritage Lifecare Limited (trading as Hodgson House Lifecare and Village) breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[28]

Changes made

109. Heritage Lifecare told HDC that to facilitate staff training, it put in place a manager for this. It also has a new facility manager who has a nursing background, who, in its opinion, is providing 'substantially better leadership'.

Recommendations

110. In the provisional report, I recommended that Heritage Lifecare provide a written apology to Mrs A's family for the issues identified in the report. Heritage Lifecare provided an apology, and this has been forwarded to the family.

111. I recommend that Hodgson House Lifecare undertake the following and report to HDC within six months of the date of this report:

a) Use an anonymised case study of this decision as the basis for staff training sessions on the following topics:

[28] Right 4(1) stipulates that '[e]very consumer has the right to have services provided with reasonable care and skill'.

i. the importance of completing widely used comprehensive resident assessments on admission, including falls assessments, and the details required to be noted in the individualised care plans;

ii. the importance of creating comprehensive care plans (including initial, short-term, and long-term care plans) and evidence of staff compliance with the 'Care planning policy and procedure'; and

iii. incident management (including how to complete incident forms and documentation comprehensively) and how to ensure that a serious event investigation is initiated and the roles/responsibilities of staff in this.

b) Provide evidence to HDC of the above training and any further staff training needs it has identified. Heritage Lifecare is to consider implementing the Stop and Watch tool to support recognition of resident deterioration and is to provide HDC with evidence of this.

c) Consider implementing the ISBAR communication tool (to better inform clinical assessments, nursing actions, and safe, evidence-based decision-making) and provide HDC with evidence of this.

d) Review the First Aid Policy and consider whether the instructions on the actions staff should take in an emergency should be incorporated into this policy and provide HDC with evidence of this discussion and/or implementation into the policy.

e) Discuss with the registered nurse team the importance of accurate contemporaneous recording of all concerns raised by the care team and family/whānau, and related actions, in the resident's clinical record. If timely recording is not possible, notes are to accurately reflect the time and date of the entry into the records. Please provide HDC with evidence of this.

Follow-up actions

112. A copy of this report with details identifying the parties removed, except the advisor on this case and Heritage Lifecare Limited (trading as Hodgson House Lifecare and Village), will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Aged Care Commissioner

The following in-house advice was obtained from RN Ferreira:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Hodgson House. 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. Documents reviewed

- Coroner's communication and file investigation information
- Provider responses 14 December 2023, 19 April 2024
- Clinical records including admission assessments, initial care plan, progress notes, prescribed medication records, incident report.
- Hospice handover forms and communication records
- Organisation policies including Care Planning, Wound Assessment and Management, Document Control, First Aid, Family-Whānau Participation and Contact, Complaints Management, Admissions and Discharge, Medical Practitioners, Falls Prevention and Management, Pain Assessment and Management, End of Life and Palliative Care, Property Maintenance, CCTV.
- Meeting minutes, education records, rosters, audits

3. Complaint

A complaint was raised by the Coroner on behalf of [Mrs A's] whānau/family regarding the care provided to her while resident at the care home between 29 [Month1] and 6 [Month2]. Concerns relate to an unwitnessed fall event, care and safety requirements.

<u>Background</u>
[Mrs A] was admitted to the care home under a palliative care contract on 29 [Month1]. Her medical history included end stage lung cancer, CHF, COPD, GORD and hypertension. Prior to admission [Mrs A] had been experiencing significant pain, shortness of breath and related health concerns, impacting her ability to remain living at home. File information at the time of admission indicated that [Mrs A] was independently mobile with a walker, assessed as a medium falls risk and required support to meet her daily care needs.

At 0645hrs on 6 [Month2] a carer found [Mrs A] lying in the garden outside the care home, unresponsive and cold to touch following a suspected fall event. She was assessed by a team member, first aid measures applied and transferred via ambulance to hospital for further care. Medical assessment identified a traumatic brain injury with multiple skin abrasions and bruising. During her hospital admission [Mrs A] contracted COVID-19 and sadly passed away on 16 [Month2] related to health complications. I extend my sincere condolences to [Mrs A's] whānau/family at this time.

4. 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:

- Admission assessment, documentation and care plans
- Wound Management
- Falls risk, prevention and management.
- Mental state
- Leaving the home unnoticed
- Sentinel event processes

Admission assessments, documentation, and care plans

- **Please review the notes and advise whether the assessments and admission documentation, including care planning were adequate for [Mrs A] given her medical background and reason for admission to Hodgson house. Please advise if her family or next of kin were involved in these assessments and care plans?**

Preadmission information showed that [Mrs A] had been assessed as requiring 24-hour care to manage symptoms of anxiety, pain, and breathlessness, and receive support with medication management and activities of daily living. She had been assessed as a High Falls Risk and required assistance of a walking frame with carer supervision to maintain safety needs. Handover information states that [Mrs A] experienced intermittent lower back and leg pain, had compromised skin integrity with identified sacral pressure injuries, lower leg oedema, with recent treatment for cellulitis and a chest infection.

File information reflects that discharge planning was in place with communication occurring between the service providers. A referral letter and nursing handover was provided by the hospice team to the care home on 25 [Month1], outlining [Mrs A's] care needs, including medication and oxygen requirements, and daily routines. It appears that a social worker was involved in the placement process, but it is unclear whether [Mrs A] or her nominated representatives had an opportunity to meet care home/clinical managers, view the care home and proposed room, consider care requirements or discuss goals for care. Records show that [Mrs A] had completed an advance care plan … which outlined her wishes about care and support during her last days and at end of life, however this document does not appear to be referenced in the nursing care record.

File information shows that [Mrs A] was admitted to the care home on 29 [Month1]. It is unclear if a delay occurred in the care transfer process, given the clinical handover

occurred days ahead of discharge. Usual practice would be for clinical leaders to reflect rationale in the resident's care record in line with accepted communication and documentation standards.

As outlined in organisational policy and the Age-Related Residential Care (ARRC) agreement, (D16.2) each resident's health and care requirements will be assessed by a registered nurse (RN) on admission to inform an initial plan of care plan. Care plans are informed by preadmission information, admission nursing assessments, and developed on admission in partnership with the resident, whānau/family, to guide a resident's care requirements until the long-term care plan is in place. Where specific concerns are identified, a short-term care plan (STCP) is commenced to direct the required care interventions.

Records show that an RN commenced an Initial Assessment and Care Plan document on the day of admission, however, there appear to be delays in completion of the nursing data collection tool and related risk assessments. The document reflects that vital signs and weight were recorded, however sections are incomplete with a lack of care guidance. The initial assessment states that [Mrs A] had no pain on admission however further prompts regarding type, signs and location of pain, and related care instructions were incomplete. The mobility section states that [Mrs A] required a walking frame however her level of mobility is not discussed and falls risk was not reflected. The tool reported a stage 2 sacral pressure injury, however related wound care responsibilities are not discussed. Food allergies are selected as "Yes" under nutritional requirements but does not state what this is which is concerning. The related Nutritional Risk Assessment assessed [Mrs A] as (1) "*extremely thin, emaciated, cathartic"*, however there is no consideration of care or dietary monitoring requirements to support quality of life measures and principles of wound healing.

The Risk Assessment Summary Form completed 30 Month1 reflects a medium risk of allergies, high risk of pressure injuries, with a history of recurring cellulitis. The document states "Risk of falls: No"; however, the Coombes Falls Assessment Form completed on 31 [Month1] assessed [Mrs A] as a medium falls risk. It is unclear why nursing information was not updated to reflect the new assessment score in line with RN responsibilities to resident care and safety.

Preadmission information provided a comprehensive handover of [Mrs A's] level of abilities at the time, areas of concern, including support and care requirements.

Documentation indicated that [Mrs A] was prone to episodes of nausea, constipation, pain, agitation and shortness of breath which required administration of regular and as-required (PRN) medications to support her quality of life. The Pain Assessment and Management policy states that "*pain will be assessed on admission and recorded on the initial assessment care plan".* The policy outlines role responsibilities, including the use of pain assessment tools, monitoring charts, and related actions, including communication and documentation responsibilities.

In summary, [Mrs A] had been admitted to a new environment as a palliative resident however the nursing assessments and interim care plan documents do not identify or discuss potential risk factors, strategies to maintain safety needs, or care requirements during the settling-in phase. While the progress note entry completed by an RN on the day of admission is comprehensive and informative, the submitted nursing admission assessments appear incomplete, the interim care plan lacks essential information to guide [Mrs A's] care requirements and there is no evidence that any STCPs or monitoring forms were commenced in line with professional care standards. Given [Mrs A's] complex history and reason for admission it would be considered accepted nursing practice to ensure that all risk factors were identified on admission so suitable care and safety interventions could be planned and implemented.

It is unclear from the submitted information if [Mrs A] or her whānau participated in the nursing assessment and interim care plan process. The provider has advised that [Mrs A's] Enduring Power of Attorney (EPOA) was in place but not enacted as she was cognitively able to make her own decisions regarding her care. File information shows that an admission form with resident details and informed consent document was completed by [Mrs A] and a support person on 1 [Month2]. There is no further evidence of collaboration with Whānau/family during the admission process.

From the evidence reviewed to respond to this question I consider the admission documentation to be below the minimal standard of accepted practice in the circumstances and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

Wound management

- **It is noted that [Mrs A] had a grade 1 pressure injury prior to admission into Hodgson House. Please review the notes and advise whether the assessment and management of [Mrs A's] pressure injury was appropriate and of an adequate standard?**
- **Please advise if this pressure injury was added to the Wound Register and if appropriate care plans were initiated to guide staff in the management of this injury?**

The Wound Assessment and Management policy provides clear guidance regarding organisational expectations for nursing assessment, resident care and related systems and processes, in line with sector standards.

[Mrs A] was admitted with compromised skin integrity which included sacral pressure injuries, lower leg oedema and a history of cellulitis. It would be considered accepted practice for RNs to ensure that an assessment of [Mrs A's] skin, wounds, lower limbs and feet occurred, with a relevant nursing plan commenced. There is no discussion of skin presentation, such as signs of rash, bruising or breakdown in the admission information. Given that [Mrs A] presented with compromised skin integrity, frailty and

other health conditions, it would be considered accepted practice to complete skin and wound assessments, commence a wound management plan, with a supporting STCP, and manage related event reporting responsibilities in line with policy guidance and accepted quality improvement practices.

Progress note entries in the care record refer to reports of sacral/buttock pain with administration of prescribed pain relief, however there is no evidence that pain assessments were completed in line with accepted practice standards. There is evidence that RNs and carers were aware of [Mrs A's] pressure injury with entries referring to application of wound care products and reminding to reposition.

The provider has advised that there was no evidence available of wound assessment, including wound photos, a wound care management plan, specific STCP or evidence of wider event reporting, such as use of a wound register. There is no evidence of communication with the nursing and care team regarding [Mrs A's] skin integrity and specific wound care needs. The provider has acknowledged that the care of [Mrs A's] pressure injury was below their practice standards which I concur with in the circumstances. It is unclear from the submitted evidence what improvements have been made by the provider in response to learnings from this complaint.

- Departure from accepted practice: Moderate to serious

Falls risk

- **Please review the notes and advise whether [Mrs A's] risk of falling was adequately assessed?**
- **Were there appropriate measures in place to prevent [Mrs A] falling?**
- **Were the appropriate assessments completed for her (such as physio assessment)?**
- **Were the appropriate care plans put in place to guide staff (such as, perhaps, reminding [Mrs A] to use her walking frame).**

The Falls Prevention and Management policy discusses systems, processes and related role responsibilities, including guidance regarding falls minimisation strategies, safety needs and post-fall assessment steps. The policy states that new residents to the care home will be assessed by an RN on admission using a validated fall risk assessment tool (FRAT) or the Coombes assessment tool, noting that interventions to minimise the risk of falling are documented in the interim care plan and reviewed as required.

As outlined in the above question, preadmission information stated that [Mrs A] had been identified as a high falls risk and used a walker, or motorised scooter at times, to assist her to mobilise. She had a history of falls with recent injury, lower leg oedema, pain, and infections, with declining health and was receiving a comprehensive list of prescribed medications, including opiates. File information described [Mrs A] as independent, motivated to maintain her mobility and reluctant to ask for assistance. Consideration of these factors would suggest that [Mrs A] was at high risk of falls.

The Falls Prevention and Management policy states that RNs are expected to apply clinical judgement to risk assessments. File evidence shows that [Mrs A] was assessed on admission to the care home as a medium falls risk. It does not appear that the clinical manager (CM) or RN team considered [Mrs A's] medical history and additional risk factors, such as a new environment, medication involvement and discussion points above, when preparing for and completing the admission process.

As outlined in policy information, a care plan is used to provide guidance to the care team regarding mobility, transfer and safety needs to minimise the risk of falls. The submitted evidence provides very limited information regarding [Mrs A's] mobility requirements at the time of her admission. There is limited discussion of [Mrs A's] tremor or lower leg oedema, pain, balance or falls minimisation strategies. There does not appear to be evidence of a mobility assessment or review completed by a physiotherapist (PT) during [Mrs A's] admission. Given her falls history, pressure injury and health comorbidities, a referral for PT assessment would be considered indicated in the circumstances.

From the evidence reviewed to respond to this question I consider the falls assessment process to be below the minimal standard of accepted practice in the circumstances with limited care and safety guidance provided, which would be viewed similarly by my peers in the circumstances.

- Departure from accepted practice: Moderate to serious.

Mental state

- **Please review the notes and advise whether [Mrs A] displayed any confusion in the days leading up to the 6 [Month2] (where she suffered a fall outside the care home). If there was confusion noted, was it appropriately recognised, documented and addressed?**
- **Was there evidence of her being confused such as by the ambulance service or at the hospital post her fall, or as noted by her family?**

Progress notes reviewed during [Mrs A's] admission do not appear to report signs of confusion or changes in behaviour prior to the fall event, however, there is a lack of supporting monitoring documentation which would usually inform evidence-based clinical decisions. There is no evidence that monitoring of [Mrs A's] oral intake or elimination patterns occurred which may have indicated potential concerns such as dehydration, constipation or infection. Progress notes and medication administration records indicate that medications were administered in response to reports of pain with effectiveness noted, but it is unclear whether side effects of medications were observed but not reported. Progress notes refer to sacral and right buttock pressure injuries with reports of pain, however it is unclear due to the lack of wound documentation whether signs of infection were noted at this time which may have influenced mood or behaviour. There is no evidence of routine skin assessment to observe for signs of cellulitis or increased lower leg oedema which might have indicated health changes.

There is limited discussion of respiratory difficulties, such as shortness of breath or fatigue which may have influenced [Mrs A's] decision-making, however progress notes provide no evidence of RN assessment or recording of vital signs in preceding days. Progress notes provide no evidence of interactions with [Mrs A's] whānau/family regarding any identified concerns with her wellbeing. Due to the limited evidence of nursing documentation, I am unable to provide further comment to respond to this question.

Leaving the care home unnoticed

- **Please review the notes and advise whether there were appropriate measures in place to prevent [Mrs A] from leaving the facility unnoticed?**
- **Was there appropriate intentional/hourly visual rounds conducted by the care staff on duty?**

The provider has advised that [Mrs A] was admitted under a palliative care contract and initially booked into a dedicated area in the hospital community near the nurses station. The provider has referred to a change in bedroom location noting that while palliative, [Mrs A] was competent and able to make her needs known, was independently mobile, and offered a room next to an exit door. The provider has advised that [Mrs A] would have received a physical tour of the care home as part of day of admission activities.

The initial assessment and care plan document reported that [Mrs A] was 'alert/well-orientated' with no safety concerns or history of risk-taking events. Communication is not well discussed, however it appears that [Mrs A] wore glasses and required hearing aids. It is unclear whether additional safety risk assessments were completed regarding falls risk or door location, or if visual prompts (signage) was required regarding fire exit use. File documentation states that as [Mrs A] was able to communicate her needs with a call bell in place, that regular visual checks (intentional rounding) were not indicated. This action would usually be considered a relevant safety intervention to support data collection during the settling-in phase.

Preadmission information outlined [Mrs A's] interests, which included gardening, and day/night routines, but there is no evidence of similar information provided in care home records outlining her preferences. Progress note entries reflect carer support with activities of daily living, noting that [Mrs A] was mobile but do not discuss her seeking assistance, engaging in activities or accessing different parts of the care home. It appears that the care team were responsive to [Mrs A's] needs with shift entries reflecting interactions.

The provider has advised that the building's exit points had door alarms with safety mechanisms, including sounders and CCTV monitoring to maintain resident safety. While door alarm, call bell records, and monitoring forms were not provided, entries in the care record refer to completion of routine resident safety checks by RNs and carers. A carer entry in the paper-based progress notes at 0328hrs on 6 [Month2] stated that [Mrs A] was awake at the start of the night shift but settled around 1200hrs, noting

"*visual checks were done, call bell in reach".* An RN entry at 0438hrs on 6 [Month2] in the electronic care record states that "*[Mrs A] appears to be asleep and comfortable on checks. No concerns raised by staff".* Further RN entries state that the RN commenced a medication round at 0600hrs, that [Mrs A] was last seen 0610–0615hrs and asleep, noting that all doors leading outside were closed and alarmed.

The provider has referred to planned improvements in the call bell system and advised that an intermittent fault had been identified with the door sounders. Submitted workplace and environmental audits identified concerns with call bell use, fire door access and function, however corrective actions and related improvement processes appear incomplete. There is no evidence of event reports for call bell or security faults, maintenance logs, or discussion of related actions.

File information suggests that while the safety checks may have indicated the door was alarmed, it is unclear what additional checks were completed given the call bell/ alarm system had an identified intermittent fault. Section 31 of the Health and Disability Services (Safety) Act 2001 requires all certified providers to notify HealthCert regarding "*any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided"*, such as issues or outages with call bell systems. It is unclear from the provider response if a hazard management plan was in place at the time of [Mrs A's] admission, or what clinical and operational measures were in place to ensure the health and safety needs of all residents, and on-duty teams, were maintained while the call bell system was under review. It is also unclear what communication occurred with residents, their nominated representatives and wider stakeholders about the system issues which would be accepted practice.

From the information reviewed to respond to this question it appears there were system and practice concerns at the time. There does not appear to be evidence of communication with [Mrs A], her whānau/family and the care team regarding environmental safety needs, with no evidence of clinical leadership or a risk management plan to ensure resident and staff health and safety needs were addressed. I consider there to be moderate to significant departures from accepted practice standards and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

Sentinel event — Fall on 6 [Month2]

- **Please review the notes and advise whether [Mrs A's] fall was managed in an appropriate way? Did she receive first aid treatment?**
- **Please comment on the adequacy of the incident reporting following this fall, was it reported promptly and appropriately in the progress notes and as an incident form? Were family/NOK notified in a timely manner? Was a Serious event investigation initiated?**

File information states that [Mrs A] was found on the ground outside the care home by a carer at 6.45am on 6 [Month2] in an unwitnessed fall event. Progress note entries and the incident reports indicate that she was promptly assessed by an RN, first aid measures applied and transferred via ambulance to hospital. Nursing documentation states that [Mrs A] was slow to respond and cold to touch. Blankets were applied while awaiting ambulance services. Records report that signs of bruising and skin abrasions were identified on repositioning during paramedic assessment. The electronic record outlines RN actions, however, there is no corresponding entry in the paper-based record by carers or RNs as first-responders in line with incident management processes and reporting responsibilities. It would be considered accepted practice for the attending RN to provide a detailed event description outlining the assessment process and related nursing actions in the care record and incident management system. It does not appear that pain, vital signs or neurological assessments were completed by the RN as part of the primary assessment, in line with post-fall policy guidance, or rationale provided otherwise if a major injury was suspected which required urgent paramedic support. It appears that the RN escalated the event to the [clinical manager] who communicated with [Mrs A's] whānau/family, as evidenced by nursing records.

An incident report was completed by the [clinical manager] however there are incomplete sections with a lack of event detail. There is no discussion of event location, resident position including distance from the exit point, clothing, footwear or mobility aid, identification of hazards, or discussion of contributing factors to the missing resident with fall event.

The pictorial diagram does not indicate where observed injuries were sustained, per event details, with limited evidence of nursing assessment, care and reporting provided by the primary RN. There is little evidence of handover provided to ambulance services and transfer documentation, with no evidence of interaction with acute care colleagues post-event regarding [Mrs A's] wellbeing, which is considered part of service provider responsibilities.

File information indicates that the on-duty team were unaware that [Mrs A] had left the care home until alerted by a colleague. It is unclear whether the [clinical manager] met with the care teams to discuss the event and debrief in line with serious event reporting processes. The provider has stated that [Mrs A] had not presented with signs of concern or confusion prior to the fall event. The submitted map suggests that [Mrs A] had exited the care home and walked a reasonable distance around the building prior to being found at 0645hrs. A late RN entry in progress notes completed 18 [Month2] referred to [Mrs A] being found outside in winter temperatures in nightwear on 6 [Month2]. Plants were found on a ramp with suggestions that [Mrs A] lost her balance, but there is no evidence of further enquiry, such as consideration of where her walking aid was positioned, potential hazards, or reference to known health conditions such as fatigue, shortness of breath or postural hypotension.

The event report indicates that a serious event was recognised, noting that an [operations manager] was informed, however there is no evidence of communication or involvement in the incident investigation process. The provider has advised that a serious event investigation did not occur in line with accepted processes, however the Incident Management policy was not sighted in the submitted evidence to inform comment regarding the organisation's investigation steps.

The incident form identified several areas for improvement, including operational issues with alarm monitoring systems and clinical delays in nursing assessment and care planning processes, however the corrective action plan does not appear to have been updated to evidence completion of the agreed interventions. The documentation is incomplete, lacking dates and signatures, with no evidence of feedback and communication shared with [Mrs A's] whānau/family in line with accepted processes. The provider has submitted education and training records with revised organisational policies, but it is unclear how this impacted learnings related to identified issues within this complaint.

From the evidence reviewed to respond to this question it appears that the care team ensured that [Mrs A] was promptly transferred to hospital for further care, however the related nursing documentation, incident reporting and event investigation process appears to be below accepted practice standards. There are identified concerns with care home leadership regarding event investigation responsibilities, including communication, documentation and reporting standards which would be viewed similarly by my peers in the circumstances.

- Departure from accepted practice: Moderate to serious.

Clinical advice

Based on this review I recommend the care home team —

- complete additional education about the resident admission and care planning process, incident management and reporting responsibilities.
- implement the Stop and Watch tool to support recognition of resident deterioration.
- discuss with the RN team the importance of accurately recording all concerns raised by the care team and family/whānau, and related actions, in the resident's clinical record.
- implement the ISBAR communication tool to better inform clinical assessments, nursing actions, and safe, evidence-based decision-making.

To support this approach, I recommend that the care home team complete the 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

Request for additional advice: 18 October 2024

Thank you for the opportunity to review my advice, 23 April 2024 and provide clarification for my decision relating to the call bell system and door alarm function.

File information indicates that the on-duty team were unaware that [Mrs A] had left the care home until alerted by a colleague. File records and the timeline of events stated that all doors leading outside were closed and alarmed, with [Mrs A] last seen asleep around 6.15am. Event documentation stated, "*there were no indications as to which door [Mrs A] may have used, or the pathway she chose to follow".*

The provider advised that an intermittent fault was identified with the alarm system during [Mrs A's] admission. It appears from the event timeline that the alarm system interfaced with the nurse-call system, with documentation stating, "*checked exit doors and noticed issues with lack of alarming/nil notification of call bell panel*". This would indicate that communication tools within the safety systems (such as pagers and visual displays) in addition to the door sounders, were not triggered to alert the duty team.

While residents rely on call bells to communicate with the care team, the duty teams rely on functioning safety systems as risk mitigation tools to enable them to respond promptly and appropriately to resident needs. There are rigorous requirements for completion of regular checks of building and care equipment to ensure environmental safety responsibilities are maintained, however auditable evidence is unavailable to make further comment at this time.

Creating a safe environment for residents requires clinical and operational systems to be collaborative, with oversight of systems and processes provided by care home leaders. While there is discussion of visual observations of [Mrs A] with routine security checks completed across the shift, it remains unfortunate that her safety needs were compromised in the circumstances.

- No change to my initial advice.

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