Anglican Care (Waiapu) Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01380)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, 87 years old at the time of the event, had been a resident of an Anglican Care (Waiapu) Limited[1] rest home (ACW) since June 2014. On 13 October 2014, he was transferred to the secure dementia unit, where he remained for the rest of his time at the rest home.

2. Mr A's nursing notes indicated that from at least early 2015, he presented with behavioural and wandering issues. ACW told HDC that challenging behaviours were identified in the nursing notes. However, a behaviour management plan was not completed, which would have identified strategies to manage the behaviours, therefore minimising potential risks to Mr A.

3. In late 2015 (Day 1[2]), Mr A was physically assaulted by another resident in the dementia unit. ACW told HDC that following the incident, Mr A's overall clinical management was not facilitated by a designated senior nurse or clinical manager. It acknowledged that with no one person taking responsibility for Mr A's care, it created a situation where no management plan was initiated to evaluate Mr A's ongoing clinical needs. During the morning, evening and night shift of this day, Mr A was checked a number of times, but was not referred to a general practitioner (GP).

4. The following morning, Mr A was checked twice. On the second check, the registered nurse requested that the Team Leader of the unit call the doctor for a medical review. In the late morning, Mr A was reviewed by the duty doctor, who arranged for him to go to the public hospital for X-rays.

5. Mr A returned from hospital at approximately 6pm having been diagnosed with multiple rib fractures (8th and 9th ribs) and fluid in his right chest. Mr A's next of kin did not want him to be given a chest drain or intubation, so Mr A received comfort cares following his discharge from hospital.

6. Mr A passed away a short time later.

Findings

7. The failure to manage Mr A's wandering behaviour appropriately over a number of months leading up to the incident, and the overall deficiencies in nursing care after the incident, demonstrated a pattern of suboptimal care and a lack of critical thinking from numerous ACW staff members. The deficiencies occurred in an environment where lines of clinical responsibility were unclear. The above shortcomings are service delivery failures that are directly attributable to ACW. ACW failed to provide services to Mr A with reasonable care and skill, and was found in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[3]

[1] ACW operated the rest home at the time of events. ACW completed a sale and purchase agreement with another rest home company in 2017.
[2] Relevant dates are referred to as Days 1–4 to protect privacy.
[3] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Recommendations

8. In response to the provisional opinion, ACW provided a formal written letter of apology to Mr A's family. The apology has been forwarded to Mr A's family.

9. It is recommended that ACW consider whether any of the learning from this investigation can be translated into improvements throughout its other aged care services.

10. The new owners will be asked to:

    a) Share this report with its staff who were previously employed by ACW and consider whether any learning can be taken from this case and translated to improvements to its own policies and procedures.

    b) Provide a report on its consideration of this investigation, within three months of the date of receiving the anonymised final report.

Complaint and investigation

11. The Commissioner received a complaint from Ms B about the services provided to her late father, Mr A, by Anglican Care (Waiapu) Limited. The following issue was identified for investigation:

    The appropriateness of the care provided to Mr A by Anglican Care (Waiapu) Limited.

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

13. The parties directly involved in the investigation were:

Ms B	Complainant
Anglican Care (Waiapu) Limited (ACW)	Provider

14. Information was reviewed from:

RN C	Provider/registered nurse (RN)
HCA D	Provider/healthcare assistant (HCA)
RN E	Provider/registered nurse
RN F	Provider/registered nurse
RN G	Provider/registered nurse

Also mentioned in this report:

RN H	Registered nurse
HCA I	Healthcare assistant
RN J	Registered nurse
RN K	Registered nurse

15. Independent expert advice was obtained from a registered nurse, Jan Grant (**Appendix 1**).

Information gathered during investigation

Introduction

16. Mr A, 87 years old at the time of the event, had been a resident of the rest home since June 2014. On 13 October 2014, he was transferred to the secure dementia unit where he remained for the rest of his time at the rest home.

17. On Day 1, Mr A was physically assaulted by another resident in the dementia unit. This report discusses the care provided to Mr A prior to and immediately after the incident.

Mr A's wandering behaviour

18. Mr A's nursing notes indicated that from at least early 2015, he presented with behavioural and wandering issues. For example, between 18 March 2015 and 22 March 2015, Mr A was found in other residents' rooms on three separate occasions. ACW told HDC that challenging behaviours were identified in the nursing notes. However, a behaviour management plan was not completed, which would have identified strategies to manage the behaviours, therefore minimising potential risks to Mr A.

19. ACW told HDC that weekly meetings between the Team Leader of the dementia unit and the Clinical Coordinator at the time were meant to take place to review residents and their ongoing management, including supervision of the implementation of behaviour management plans. ACW acknowledged that these meetings did not occur weekly prior to the incident complained about (see below).

Day 1

The incident

20. At approximately 4am on Day 1, HCA I heard Mr A yelling and went looking for him. HCA I found Mr A in the room of another resident. HCA I saw the other resident kicking Mr A in the abdomen. HCA I rang the duress bell and RN C attended.

21. RN C documented that Mr A was found on the floor and that HCA I saw another resident kicking Mr A. RN C assessed Mr A and documented the following:

> "On assessment, found a large bruise (lump) on his [left] forehead, a skin tear on [left] wrist [and] a small tear on the [right] elbow. Tummy/shoulder/back/legs checked — no bruising noted. [Complaining] of pain over back area but unable to specify the site. [Refusing] pain relief (spitting it out). Skin tears dressed, ice[pack] on [left] forehead …
>
> [Mr A] responding verbally but [with] usual confusion. [Refusing] initial [neurological observations] but able to get it once in the [first two] hours. GCS 12.[4]
>
> [Mr A] able [to] ~~walk~~ move both legs (kicking when cares done). Arms [with] usual strength but noted to be guarding his [left] elbow — no lumps, bruising noted. Checked regularly …"

[4] Glasgow coma scale. A moderate head injury is usually associated with a GCS score of 9 to 12.

22. RN C commenced a neurological observation chart and a health variance care plan[5] for Mr A's skin tears and bruising; however, these were not continued after RN C's shift. HCA I and RN C completed the first page of ACW's incident form, which included a description of the event and assessments carried out. RN C told HDC that she handed over Mr A's care to the Team Leader (TL), HCA D, a healthcare assistant.

23. HCA D reported that she was in charge of the secure dementia unit. ACW told HDC that having HCA D as a team leader in the dementia unit was accepted practice at the time of events. According to ACW, this practice was consistent with its contractual obligations and the Ministry of Health certification.

24. ACW told HDC that following the incident, Mr A's overall clinical management was not facilitated by a designated senior nurse or clinical manager. It acknowledged that with no one person taking responsibility for Mr A's care, it created a situation where no management plan was initiated to evaluate Mr A's ongoing clinical needs.

Morning shift

25. The roster for Day 1 indicates that the staff on the morning shift were HCA D, the Acting Clinical Manager (ACM) RN F, and registered nurses RN J and RN H. This differs from RN C and RN F's recollection. They reported that another Acting Clinical Manager, RN G, was also present for the morning shift. RN G stated that she came into work the day after the incident on Day 2.

26. At 7.40am, HCA D visited Mr A and carried out observations, including taking his blood pressure and temperature. She noted that Mr A was "very alert".

27. RN F recalled that when she started her morning shift, there would have been a discussion about Mr A, and she understood that he had appeared to be comfortable and his usual self. RN F further recollected that around mid-morning she went to see Mr A and he was asleep, which was not unusual for Mr A. RN F stated that "no notes [were] written at this time as [there was] nil to report".

28. At 11.10am, another HCA tended to Mr A and noted that he was "good" with "no other concerns".

29. RN F advised HDC:

> "[HCA D was] quite capable of informing us if anything changed [or] was different than usual … [T]here were plenty of RNs involved in [Mr A's] care over this period … [HCA D], as team leader is very capable and experienced with dementia care, more so than many RNs, and she gets guidance from RNs."

Evening shift

30. At 9.15pm, RN K documented the following from her shift:

> "[Mr A] was very restless this shift. Wandering and confused. Refusing to go to toilet …

[5] Also known as a short-term care plan.

> Still refusing to get out of chair [after bedtime medication]. He was not weight bearing. He was complaining of sore back. [Three] person assist and standing hoist to stand [Mr A] and transfer to a wheelchair …
>
> Bedtime cares done in bed as [Mr A] refused to stand …
>
> [Mr A] was complaining of sore right shoulder. No dislocation or unusualities noted. Monitored. [Mr A] on regular Pamol for pain."

31. There is no further documentation until 5 o'clock the following morning.

Night shift

32. RN E was the nurse rostered to work the night shift. She told HDC that she received a verbal handover from RN K at 11pm. She said that she would have been informed about the incident and the treatment that had been provided to Mr A. She stated that her usual practice following handover would be to physically check on all residents, prioritising palliative care, and sick and injured residents first. RN E told HDC:

> "I went to the [dementia unit] to check on [Mr A] and found him to be asleep in his bed at the time. As [Mr A] appeared to be comfortable and was sleeping peacefully, I continued with resident checks and my other duties …
>
> Although I was carrying out my other duties and care needs of other residents, I went back to the [dementia unit] and checked on [Mr A] at regular intervals during the night."

Day 2

Morning shift

33. At 5am, RN E visited Mr A and documented: "[Mr A] awake and alert … not cooperative with [blood pressure], unable to obtain. 20mls Pamol given as [Mr A] said he has pain in his back."

34. At 8.30am, RN G attended to Mr A and documented:

> "Asked to assess [Mr A]. Could move arms [and] legs [with] no pain but he found it painful to stand [and] put his hand on his back. Second time he was asked to stand he found it more painful [and] requested to be left alone. Advised [Team Leader] to seek medical advice."

35. RN G advised that "as his team leader, it is [HCA D's] responsibility to call the doctor". HCA D sent a fax to the medical centre at 9.11am. The fax stated:

> "[Mr A] had a fall yesterday morning, he had been up mobilising yesterday after it, but last night and this morning [complained of] pain not willing to mobilise, have used standing hoist with him this morning. Please could we get a visit."

36. At approximately 11.15am, the duty doctor from the medical centre visited Mr A and arranged for him to go to the public hospital for X-rays. Following this, HCA D completed the first half of the "Review" section of the incident form.

37. Mr A returned from hospital at approximately 6pm having been diagnosed with multiple rib fractures (8th and 9th ribs) and fluid in his right chest. Mr A's next of kin did not want him to be given a chest drain or intubation, so Mr A was given comfort cares following his discharge from hospital.

Subsequent events

38. Mr A passed away a short time later.

39. On Day 4, RN F completed the remaining part of the "Review" section of the incident form. ACW told HDC that the incident form was not completed within the expected timeframe.

Policies and procedures

Behaviour Management Policy and Flowchart policy[6]

40. This policy and associated documents (flowchart, behaviour assessment form, behaviour management plan, nursing progress notes, and behaviour log) are to be used to identify, assess, monitor, manage, and review behaviours in a manner that promotes safety, dignity, and respect. The policy provides that where there is a known or identified challenging behaviour, staff should carry out a behaviour management assessment that will lead to the establishment of a behaviour management plan.

Challenging Behaviour Management policy[7]

41. This policy describes how staff at ACW support and manage a resident's behaviour that is causing concern to staff, or behaviour that is adversely affecting other residents or themselves. It specifically identifies wandering as a common challenging behaviour. The policy states that a management plan will be developed using a multidisciplinary approach for residents exhibiting challenging behaviour.

Resident Incident/Accident Procedure[8]

42. The incident/accident form required staff to complete it "promptly". The first section of the form requires staff to document the following:

- The date, time and location.
- Whether the incident was "fall" or "non-fall" related.
- Whether the incident was witnessed.
- The details of the events.
- The name of the staff member completing the form and his or her designation.

43. The "Assessment — RN/Clinical Manager/Other" section of the form requires staff to document:

- Whether neurological observations are required.
- What actions have been taken.
- Whether further monitoring is required.

[6] Effective between September 2014 and May 2015.
[7] Effective between May 2015 and July 2017.
[8] Effective May 2015.

44. The "NOK notification" section of the form requires staff to refer to the Lifestyle Care Plan Notification requirements and document:

- The name of the next of kin notified.
- Whether the general practitioner was notified.

45. The "Review — RN/Clinical Manager/Other" section of the form requires staff to document:

- The date on which the section was completed and the designation of the staff member completing it.
- A review of the incident.
- Whether any corrective actions have been taken.

Further information — ACW

46. In July 2015, RN F signed a variation to her employment agreement, accepting an Acting Clinical Manager position. She held this position at the time of the incident. ACW informed HDC that it was unable to find a copy of the updated job description on RN F's file. ACW commented: "[T]his is unusual as our usual practice is to update job descriptions when a variation was made."

47. RN F told HDC that she never saw a job description for the role. She stated:

> "[W]hat I was basically asked to do was be on call till [ACW] hired someone … and delegate jobs out where I needed to and that I had [RN G] (a senior RN) to help out as well."

48. ACW acknowledged that there were several failings and areas of concern in its practice. It has learned from the events and has since reviewed its policies and practices and provided training to staff to minimise the potential risk of such an incident occurring in the future, and to ensure safe care of residents.

49. ACW added that a registered nurse is now required to be rostered to work in the dementia unit to ensure clinical accountability.

Responses to provisional opinion

Ms B

50. Ms B was given an opportunity to comment on the "information gathered" section of the provisional opinion. She did not provide comment.

ACW

51. ACW was given an opportunity to comment on the provisional opinion. It advised HDC that it accepted the proposed findings and recommendations. It acknowledged that it failed to ensure that its policies and procedures relating to Mr A's clinical management were adhered to. It remains deeply distressed over the death of Mr A and acknowledged its shortcomings.

52. ACW brought the relevant sections of the provisional opinion to the attention of HCA D and RN F. HCA D advised HDC that she had no comment to make on the provisional opinion. Where relevant, RN F's response has been incorporated into the "information gathered" section above.

Opinion: Anglican Care (Waiapu) Limited — breach

Introduction

53. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), ACW had a responsibility to operate the rest home in a manner that provided its residents with services of an appropriate standard. My expert advisor, RN Grant, advised that ACW had adequate policies and procedures, yet staff at the rest home failed to manage Mr A's wandering behaviour appropriately prior to the incident on Day 1, and did not care for Mr A with the urgency he required after he was physically assaulted by another resident. RN Grant highlighted that there was a lack of importance placed on the physical assault of one resident by another, and that any physical assault should be treated with the utmost urgency by senior staff. In my view, the inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not sufficiently support and assist staff to do what is required of them, and ACW must bear overall responsibility for this.

Management of Mr A's wandering behaviour

54. RN Grant advised that Mr A's notes frequently documented his wandering behaviour, which included going into other people's rooms. Nursing progress notes show that this behaviour was evident from March 2015 onwards and occurred regularly. ACW amended its policies in May 2015, and therefore there are two behaviour management policies that relate to the time period of Mr A's wandering behaviour. Both set out that management plans will be developed for residents who exhibit challenging behaviours, and the first policy specifies "wandering" as a challenging behaviour. Despite staff recording Mr A's wandering behaviour for approximately eight months, a behaviour management plan was not completed for him by any staff member. RN Grant noted that there was no proactive plan to identify triggers and prevent Mr A's behaviour. RN Grant concluded that "there was poor planning and documentation" in relation to Mr A's behaviour management plan, and considered this to be a "moderate to severe departure" from accepted standards.

55. I am critical that a behaviour management plan was not implemented for Mr A prior to the incident, given his wandering behaviour. Despite these behaviours being documented, they did not result in Mr A's behaviour being assessed further and strategies developed to prevent the behaviours. It also concerns me that ACW reported that weekly meetings were not occurring between the Clinical Coordinator and Team Leader to ensure that challenging behaviours were being identified and managed appropriately. In my view, this also contributed to a failure to implement a behaviour management plan. Whilst it may not have prevented the incident on Day 1, it could have minimised the risk of it occurring.

Incident on Day 1

56. RN Grant advised that the initial call for help was appropriate and timely, and the night shift nurse appropriately documented the actions taken by staff, including the frequency and results of assessments. I accept that the response from HCA I and RN C immediately after the incident was appropriate in the circumstances.

57. However, RN Grant considered that there were deficiencies in Mr A's nursing assessments across Day 1 and Day 2 in the following ways:

- Mr A should have been referred to a general practitioner (GP) on the morning shift of Day 1. RN Grant considered that as the morning shift senior nurse, RN F was responsible for contacting the doctor.
- Short-term care plans were not commenced for ongoing essential cares such as pain management and personal cares.
- The clinical notes show that Mr A was in pain following the assault, and continued to be in pain, yet no accurate and thorough pain assessment was carried out for Mr A. RN Grant noted that patients with dementia will express pain in different ways, such as reluctance to accept cares, aggression, and refusing to follow instructions. She considered that it would be reasonable for any registered nurse to understand this.
- RN F stated that she visited Mr A mid-morning on Day 1 and felt that as he was sleeping and appeared comfortable, she did not need to document anything in the notes.
- RN G assessed Mr A on the morning of Day 2, but did not complete a full nursing assessment. RN Grant advised that "it would be reasonable to expect that his chest would be examined for any bruising and presence of pain".

58. RN Grant advised that any patient who suffers a head injury, or any injury involving assault, must be assessed by medical staff as early as possible following the event, and the failure to seek prompt medical attention for Mr A was a "moderate departure" from accepted standards. She further advised that the process of not having one registered nurse responsible for the unit and overseeing the incident meant that registered nursing staff missed implementing a short-term care plan for Mr A's pain, and this failure was a "moderate to severe departure". RN Grant reported that overall, across the two days, the nursing care provided to Mr A was a "severe departure" from accepted standards.

59. I agree with RN Grant. I accept that as the senior nurse on the morning shift, it was RN F's responsibility to seek a medical review for Mr A, and I am critical that this did not occur. I note that RN F stated that she visited Mr A mid-morning. This was a missed and important opportunity to escalate his care to a GP or the hospital.

60. Moreover, having knowledge of the nature of Mr A's incident and how that could present in a man with dementia, I am concerned about the apparent lack of critical thinking from ACW staff to provide Mr A with the care he needed. Staff at ACW individually and as a team failed to recognise the seriousness of the incident on Day 1 and think critically about what Mr A required, and therefore failed to ensure that Mr A was assessed and monitored adequately and received timely medical attention.

Request for medical review

61. RN Grant also noted that the fax that was sent to the medical centre on Day 2 was "incorrect and misleading", as it stated that Mr A had had a fall and had been mobilising. It is vital that requests for medical reviews present an accurate clinical picture to the attending clinicians. I am critical that HCA D did not communicate Mr A's presenting problem effectively to the on-call GP.

Clinical responsibility

62. RN Grant advised that it is evident from her review that the Team Leader of the secure dementia unit took full responsibility for the residents, including completing incident forms and requesting GP visits. RN Grant noted that HCA D is not a registered nurse. RN Grant considers that Mr A's management following the incident should have been handled on a more consistent basis and at a more senior level. In her view, Mr A's management should have been allocated to RN F as the senior registered nurse on duty.

63. ACW's accident/incident form required staff to document the incident, carry out an assessment of the resident, and review the incident (and record the corrective actions taken). The form stipulated that a registered nurse, Clinical Manager, or "Other" staff member could complete a review of the incident. Mr A's incident was reviewed by HCA D, and corrective actions were documented by RN F. RN Grant advised that all incident forms should be viewed and evaluated by senior staff daily. She is critical of ACW's process of sending the incident form to the Facility Manager and the Team Leader, neither of whom are registered nurses. RN Grant's expectation for serious events such as Mr A's assault would be for all senior nursing staff and management to view the incident form as a priority, carry out appropriate interventions, and ensure that plans were in place and support provided to care staff.

64. I accept RN Grant's advice. In my view, ACW did not have clear processes for ensuring appropriate clinical oversight for a resident following a serious incident. Nursing staff continued to carry out assessments when requested or waited to be notified by the Team Leader of any changes in Mr A's condition. The incident report was also not reviewed and completed until three days after the assault, despite ACW's incident reporting policy requiring it to be completed "promptly". Whilst ACW has implemented corrective actions to address these issues, I am critical that it did not have adequate systems and processes in place at the time of the event.

65. I am also concerned that RN F was appointed to the role of Acting Clinical Manager but did not receive a job description. In my view, this added to the lack of clarity around lines of clinical responsibility at the rest home at the time of the events.

Conclusion

66. As I have stated previously, aged care facilities are responsible for the operation of clinical services they provide, and can be held responsible for any service failures.[9] In my view, the failure to manage Mr A's wandering behaviour appropriately over a number of months leading up to the incident, and the overall deficiencies in nursing care after the incident, demonstrate a pattern of suboptimal care and a lack of critical thinking from numerous

[9] 16HDC01148 (issued 9 April 2018).

ACW staff members. The deficiencies occurred in an environment where lines of clinical responsibility were unclear. I consider the above shortcomings to be service delivery failures that are directly attributable to ACW. In my view, ACW failed to provide services to Mr A with reasonable care and skill. Accordingly, I find that ACW breached Right 4(1) of the Code.

Recommendations

67. In response to the provisional opinion, Anglican Care (Waiapu) Limited provided a formal written letter of apology to Mr A's family. The apology has been forwarded to Mr A's family.

68. I recommend that Anglican Care (Waiapu) Limited consider whether any of the learning from this investigation can be translated into improvements throughout its other aged care services, and report back to HDC on its consideration within one month of the date of this report.

69. The new owners will be asked to:

a) Share this report with its staff who were previously employed by ACW and consider whether any learning can be taken from this case and translated to improvements to its own policies and procedures.

b) Provide a report on its consideration of this investigation, within three months of the date of receiving the anonymised final report.

Follow-up actions

70. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Anglican Care (Waiapu) Limited, will be sent to the new owners, who will be advised that the report relates to the care provided at the rest home.

71. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Anglican Care (Waiapu) Limited, will be sent to the Ministry of Health (HealthCERT), so that specific learnings from this case, in the context of dementia care services, can be taken into consideration as the Ministry initiates its review of the Health and Disability Services Sector Standards.

72. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Anglican Care (Waiapu) Limited, will be sent to the Coroner, and the district health board and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Jan Grant:

"I have been asked to provide an opinion on the care provided to [Mr A].

I have no personal or professional conflict of interest in the case. My advice is based on a review of the documentation provided.

I have read and agreed to the Commissioner's guidelines.

I am a Registered Nurse with over 30 years of experience in Aged and Community Care. In that time I have had a variety of roles. I have been Manager and Director of Nurses of an aged care facility and in community care for 17 years. I have represented the NZNO and the Aged Care Sector on a number of national working parties. I have been involved in setting standards for Practice for Gerontology Standards. I have been a clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My immediate past role was as clinical advisor/ rehabilitation coordinator in the community. I am a designated assessor for ACC. I have post graduate qualifications in nursing and a Master's degree in management, with nursing ethics and research as a focus.

Background

[Mr A] had been a resident of [the rest home] since June 2014. He had dementia and was in [the secure dementia unit] at the facility.

On [Day 1] a caregiver heard cries of help and discovered [Mr A] on the floor of another patient's room. A staff member witnessed the patient kicking [Mr A] in his torso. She sounded the alarm and staff from other areas of the facility attended.

[Mr A] suffered a bruise to his forehead, a skin tear on his left wrist and right elbow, pain in his back and pain in his left arm and elbow. Following the events over the next 24 hours, staff noticed [Mr A] appeared restless, refused to get out of his chair and was not weight bearing. He also complained of a sore shoulder.

On [Day 2], following medical assessment at the rest home, [Mr A] was seen at the public hospital where it was identified he had fractured ribs and an effusion and/or haemothorax on the R side of his chest. Family members were consulted. They advised that they did not want insertion of a chest drain or intubation. [Mr A] returned to [the rest home] for ongoing nursing care.

[Mr A's] breathing deteriorated and he passed away at 0745hrs on [Day 4].

The standard of nursing care immediately after the assault

Clinical notes that relate to the assault include:

Incident/Accident form, Nursing Progress Notes, Medical notes, Family Communication Record and Care Plans. There are also police statements from staff involved at the time of the assault.

Nursing Progress notes, dated [Day 1], stated at 0600hrs that:

A staff member heard [Mr A] calling for help and found him on the floor in a room where it was observed that the resident of that room was kicking [Mr A]. He sustained a lump on his L forehead and skin tears on his L wrist and R elbow. The RN checked [Mr A's] abdomen, shoulders, back and legs and noted no bruising. He was complaining of pain over his back area but was unable to specify the site of the pain. The nursing notes state that he refused pain relief. The assessment notes that he was able to move both legs (kicking when cares done). His arms had usual strength but he was guarding his L elbow. An incident form was completed. The notes indicate that family was to be informed. A health care variance plan was commenced.

A Neurological observation chart was commenced and recordings taken at 0430hrs and then half hourly until 0700hrs. [Mr A] refused to have his blood pressure taken and he refused for the nurse to observe his pupils.

At 0740hrs observations were taken and recorded as BP 150/90, Pulse 60, Respirations 18 and Temperature 35.8. Staff phoned [next of kin] at 0745hrs.

Notes indicate that at 1110hrs all cares were given and no concerns were noted. There was no other information recorded for the morning shift.

At 2115 hrs on [Day 1], the nursing notes stated that [Mr A] had a very restless shift. He was wandering and confused. He was refusing to go to the toilet, and unable to weight bear. The notes state that [Mr A] had complained of a sore back and needed the assistance of the standing hoist in order to be transferred to a wheel chair. [Mr A] also complained of a sore right shoulder. The records indicate no dislocation was noted.

The night shift of [Day 2] states that [Mr A] was awake and alert at 0500 hrs. His observations were taken and it was noted that he was not co-operative with his blood pressure being taken. He complained of pain in his back.

At 0830hrs on [Day 2], a nurse assessed [Mr A] and found that he was able to move arms and legs but that it was painful for him to stand. A request was made for the Team Leader to seek medical advice. At 0930hrs a fax was sent to [the medical centre] and the Doctor visited at 1115hrs. [Mr A] was sent to the public hospital where assessment showed that he had fractured ribs on the right side and fluid in the right chest indicating either effusion or haemothorax. An X ray of the pelvis and hips showed no fractures were seen.

The management of [Mr A's] injuries was discussed with his [next of kin]. She requested that intubation and insertion of a chest drain were not to be done. Risks of developing an underlying pneumonia were discussed.

[Mr A] was discharged back to [the rest home] with morphine elixir PRN and Paracetamol QID to be given for pain relief.

The incident form states the initial event took place at 0400hrs on [Day 1]. [Mr A] was yelling and was found on the floor being kicked in the abdomen by another resident. The caregiver rang the distress bell.

Family were phoned at 0745 hrs and the incident was reported to them.

The Registered Nurse has documented her findings. It is listed that [Mr A] sustained a 3cm oval lump/bruise on his left forehead as well as other documented injuries.

Summary

From the documentation reviewed I am of the opinion that the initial call for help was appropriate and timely. I would however question the caregiver for yelling. The other staff in the facility came to assist. The Registered Nurse, [RN C], in her statement indicates that she gave first aid and checked [Mr A] for bruising but couldn't see any at the time. She applied an ice pack with bandage to [Mr A's] head. Following removal from the room [Mr A] was wheeled to the nurses' station where his wounds were dressed, after which he was settled in his bed. He was commenced on regular neurological observations, starting at 0430 and finishing at 0700 hrs. Recordings were taken again at 0740hrs. No other recordings were taken again that day.

In her statement the Team Leader, [HCA D], notes:

'On [Day 1] [Mr A] was walking, eating and drinking. I had no concerns about him. I finished at 3.15 pm'

It was not until 2115 hrs that staff identified that [Mr A] was restless, wandering and confused and refusing to weight bear. This statement is confusing as it indicates that [Mr A] was wandering and then goes on to state that he was non-weight bearing. It was also noted he was complaining of shoulder pain.

I am of the opinion that a medical assessment should have been carried out as soon as possible on the morning of [Day 1]. Any patient who has had an event such as the assault which [Mr A] suffered should have been assessed by a Doctor as soon as possible following the event. Had early medical assessment taken place, the presence of fluid in his chest would possibly have been diagnosed on examination of the chest by the doctor in attendance. In addition, the presence of shoulder pain in the absence of shoulder injury would have supported this finding. The nature of the assault [kicking in the torso] and the presence of back pain, should also have alerted staff to possible kidney injury. There is no evidence that a urine specimen was examined for haematuria. Again, early medical assessment was essential to rule out renal damage.

I am of the opinion that the day management of [Mr A] should have been managed by a senior Registered Nurse. The Team Leader of the dementia Unit was not a Registered Nurse. Senior staff, including the Clinical Manager should have been involved in the management, assessment and follow up.

The nursing notes for the evening of [Day 1], which were written by a Registered Nurse, indicate that [Mr A] was very unsettled, refusing to mobilize, was non weight bearing and was resistive to cares.

I believe that any patient who suffers a head injury, or any injury involving assault, must be assessed by medical staff as early as possible following the event. If a doctor had not been able to visit within this time frame, in my opinion [Mr A] should have been taken to the Accident and Emergency Department for a full assessment.

I am of the opinion that the failure to have a medical assessment immediately following the event would be viewed as a moderate departure from acceptable standard by my peers.

The standard of nursing care in the days between the assault and [Mr A's] hospital admission

The standard of nursing care following the event was less than optimal due to:

No medical assessment took place immediately after the assault. The medical assessment was undertaken over 24 hours after the assault.

No accurate and thorough pain assessment was undertaken. Clinical notes, in my opinion, show that [Mr A] was in pain immediately following the assault and continued to be so. Patients with dementia will present with pain in different ways, for example increasing reluctance with cares, non-weight bearing, increasing confusion etc, all of which [Mr A] demonstrated.

A short term care plan was commenced in relation to wound and injuries but not in relation to on-going essential cares, including pain management and personal cares.

Senior management should have been involved immediately following the assault. It is noted that the Team Leader is not a Registered Nurse, and in my opinion [Mr A's] management should have been handled on a more consistent basis and at a more senior level. It is noted in the progress notes that the Registered Nurse had asked the Team Leader to seek medical advice. The entries in the notes from the day shift on [Day 2] are from the Team Leader not the Registered Nurse.

Summary

I am of the opinion that [Mr A's] care was inconsistent due to a lack of Registered Nursing input and follow up, and to delayed medical assessment. I am of the opinion that this would be viewed as a moderate departure from acceptable standard by my peers.

Any other matters in this case that you consider warrant comment

Clinical notes, in particular the progress notes, indicate that [Mr A] was prone to wander into other people's rooms. This appears to have been an on-going issue for some time and that at times staff found it difficult to re-direct him. On the night of [Day 1] [Mr A] had been wandering and due to the caregiver's duties, which included

mopping the floor, he was advised to '*turn around and walk that way. I turned around to start mopping the floor at the end of the corridor I was in. This corridor is off the corridor where [Mr A's] room is located. [Mr A] went towards his room and out of my sight' (page 5 of statement to police by [HCA I]).*

This comment and action indicates to me that appropriate assistance and direction was not given to [Mr A]. It was not sufficient to assume [Mr A] found his way back to his own room. Redirection and support, in person rather than verbally, at this time may have averted his entering another patient's room. Clinical notes show he had done this often and this suggests that the verbal instructions given were unlikely to have been enough to redirect him to his own room.

The medical notes of [Day 2] state '*fall yesterday pushed over by another resident and fell backwards No LOC. Mobilising yesterday but today unwilling to weight bear and needing hoist. OE tender over R lower chest … Probable # ribs ? Vertebral # ?? hip # [public hospital] for X rays'*

It is uncertain if the doctor was told that [Mr A] was assaulted and kicked by another resident. This information is important and relevant and should have been passed on to the Doctor.

Jan Grant"

The following further expert advice was obtained from RN Grant:

"I have been asked to provide further expert advice in relation to [Mr A's] care.

1. You advised that the delay in seeking a medical assessment was a moderate departure from accepted standards. Please advise who was responsible for this departure.

[Mr A's] assault happened at 0400hrs on [Day 1], as reported in the incident form. He was provided with assistance from the registered nurse on duty. Observations were taken regularly until 0740hrs. His wounds were dressed. The clinical notes by the night RN state that family was to be informed on the morning shift.

I believe that the morning shift senior RN was responsible for contacting the Doctor. The night shift had appropriately documented the actions staff had taken, including the frequency and results of recordings. The roster shows that the RN on duty on the morning of [Day 1] was the Quality Coordinator, [RN F], from 0845–1400hrs, and [RN H] from 0900–1700 hrs. The roster shows that [RN J] commenced work at 0645hrs.

In a statement dated [Day 1] by [RN C], (the RN on night duty when the assault occurred), she stated that she handed over [Mr A's] care to the Team Leader, [HCA D]. She also gave a verbal hand over to the two RNs working that morning — [RN J] and [RN G].

In [RN G]'s statement she indicated that she was not working on the morning of [Day 1], but was working on the morning of [Day 2], hence there is some confusion in the

statements. However, clearly [RN F] was on duty for the morning shift on [Day 1], and as she was the senior RN, I am of the opinion it was her duty to contact the doctor.

I do have some criticism of the process and the facility as a whole. It appears that the process followed was to send an incident form to the Facility Manager, who is not a Registered Nurse. The incident form was also sent to the Team Leader who managed the dementia unit — also not a Registered Nurse.

I am of the opinion that [Mr A] should have been referred to be seen by his GP on the morning shift of [Day 1]. The Registered Nurse on duty that morning should have facilitated the medical review.

As previously stated in my initial opinion any patient/resident who has been physically assaulted should be fully reviewed by medical staff. In the event that there was not an allocated RN on duty in the dementia unit, then the responsibility of contacting the Doctor to arrange this should fall to the Clinical Manager or Facility Manager.

2. You have identified a moderate departure in the nursing care provided to [Mr A]. Please advise who is responsible for this departure.

My initial opinion lists a moderate departure from acceptable standards. This was due to the adequate assessment undertaken by [RN C] on the night the assault happened. However, my overall opinion of the delay in seeking medical assessment has changed following a review of the statements by [RN F] and [RN G].

The statement of [RN F] indicates that she, [HCA D] (a dementia unit caregiver and Team Leader) and [RN G], all discussed [Mr A] when she arrived at work on [Day 1]. She states that they went to see [Mr A] mid-morning, but he was asleep and that no nursing notes were written. It is also stated that [RN G] visited [Mr A] after lunch and again there was no entry made in the nursing progress notes. I was not aware of these visits when I wrote my original advice.

As previously stated there is some confusion as to who was on duty on the morning of [Day 2]. I have read the statements and it appears that [RN F] was on duty that morning, as well as [RN J] and [RN H].

If the roster is correct then there appears to have been three RNs on duty the morning of [Day 1]. I am of the opinion that this number is certainly adequate to initiate and document an appropriate response to the event.

3. Please review the additional information and advise if this information causes you to change your previous advice.

Yes. Having reviewed the subsequent statement from [RN F] and [RN G], I find their statements and comments to be a concern.

[RN F] has stated her lack of understanding of the policies and procedures.

In [RN G]'s statement, she indicates that she was on duty on [Day 2] and not on duty on [Day 1]. Therefore I must conclude that [RN F]'s statement was incorrect.

[RN F] stated that on [Day 1] she went with the Team Leader to visit [Mr A] mid-morning and felt that as he was sleeping and appeared to be comfortable she did not write anything in the notes. She also goes on to state that she felt that [HCA D], the Team Leader, was '*quite capable of informing us if anything changed/was different than usual as she was very familiar with the dementia unit residents'.*

The following morning, [Day 2], [RN G] assessed [Mr A].

[RN G] in her statement indicates that her assessment on [Day 2] involved assessing [Mr A] as he looked like he was in pain. She asked him if he was in pain and she states that he did not respond but he was holding his right side with his right arm. [RN G] asked him to squeeze her hands — she states he was fine and applied pressure to her hands. She states that he rotated his shoulder and it appeared to be fine. On asking [Mr A] to stand, he initially refused and a lifting belt was obtained. Together with [HCA D] they assisted [Mr A] to stand. She states that he was obviously in pain and not happy. It must be noted that [Mr A], when X rayed was diagnosed with fractured 8th and 9th ribs on his right side. In fact the use of a transfer belt which is usually tightened against a resident's waist may have increased his pain hence his reluctance to stand. I believe a full nursing assessment would have identified the source of his pain. [Mr A] was demented and it would be realistic for any registered nurse to understand that residents with dementia express pain in different ways such as resistance to do tasks and in this case a reluctance to stand. A full nursing assessment would not have been limited to his shoulder, right arm and hand. Given the history of being kicked during the assault and that he was observed to be holding his right side, it would be reasonable to expect that his chest would be examined for any bruising and presence of pain.

On [Day 2] [RN G] then asked [HCA D] to contact his Doctor to arrange a medical review. [RN G] states that as [HCA D] was the Team Leader it was her responsibility to contact the Doctor.

I also question the opinion of the RN in requesting the care worker to phone and liaise with the GP.

This man was physically assaulted and sustained serious injuries. It is in my opinion, and also very concerning, that an RN does not feel that it is her responsibility to contact medical staff following such an event.

It is also noted that the fax dated [Day 2] at 0911hrs requesting a visit from the Doctor states that [Mr A] 'had a fall yesterday morning'. This fax also states that the standing hoist was used to assist [Mr A] to mobilize when the statement from [RN G] states that they used the transfer belt.

I am now of the opinion that the failure to adequately assess both on [Day 1] and [Day 2] would be viewed by my peers as a severe departure from acceptable standards.

4. Comment on the adequacy of the monitoring and plans in place to manage [Mr A's] wandering behaviour.

Information relating to [Mr A's] behaviour included

- Clinical notes viewed from [2015].
- LTCF assessment done by [RN G] [2015]
- Clinical assessment form dated [2014]
- Lifestyle care plan reviews
- Challenging behaviour monitoring chart
- Medical notes

Clinical progress notes document at least daily, and at times more frequently, [Mr A's] cares and behaviours. Most appear to be documented by caregivers with minimal RN documentation with the exception of [RN K]. From [March] it is evident that [Mr A] presented with behaviour and wandering issues. Notes frequently document his wandering and aggression/agitation at times when being redirected. They also show that at times he refused medication. His wandering included going into other people's rooms. Nursing progress notes show this behaviour is evident from March onwards, and occurred quite regularly. Nursing progress notes also show interactions with other residents and that at times [Mr A] was aggressive ([8 occasions in 2015]). The notes also show that he had a number of falls and injuries which were not witnessed. Staff had assessed [Mr A] as a high falls risk which was completely appropriate. He used a sensor mat by his bed to assist staff to identify when he got up and out of bed.

[Mr A's] clinical file included a Challenging Behaviour Monitoring Chart. This chart indicated the type of behaviour he displayed and the interventions in relation to his care. There are approximately 12 behaviour events and interventions range from statements such as 'diversion, removed from other resident and PRN medication'. Evaluations of the interventions include statements such as 'settled, sitting in chair, remains aggressive'.

Policies supplied by the facility include the Behaviour Management Policy. This policy states that a management plan will be developed using a multi-disciplinary approach for residents exhibiting challenging behaviour.

Number 8 in the procedure states that staff will document in the Resident's Lifestyle Care Plan and that the interventions documented have been assessed and evaluated as being appropriate for this resident. The management plan will provide guidelines to prevent episodes of challenging behaviours if it occurs.

The policy also lists non-pharmacological prevention and management strategies for behavioural problems. Included is a Challenging Behaviour assessment form. The policy goes on to describe how to manage out of character behaviours.

A challenging behaviour assessment form was completed [in late 2014], but does not identify any challenging behaviours. The challenging behaviour monitoring chart is filled in starting from [early 2015] with 11 entries.

There is no evidence of a current management plan using a multi-disciplinary approach as required in the policy. [Mr A's] clinical status, in my opinion after reading his clinical notes, indicated he would have required a management plan to identify and support his periods of aggression and wandering. Clinical nursing notes are a reflection

of his behaviour and challenges but in my opinion there is not a proactive plan to identify and prevent triggers to his behaviour. The nursing notes identify that at times 2 and sometimes 3 staff were used to redirect him.

One would expect to see a current plan with key indicators and interventions to support his care. It would be an expectation that this plan would be documented by registered nursing staff and that evaluations would be documented by both registered staff and caregivers who provided daily care for [Mr A]. I would also expect to see family having been consulted in this process.

I am of the opinion that there was poor planning and documentation in relation to a behaviour management plan. I am of the opinion that this would be viewed as a moderate to severe departure from acceptable standards by my peers.

5. Following the incident should an individual RN have had overall responsibility/clinical oversight of [Mr A]?

Yes I believe that [Mr A's] management should have been allocated to the senior RN, [RN F] as she was the acting Clinical Manager. The roster shows she was on duty for the two days following the incident. In the event that she was unable to undertake this role then I believe another RN should have been allocated for this position.

Often facilities will have incidents which may be viewed as minor with no subsequent injuries for residents. An incident form should always be documented, and these are usually read on a daily [basis] by the charge nurse or equivalent staff member. All incident forms should follow a process to be viewed and evaluated by senior staff daily. For serious events such as [Mr A's] assault I would expect that all senior nursing staff and management would view the incident form as a priority, carry out appropriate interventions, ensure plans are in place as well as provide support to the care staff.

6. Following the incident should [Mr A] have had a short term care plan for pain?

Yes [Mr A] should have had a short term care plan for pain. The seriousness of the assault and the injuries sustained would indicate that there will be pain associated with the assault, even though [Mr A] may have been unable to verbalise this.

[Mr A's] medical conditions listed in his file include conditions such as Polymyalgia Rheumatica, Osteoarthritis R knee CVA, TKJR, MI, Hypertension, Renal impairment. Certainly the Polymyalgia Rheumatica and the osteoarthritis would have caused discomfort on an ongoing basis and would have required regular assessment of and management of his pain levels.

Also it must be acknowledged that Dementia residents are not able to express pain in the same way that a resident who is cognitively aware is able to. Reluctance to accept cares, aggression, refusing to follow instructions would all, I believe, indicate that pain is present. Any change in [Mr A's] normal behaviour would also indicate that there were injuries and pain present. Dementia unit staff should have an understanding of this and therefore be more vigilant when assessing not only for the presence of pain, but also the causes and the possible clinical consequences. These are situations where a medical review is important in assisting with diagnosis and management.

A short term care plan would have indicated that regular cares and assessments were being completed and also what treatment was being given.

The short term care plan for pain should have been commenced by registered nursing staff. Again the process of not having one RN responsible for the unit and therefore overseeing the incident, meant this was missed. It would be an expectation that caregivers would report each shift and that education around what staff should observe be documented and evaluated by staff.

I believe the absence of a short term care pain assessment and plan would be viewed as a moderate to severe departure from acceptable standards by my peers.

7. Please comment on the appropriateness of staffing levels during the overnight shift on [Day 1].

The roster shows that there were [3 staff on duty overnight]. In [RN C's] statement she has stated that [HCA I] was a caregiver in the unit. This is not shown on the roster. [RN E] states that she was the only RN on duty for 65 residents with varying health needs.

It is my opinion that staffing is very light when there is only one RN on duty for hospital, rest home and dementia level care. However, the staffing level is what one frequently finds in aged care facilities and I believe ACWL's would be in line with other facilities of similar size.

8. Please comment on the appropriateness and adequacy of ACWL's policies/procedures in place for managing behaviours of Dementia patients and incidents of this nature.

I believe the policies and procedures are adequate but need clearer direction for untrained staff in the event of challenging behaviours. I also believe the process of when to escalate to involve senior staff in a situation should be very clear. There needs to be a process documented for caregivers to follow and be enabled to achieve this outcome.

Clearly the multidisciplinary team was not involved in [Mr A's] care, as stated in the policy. A proactive approach rather than a reactive one would have enhanced cares and improved support for this very vulnerable group of residents. I have not viewed the updated policies which replace the ones used at time of [Mr A's] care.

ACWL have acknowledged that this was an issue and the facility has addressed this. More RN involvement is now facilitated.

There are excellent resources and education material available for dementia units as are unit standards for caregivers.

9. Please provide guidance on whether this case highlights more systemic or individual issues related to [Mr A's] care and any other comments you consider pertinent.

I would like to identify three issues which I feel are important.

1. In reviewing [Mr A's] file it is evident that the Team Leader in the dementia unit takes full responsibility for the residents. This includes incident reports and requests for GP visits, which are all signed and facilitated by the Team Leader. The Team Leader is not a registered nurse but the documentation shows that the Team Leader had in the past requested such drugs as sleeping tablets ([2 occasions in 2015]). The clinical notes also show that she administered drugs on a PRN basis ([2015], Risperidone 0.5 mls at 12 md). There is no documentation in the nursing notes as to why this was given PRN. Again on [another date], 0.5ml of Risperidone was given at 1200hrs, but no reasons for this were documented. I believe this is a dangerous situation and puts the caregiver, registered nurses and residents at risk.

2. The second is the fax that was sent to the Doctor on [Day 2] indicates that [Mr A] had a fall on [Day 1]. The information indicates that [Mr A] had been up mobilizing after his initial fall, but that on the previous night and that morning he was in pain and the standing hoist was used. This information is factually incorrect. [Mr A] was physically assaulted by another resident and it was visually observed that another resident was seen kicking him when he was on the ground. I believe the Doctor was given incorrect and misleading information in the fax requesting medical review. The entry in the medical notes indicates that [Mr A] was pushed over by another resident.
3. Third is the lack of importance placed on a physical assault by one resident to another. Any physical assault should, in my opinion, be treated with the utmost urgency by senior staff.

Jan Grant"