Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 20HDC01252)

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Introduction

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

2. The report discusses the care provided to Mrs A (aged in her nineties at the time of events) at Tamahere Eventide Home and Retirement Village.

3. In 2020 this Office received a complaint from Mrs B about the care provided to her mother, Mrs A, at Tamahere Eventide Home and Retirement Village (Tamahere). The complaint concerns the care provided following Mrs A's unwitnessed fall and that healthcare assistants (carers) were falsifying their hourly observations records.

4. The following issues were identified for investigation:

- *Whether Tamahere Eventide Home and Retirement Village provided Mrs A with an appropriate standard of care in Month1[1]–Month6.*
- *Whether Enrolled Nurse EN C provided Mrs A with an appropriate standard of care in Month6.*

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[1] Relevant months are referred to as Months 1-6 to protect privacy.

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- *Whether Registered Nurse RN D provided Mrs A with an appropriate standard of care in Month6.*

Background

5. Mrs A had been a resident of Tamahere since 2012. At the time of these events, she resided in the rest-home wing.

6. Mrs A had osteoarthritis[2] of the right hip, myelodysplastic syndrome,[3] and Alzheimer's dementia.[4]

7. Mrs A's emergency contact was her son.

Falls risk management

8. Mrs A's long-term care plan noted that the Coombe assessment score[5] for falls was nine, which placed her as a low risk of falling.

9. Mrs A was prescribed regular long-acting morphine sulfate 10mg tablets, to be administered twice a day, at breakfast and before bed. She was also prescribed paracetamol 500mg + codeine phosphate 8mg tablets, two tablets to be taken three times a day. Mrs A also had PRN (as needed) pain relief prescribed, which was codeine phosphate 30mg tablets, oral liquid morphine 5mg, and paracetamol 500mg tablets.

10. Mrs A's long-term care plan noted that she required assistance and oversight with her personal and hygiene cares. It also noted that due to her short-term memory loss, care staff were to monitor her for any discomfort in her abdomen and report this to the registered nurse.

11. On 28 Month2 medical notes state that GP[6] Dr E discussed with Mrs A's family the possibility of Mrs A moving to hospital-level care, as she had been 'declining significantly over [the] past 3 months'. However, the family and GP agreed that such a move could be very disruptive to her, so Mrs A remained at rest-home level care.

12. Mrs A had an Advanced Care Plan[7] in place in which she wished for no major interventions and not to undergo a major operation if she fell and broke her hip or leg, for example, and instead she wanted to be kept comfortable and pain free.

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[2] Osteoarthritis is a type of arthritis that occurs when the flexible tissue at the ends of bones wears down. Chronic joint pain in the hands, neck, lower back, knees, or hips is the most common symptom.
[3] Myelodysplastic syndromes are a group of cancers in which immature blood cells in the bone marrow do not mature or become healthy blood cells.
[4] Dementia is a general term for a decline in mental ability severe enough to interfere with daily life, while Alzheimer's is a specific disease. Alzheimer's is the most common cause of dementia.
[5] A Coombe assessment score predicts falls risk.
[6] General practitioner.
[7] A document outlining how the person would like to be cared for in the future.

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Care provided to Mrs A before her unwitnessed fall

13. Mrs A's long-term care plan noted that she was to wear an underwear-style continence product day and night due to episodes of urinary incontinence. Staff were also to remind and prompt her to use the toilet to prevent episodes of urinary incontinence.

14. It was also documented that Mrs A had to use a walking frame, with prompting and reminding from staff if she forgot to use it.

15. As part of Tamahere's Falls Prevention policy, hourly resident welfare checks were to be performed for every resident to ensure that their needs were met at all times. This was the responsibility of the carers, who completed the hourly checklist each time this was done. CCTV footage revealed that on 2 Month6 at approximately 5am, Mrs A appeared to be wearing a very wet underwear-style continence product, as it was hanging down near her knees. She appeared to be unsettled as she was mobilising (without her walking frame) out of her room. CCTV footage showed that she was met by a carer, who redirected her back to her room, but did not attend to her personal cares and change her continence product. Mrs A remained unsettled, and CCTV footage showed that she was still wearing her wet continence product when she walked out of her room at 5.58am and into another room close by. Further review of CCTV footage showed that the overnight carer did not check on Mrs A every hour, even though she had ticked the hourly checklist that this was done.

Incident

16. On 2 Month6, senior enrolled nurse[8] EN C was the nurse on the night shift ending at 7am and was responsible for residents in the dementia units and the rest-home wing, a total of 77 residents. She had four carers working with her, one in each of the four units. The morning registered nurses started their shift at 7.00am.

17. On 2 Month6 at around 6.36am Mrs A was found lying on the floor behind the door and she had soiled herself. The carers alerted EN C, who noted that at that time there were two emergency call bells alarming at the same time.

18. EN C attended to Mrs A and undertook neurological observations[9] but did not complete a head-to-toe assessment[10] or vital observations.[11] EN C documented her assessment of Mrs A as follows:

> '[Possible fracture of the left] Humerus (upper arm bone) [a]rea … swollen, tender and bulged … Has [signs and symptoms] of pain … to touch … [n]il further injuries noticed … [n]euro [o]bs NAD[12] … For ? transfer to [the public hospital] for X-ray … Notify [Dr E] …

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[8] Enrolled nurses practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care.

[9] Neurological observations assess a person's level of consciousness.

[10] A head-to-toe assessment is a comprehensive physical assessment that examines the entire body in a systematic and thorough manner to identify health issues.

[11] Vital observations include a person's temperature, heart rate, respiratory rate, blood pressure, and oxygen saturation.

[12] No abnormality detected.

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> Handed over to [RN D] … For set of OBS[13] when resident has settled … To notify NOK[14] [p]lease.'

19. EN C directed the carers to assist Mrs A to stand with the help of a transfer belt. She was given her walking frame and she walked to her room for a shower by the carers. In response to the provisional opinion, Mrs B stated that Mrs A was not showered in her room as she did not have a shower in her room. Video footage of the residents' hallway on the day of the incident was provided by Tamahere. Mrs B noted that although Mrs A had her walking frame in the video footage, it appears to show that 'one carer [was] pulling her and one pushing from behind', and it appeared that Mrs A 'dragged herself with one hand on her walker dragging her left arm with its broken shoulder and left leg with its broken hip' down the hallway to the communal bathroom.

20. EN C also recorded:

> '[Mrs A] has generally been declining and more disorientated. She forgets to use her walker and forgets where her room is … Please continue with Q1H[15] checks and when passing by … Please encourage [Mrs A] to use her walker (difficult due to being disorientated[)] … Please continue with assisted toileting during the night.'

21. EN C informed the morning nurse, RN D, of the incident, and they visited Mrs A while she was showered by the carers. RN D visually assessed Mrs A and noted a possible fracture of her left arm, but considered that her standing posture appeared to be normal. RN D asked the carers about Mrs A's mobility, and they stated that 'it was okay'. RN D documented that Mrs A had a bruise on her left upper arm, and that she expressed pain when she tried to move her left arm or left leg.

22. It was documented that at 7.31am RN D gave Mrs A her usual morning dose of pain relief, which was a 10mg long-acting morphine tablet, and at 8.03am she was given two tablets of paracetamol 500mg + codeine phosphate 8mg. Mrs A was not given any PRN (as required) pain relief.

23. At around 9.30am RN D informed GP Dr E of Mrs A's fall. Just before 10.00am Dr E visited Mrs A and assessed her injuries. Dr E noted:

> '[M]arked bruising, swelling and [p]ain related to [l]eft upper arm … also has pain localised to [l]eft hip with pain with internal and external [rotation] of hip … Clinical impression of [l]eft humeral as well as suspected left hip fracture.'

24. Dr E sent a referral to the on-call orthopaedic surgeon at the public hospital as she suspected that Mrs A had fractured her left humerus and left hip and that she required further assessment to exclude/confirm the fractures, and appropriate hospital treatment.

[13] Vital observations.
[14] Next of kin.
[15] Hourly.

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25. At 1.02pm RN D informed Mrs A's next of kin of Mrs A's fall and subsequent hospitalisation. In response to the provisional report, Mrs B noted the delay of '6 [and a half] hours after [Mrs A] was found [having] fallen' before the next of kin was informed and added that '[by] this time [Mrs A] was in an ambulance to be taken to [the public hospital] with no family support. This delay is unreasonable given the severity of the situation.'

Hospital admission

26. Mrs A arrived at the Emergency Department (ED) via ambulance at 12.19pm on 2 Month6 and was admitted to the orthopaedic[16] ward.

27. The locum[17] on-call orthopaedic surgeon at the time, documented:

> '[Mrs A] sustained a subcapital neck of femur fracture[18] on the left hand side as well as a proximal humerus fracture[19] on the left. She has got an advance [healthcare] directive[20] which [states] no surgery and not for resuscitation etc. I have discussed this further with the family and they are in agreeance that we should take the opportunity to contact the palliative care[21] team … for comfort cares …'

28. Mrs A was placed on end-of-life comfort cares with no active treatment. She was administered a fentanyl[22] and midazolam[23] infusion to keep her comfortable. She remained under palliative care at the public hospital and did not return to Tamahere.

29. Sadly, Mrs A passed away in the public hospital.

Further information

Statements from staff

30. EN C accepted that '[b]y standards and policy it was not appropriate for [Mrs A] to be stood up and walked to her room even with support from two [carers] before the assessment was fully completed'. EN C stated that she did feel she had the 'skills and knowledge' to manage this event as she had done this previously. However, she noted difficulties/hindrances to her doing so, such as two emergency bells ringing at the same time, hourly checks not being performed by the night carer (at that time she was unaware that the checks had been signed but not actually done). She noted: '[I was] so saddened by this particular fall that soon after I accepted a change of role and cut my working hours by half.'

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[16] Orthopaedic care focuses on treating the musculoskeletal system (muscles, bones, joints, ligaments and tendons).
[17] A person who temporarily fulfils the duties of another.
[18] A fracture in the neck of the thighbone.
[19] A fracture of the shoulder at the top of the upper arm bone.
[20] A statement signed by a person setting out, in advance, the treatment they would want (or not want) in the event of becoming unwell in the future.
[21] Palliative care focuses on providing the person with comfort and relief from pain where a cure is no longer possible.
[22] Fentanyl was charted to help relieve pain and shortness of breath.
[23] Midazolam was charted to help relieve anxiety.

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31. EN C said that amongst other training provided by Tamahere:

> '[I had] attended as many as possible Nurses' Meetings, Education regarding falls, as presented by Tamahere Eventide. I look back at this sad event today and realize I could have done things differently but at the time I did what I thought was right. Hindsight is a wonderful tool.'

32. RN D accepted that on reflection, staying with Mrs A, giving comfort, reassuring her, and performing a head-to-toe assessment would have been better. RN D stated:

> 'Initially I believed that I performed to the best of my ability at that moment. However, every time I looked back, I have recognized that my performance towards her was less competent than I am currently. This is because I have become more competent for our residents safety with more experience.'

33. RN D reflected that '[w]hen a resident falls, do not assume that no injury has occurred, this can be a devastating mistake'. RN D joined the falls prevention team, which provided opportunities to investigate the possible reasons why falls occur and to review the current falls assessment tools. RN D said that this 'helped with effective strategies for planning cares to reduce the [occurrence] of falls'. RN D noted that when looking back at the situation, the lack of experience held at the time is obvious when compared with current knowledge. RN D stated: 'I have realised again how important it is to make myself study, educated and trained well for the moment of an accident that might happen …'

Tamahere's response

34. Tamahere agreed that the camera footage showed that there was a delay in responding to Mrs A's personal needs, and they were not met in a timely manner.

35. After receiving a complaint from Mrs A's family regarding the falsifying of hourly checklists, Tamahere initiated an internal review and conducted an internal disciplinary process. A disciplinary meeting was held with the carer involved, who resigned. Tamahere identified areas for improvement and completed corrective action.

36. Tamahere accepted that a full and comprehensive assessment was not completed at the time of the fall, and that policy guidelines were not followed. However, it highlighted that two emergency call bells were alarming at the same time, and EN C left Mrs A in the care of the care staff, who showered her, and that on her way back to Mrs A she took RN D with her.

37. Tamahere stated that both EN C and RN D had met their nurse competencies prior to the incident, and the incident did not reflect their overall competence entirely.

38. Tamahere accepted that staff training was not completely up to date at the time of the events but noted that RN D 'continues to [learn further]'.

39. Tamahere acknowledged:

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> 'We continue to educate and provide support to our staff to provide optimal care. We will take any recommendations from the HDC to improve practice and resident outcomes. Of note both staff [have] reflected on this incident and made positive changes to their practice.'

Falls policy

40. The purpose of the Falls Prevention policy is to '[r]educe [the] amount of falls across [the] hospital, rest home and village, therefore reducing resident injuries'. The policy stipulates that one way to achieve this is for the resident's Coombe assessment (for predicting falls risk) to be up to date.

41. The policy also provides that if a resident has fallen: 'DO NOT move [the] resident if a fracture … is suspected. Leave [them] on floor, make comfortable. Ring ambulance if required.'

42. The policy stipulates that following a fall, the registered nurse is to complete a 'thorough' assessment, including neurological observations, and these are to be done whether or not it is known that the resident hit their head. A Post Fall Assessment Form must also be completed and a 24-hour post-fall observation log notes that vital observations should be done as soon as possible after the fall and then as follows: 'Every 15 minutes for one hour. Once half an hour later. Once one hour later. Once two hours later. Every four hours until 24 hours post-fall.'

43. Following the fall, the Coombe assessment is to be updated and the family is to be notified of the fall.

First Aid policy

44. Tamahere's First Aid policy (June 2016) notes:

> '[Do not move the resident] until you are absolutely sure that there is no fracture. Observe if any limb is in an awkward position or if there is any swelling. If not sure make person comfortable on the floor, keep warm and phone emergency services.'

Hourly checks

45. Tamahere's Falls Prevention policy stipulates that hourly checks are to be performed on every resident, the objective being to ensure that residents' needs are met at all times. The policy states:

> 'By completing these checks and ensuring needs are met, falls will be prevented, behaviours of concern will reduce, and the likelihood of incidents and accidents will reduce.'

46. The checks are the responsibility of the carers, who are required to 'sight' the resident before ticking and signing the hourly checklist. 'Sight' in this context is not just a visual check, but is also to consider factors such as whether the resident is unsettled and needs toileting, is hungry or thirsty, or is in pain. At the end of the shift, the senior staff nurse on duty checks that the list has been completed.

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Responses to provisional opinion

47. Mrs B was given the opportunity to respond to the 'information gathered' section of the provisional opinion and her comments have been incorporated into this report where relevant.

48. Mrs A told HDC that 'whether or not in hindsight [EN C and RN D] would have made different decisions doesn't alter the fact that they didn't follow the established policies and procedures'.

49. Mrs B also added that her brother (next of kin) was told that Mrs A had had a fall and may have hit her head and that she was going to the hospital and, when he asked whether he should attend ED with her, he was told that someone would go with her and 'it was nothing to worry about'. He went to ED regardless and was alarmed to find Mrs A on a stretcher, alone, in ED with 'severe bruising and swelling down the left side of her body'. The family was further 'shocked to hear that the injury that they thought was minor, was in fact life-threatening'. Mrs B said that it would have been very disorientating to Mrs A being taken out of her immediate environment without reassurance from a family member. Mrs B feels that Mrs A would have been 'extremely' distressed.

50. Mrs B told HDC that their mother's treatment 'before and after her fall would appear to be, at best, neglectful and at worst, brutal,' and that dying in hospital was not 'the end-of-life experience for her that the family, including [Mrs A] herself, would have wished'. Mrs B stated:

> '[Tamahere Eventide] let us down completely at this final stage, leaving [the] family distressed, broken-hearted and betrayed by the trust we had put in her having, at the very least, competent and adequate resthome care.'

51. Tamahere was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. It accepted the Aged Care Commissioner's breach decision and noted that it has 'consistently continued to address and improve [its] services …'

52. Additional changes made to Tamahere's service include:

- The introduction of a preceptor role for its carers and provision of additional training;
- The introduction of a mock fall scenario and training/discussion;
- Hip protectors being worn by all residents who are a high falls risk; and
- An update of its first aid policy.

53. EN C was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. EN C had no further comment.

54. RN D was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. RN D had no further comment.

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Opinion: Tamahere — breach

55. First, I acknowledge the distress that this event has caused Mrs A's family, and I offer my condolences for their loss. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. In addition, to help determine whether the care provided by Tamahere was appropriate, I have considered clinical advice from RN Megan Sendall (Appendix A).

Falls risk management

56. Mrs A was in her nineties at the time of the event and had osteoarthritis of the right hip, myelodysplastic syndrome, Alzheimer's dementia, and short-term memory loss. Her regular pain relief included long-acting morphine sulfate 20mg a day. Mrs A was also prescribed PRN oral liquid morphine 5mg. In Month2, the GP considered moving Mrs A from rest-home level care to hospital-level care because she had been 'declining significantly over [the] past 3 months'. However, after discussions with her family, Mrs A remained in rest-home level care because it was thought that such a move could be disruptive for her. Mrs A's long-term care plan noted that she was assessed as a low risk of falls.

57. RN Sendall advised that Mrs A's falls risk score should have been higher because of her advancing Alzheimer's disease and because she was on twice-daily morphine. RN Sendall noted that '[Mrs A's] risk of falls assessments, did not represent the actual risk of falls given her advanced cognitive change, impact of opioid medication, alongside her underlying pain and multiple comorbidities'. RN Sendall indicated that had Mrs A been assessed as a high risk of falls, then preventative actions, such as wearing hip protectors, could have been implemented to avoid or reduce injuries related to falling. RN Sendall stated that '[a]s all assessments inform the nursing care plan, care planning documents reviewed did not completely reflect the care required to safely manage this risk'. She considers that this constitutes a moderate departure from expected care. I agree. Mrs A's falls risk should have appropriately reflected that she was a high falls risk. I consider that her care plan did not provide adequate support to manage her falls risk.

58. The Falls Prevention Policy stipulated that a way to reduce the incidence of falls and therefore reduce resident injuries was to ensure that the resident's Coombe assessment was up to date.

59. In response to RN Sendall's advice that Mrs A's probable falls risk was higher than that recorded in her Coombe assessment, Tamahere accepted that Mrs A's primary registered nurse had scored the Coombe assessment lower.

60. I further note that Mrs A's Coombe score was not updated despite her GP having identified that Mrs A was declining and having considered moving her to hospital-level care in Month2. In my view, Mrs A's decline provided an opportunity for Tamahere to reassess her risk.

Care provided to Mrs A before her unwitnessed fall

61. Mrs A's long-term care plan noted that she was to wear an underwear-style continence product day and night due to episodes of urinary incontinence, and that staff had to remind

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and prompt her to use the toilet. Mrs A also required a walking frame with prompting and reminding from staff if she forgot to use it.

62. At around 5.00am on 2 Month6, CCTV footage revealed that Mrs A had a very wet continence product, which was hanging down to her knees. She was unsettled and had mobilised outside her room without her walking frame. She was met by a carer, who redirected her back to her room but did not change her wet continence product. Around 5.58am CCTV footage revealed that Mrs A had again mobilised outside her room without her frame and had walked into a room nearby. She was still wearing a very wet continence product.

63. RN Sendall advised that Mrs A required 'prompt attention with an emphasis on maintaining her dignity and comfort'. RN Sendall noted that staff failed to meet Mrs A's hygiene and comfort needs when they redirected her back to her room but did not change her wet continence product. Staff missed the opportunity to provide Mrs A with the appropriate care, which could have prevented her from remaining unsettled and moving to the room next door. RN Sendall advised that the lack of personal care support provided to Mrs A on the morning of 2 Month6 was a moderate departure from expected practice. Tamahere agreed that the CCTV footage showed that Mrs A's personal care needs were not met in a timely manner.

64. I accept RN Sendall's advice, and I am critical that Tamahere did not have adequate systems to ensure that its carers provided appropriate care and support to Mrs A.

Care provided to Mrs A after her fall

65. The Falls Prevention policy states that if a resident has fallen and a fracture is suspected, then the resident is to be left on the floor, and, if appropriate, an ambulance is to be called. The policy also states that a 'thorough' assessment is to be completed by the attending nurse, along with neurological and vital observations. Following this, the post-fall Observation log needs to be completed as soon as possible after the fall, and regular vital observations carried out regularly for 24 hours after the fall.

66. Mrs A was found on the floor and was attended by EN C, who undertook neurological observations, but not a head-to-toe assessment or vital observations. EN C noted that Mrs A might have fractured her arm. EN C directed the carers to assist Mrs A to stand and, with the assistance of her walking frame, they walked her to the bathroom for a shower. EN C informed the morning nurse, who initially performed only a visual assessment of Mrs A and did not perform a comprehensive assessment.

67. RN Sendall advised that the actions of the staff in moving Mrs A without completing a thorough assessment, and assisting her to walk to the bathroom, would not meet best practice guidelines for post-falls care. RN Sendall was critical that both nurses failed to provide appropriate post-fall direction to other staff.

68. Tamahere accepted that a full and comprehensive assessment was not completed at the time of the fall, and that policy guidelines were not followed.

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69. I accept RN Sendall's advice, and I am critical that a thorough assessment was not completed by either nurse, and that Mrs A was assisted off the floor and required to walk to the bathroom when a fracture of her arm was suspected.

Completion of hourly checklist

70. To ensure that residents' needs are met at all times, hourly checks are to be performed by the carers. The carer is to 'sight' the resident each hour. 'Sight' in this context is not just a visual check on the resident but is also to assess whether they are in pain, hungry, thirsty, or in need of toileting. After the carer has sighted the resident, they then can complete the hourly checklist by ticking the corresponding box and signing it. At the end of the shift, the senior staff nurse on duty checks that the list has been completed. According to Tamahere's Falls Prevention policy, these hourly checks can prevent falls.

71. CCTV footage on 2 Month6 revealed that the overnight carer working in Mrs A's wing did not check each resident every hour, although she ticked the hourly checklist to show that this had been done. Mrs A did not receive hourly checks between 12.00am and 4.00am.

72. After receiving a complaint from Mrs A's family, Tamahere initiated an internal review and conducted an internal disciplinary process. It identified areas for improvement and reminded staff about the importance of hourly checks. RN Sendall noted that '[o]ngoing oversight of [healthcare assistants] by [registered nurses] and management will support accurate completion of documentation, including the hourly checklist, in the future'. She advised that the failure to complete and document the physical checks, in particular the hourly checklist, was a mild departure from accepted practice.

73. I agree with RN Sendall. Although it is the carers' responsibility to undertake hourly checks, ultimately they work under the direction of registered nurses, and Tamahere should have had adequate systems in place to ensure that hourly checks on residents were carried out by staff.

Conclusion

74. Tamahere is responsible for the operation of its clinical services and can be responsible for service failures. In my view, it was Tamahere's responsibility to have in place adequate systems and appropriate oversight of staff to ensure that Mrs A received appropriate care. Tamahere is also responsible for the actions of its staff. In my view, the failures by staff across multiple areas (the risk of falls assessment and care planning, the lack of support on the morning of 2 Month6, the initial assessment and management of Mrs A's fall, and management of the hourly checklist) demonstrate a pattern of suboptimal care and service failures at Tamahere.

75. In light of the above, I accept that the departures from an appropriate standard of care (as outlined by RN Sendall) are attributable to Tamahere.

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76. Accordingly, I consider that Tamahere failed to provide Mrs A services with reasonable care and skill and breached Right 4(1)[24] of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: EN C — breach

Care provided to Mrs A following her unwitnessed fall

77. On 2 Month6 at approximately 6.36am Mrs A was found lying on the floor in another resident's room, after an unwitnessed fall. The carers alerted EN C. EN C undertook neurological observations but did not complete a head-to-toe assessment or vital observations. She documented that Mrs A's left humerus appeared swollen, tender to touch, and was bulging, and she queried a fracture. She noted no further injuries. Mrs A was then assisted to stand with the help of a transfer belt, and with the use of her walking frame she was walked to the communal bathroom for a shower by the carers. EN C handed over Mrs A's care to the morning nurse, RN D.

78. EN C stated that she did feel that she had the 'skills and knowledge' to manage this event, as she had done this previously. However, she noted hindrances to her doing so, such as two emergency bells ringing at the same time.

79. As part of this Investigation, I considered clinical advice from RN Sendall. RN Sendall advised that there must be staff on each shift who can provide first aid and understand the organisation's policies in terms of the safe management of unexpected events.

80. Tamahere's First Aid policy states not to move a resident until 'absolutely sure that there is no fracture'. If the nurse notes any swelling of the limb, and suspects a fracture, then the resident is to remain on the floor and be made comfortable, and an ambulance is to be called.

81. The Falls Prevention policy states that following a fall, a 'thorough' assessment is to be completed by the attending nurse, including neurological observations (whether or not it is known that the resident hit their head when they fell). The 24 hours post-fall Observation log is to be completed as soon as possible after a fall, and this includes doing vital observations regularly for 24 hours following the fall.

82. RN Sendall noted that although EN C did perform neurological observations, she failed to provide first aid and complete a thorough head-to-toe assessment before any other actions were taken. RN Sendall advised that Mrs A should have been made comfortable and left on the floor until the appropriate assessments had been completed and it had been established that it was safe to move her. RN Sendall said that it was not appropriate to stand Mrs A, walk her, or shower her while she stood. EN C's attendance and direction to staff fell short of appropriate knowledge and competency to manage the situation safely. RN Sendall

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

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advised that EN C's actions represented a significant departure from the expected standard of care.

83. I agree with my advisor and, while I acknowledge that it was a busy morning and that two emergency call bells were ringing at the same time, a potential fracture of Mrs A's left arm was identified by the attending nurse and, according to the First Aid policy, Mrs A should not have been moved off the floor. I understand that Mrs A had soiled herself, but carers could have been directed not to move Mrs A, but to assist her while she was lying on the ground, which would have protected both her dignity and any potential injuries. I am critical that Mrs A was asked to stand and walk to the communal bathroom and then to stand in the shower.

Conclusion

84. EN C had a responsibility to provide Mrs A with an appropriate standard of care. As the enrolled nurse on night duty, the fall should have been escalated to the registered nurse in the care home and a thorough head-to-toe assessment should have been completed before considering moving Mrs A. EN C had identified a possible fracture of Mrs A's left arm, but she still directed that Mrs A be assisted to her feet and then walked to the shower.

85. I accept that the departure from an appropriate standard of care (as outlined by RN Sendall) is attributable to EN C. Accordingly, I consider that EN C failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: RN D — breach

Care provided to Mrs A following her unwitnessed fall

86. On 2 Month6, RN D was rostered on the morning shift. RN D was approached by EN C and informed that Mrs A had experienced a fall, and together they visited Mrs A in the communal bathroom where she was being showered by the carers. RN D conducted a visual assessment and noted a possible fracture of Mrs A's arm, and considered that her standing posture appeared to be normal. RN D asked the carers about Mrs A's mobility, and they stated that 'it was okay'. RN D then decided to give Mrs A her usual morning dose of pain relief and went to inform the GP of her fall.

87. On 2 Month6 at 10.04am RN D documented that Mrs A had a bruise on her left upper arm and expressed pain when she tried to move her left leg or lift her left arm.

88. The Falls Prevention policy states that post fall, a 'thorough' assessment is to be completed by the nurse. This was not completed by RN D.

89. As part of this investigation, I considered clinical advice from RN Sendall. RN Sendall advised that although RN D did undertake vital observations and contact the GP, did not provide appropriate direction to staff regarding prioritising Mrs A's care and how to manage her safely until further direction from the GP, and did not stay with Mrs A and complete a head-to-toe assessment. RN Sendall considered this to be a significant departure from expected practice.

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90. I agree with my advisor and further note that RN D asked the carers about Mrs A's mobility instead of assessing this personally as part of a thorough assessment. In my view, RN D should have carried out this assessment. However, it is pleasing to learn that RN D has completed further training and has reflected honestly on the role taken at the time of this event.

Conclusion

91. RN D had a responsibility to provide Mrs A with an appropriate standard of care. As the senior staff nurse on the morning shift, RN D had the responsibility to undertake a thorough head-to-toe assessment of Mrs A. Further, RN D was responsible for directing staff to ensure that Mrs A received safe, appropriate care until further assessment from the GP.

92. In light of the above, I accept that the departure from an appropriate standard of care (as outlined by RN Sendall above) is attributable to RN D. Accordingly, I consider that RN D failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Recommendations

93. I recommend that Tamahere undertake the following, within three months of the date of this report:

- Review the education/training being provided to staff in relation to falls management and ensure that it aligns with accepted practice and guidelines;
- Provide evidence of the education/training occurring in the form of education/training material and staff attendance records;
- Review and update, if needed, the Falls Management and First Aid policies, in particular the post-falls process and whether the information provided in these policies provides staff with clear, sequential information on the management of unwitnessed/witnessed falls;
- Conduct an evaluation of the effectiveness of the updated policies three months following their introduction via an audit of compliance, and provide HDC with a report, including any corrective actions implemented;
- Review the education/training being provided to staff in relation to hourly resident checks and ensure that it aligns with accepted practice and standards; and
- Provide evidence of the education/training occurring, in the form of education/training material and staff attendance records.

94. I note that Tamahere has already provided Mrs A's family with an apology.

95. In light of the changes already made by EN C and RN D following the event, I recommend that individually EN C and RN D write a letter of apology to Mrs A's family for their failings, as identified in this report, and provide the apology letters to HDC, for forwarding, within three weeks of the date of this report.

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Follow-up actions

96. A copy of this report with details identifying the parties removed, except the advisor on this case and Tamahere Eventide Home and Retirement Village, will be sent to HealthCERT (Ministry of Health) and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Clinical advice to Aged Care Commissioner

The following independent advice was obtained from RN Megan Sendall:

'The advice provided in this document is related to the assessment of care provided to [Mrs A] by Tamahere Eventide aged care facility. Documents supplied to the Health and Disability Commissioner by Tamahere Eventide aged care facility, [the district health board], [the ambulance service] and documents generated through the Health and Disability complaint process were reviewed alongside CCTV footage. The key areas for consideration relate to actions taken prior to and following an unwitnessed event during which [Mrs A] sustained serious injuries.

It is acknowledged by the writer, the distress felt by the family of [Mrs A], through the passing of their mother, the family's grief and response to the event involving their loved one.

The advice provided, is limited to comments related to six questions raised by the Commissioner's office:

1. Whether the care provided to [Mrs A] by Tamahere Home was reasonable in the circumstances. In particular:

- The appropriateness of [Mrs A's] falls planning;
- The care provided to [Mrs A] before her unwitnessed fall;
- The care provided following her unwitnessed fall;
- The appropriateness of the compliance and management by Tamahere Home staff in relation to the hourly checklist and
- Any other issues considered a departure from expected standards.

2. Care provided by the following individuals and comment on any care considered a departure from expected standard of care.

- [EN C];
- [RN D];
- Any health care assistant(s)

3. Consideration of the issues identified (above) to be systemic issues at Tamahere Home or whether it was more attributable to an individual, or both.

4. The appropriateness of the training at Tamahere Home to its staff

5. The appropriateness of the policies provided by Tamahere Home.

6. Any other matters that warrant comment.

For all questions/statements the following is also requested by the Commissioner's office:

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- What is the standard of care /expected practice?
- Was there a departure from the expected standard of care or accepted practice?
- How this would be viewed by your peers?
- Recommendations for improvement that may help a similar situation occurring in the future.

The following is my response to the questions/statements.

1. Whether the care provided to [Mrs A] by Tamahere Home was reasonable in the circumstances;

The appropriateness of [Mrs A's] falls planning.

[Mrs A's] care plan was up to date at the time of her unwitnessed fall having been completed on 26 [Month1] and nearing the six monthly review date. The care plan was informed by a suite of assessments including a risk of falls assessment (coombe). Previous falls assessments were conducted and completed on the following dates: [three occasions] and 26 [Month1]. It is noted that the risk of falls assessment was not completed within required timeframes (minimum of 6 monthly) following the first recorded assessment. [The second assessment was 10 months later] and does not meet required timeframes for reassessment).

[Mrs A's] last recorded falls assessment (6 [Month1]) documents a set of scores that represent [Mrs A's] assessed risk of falls. The score recorded was a "low risk of falls" with a total risk factor of 9. This was consistent with previous scores of 9 for all risk of falls assessments completed following admission.

On review of [Mrs A's] nursing and medical notes, it is identified that [Mrs A's] scores for both mental status, (2) and medication status, (2) was inconsistent with her recorded state i.e. that she had been scored lower for these areas than her notes reflect. Given [Mrs A's] advancing Alzheimer's Disease with associated cognitive change, and twice daily medication of Morphine LA (long acting morphine sulphate, 20 mgs/day) the scores should have reflected this. Considering the information provided, the scores should have been, mental status 4 and medication status 3. Alongside these scores, general factors were assessed as 0. Consideration should have been given to [Mrs A's] history of cognitive change and comorbidities (osteoarthritis of the right hip and myelodysplastic syndrome). The score of general factors should then have been 4. Therefore, the overall score for all 6 areas assessed would be recorded as 16 and reflect a high risk of falls. It is also noted that there was no recorded evidence that [Mrs A] sustained any falls prior to the unwitnessed fall on 2 [Month6].

The advice provided, considers that the falls assessment records indicate [Mrs A's] probable risk of falls was higher than recorded. As all assessments inform the nursing care plan, care planning documents reviewed did not completely reflect the care required to safely manage this risk. If the high risk of falls had been identified at the

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time of assessment, the utilisation of hip protectors alongside other preventative actions may have been implemented to avoid falls and/or injuries related to falls.

It is my opinion that [Mrs A's] risk of falls assessments, did not represent the actual risk of falls given her advanced cognitive change, impact of opioid medication, alongside her underlying pain and multiple comorbidities. Therefore, the plan of care, informed by the risk of falls assessment, did not identify the actions that could have ensured preventive and proactive falls management was completed accurately and appropriately for [Mrs A]. This fell short of industry standards.

The care provided to [Mrs A] before her unwitnessed fall;

Documents record [Mrs A] was seen early on the morning of the 2nd of [Month6] wearing continence products that required changing. Staff redirected [Mrs A] to her room but failed to attend to her personal needs. [Mrs A] remained unsettled and moved soon after into another room close by. [Mrs A's] care plan identified staff provide vigilance when managing her continence needs. It included prompt attention with an emphasis on maintaining her dignity and comfort. Delay in staff attending to [Mrs A's] personal needs, in my opinion, would have increased her discomfort and made her unsettled.

Records indicate [Mrs A] required prompting to use her walker reflecting her advanced cognitive change. Close attention to her needs, in particular oversight of [Mrs A's] mobility, was required to ensure she remained safe and comfortable. Early mornings are busy as residents rise and start the day whilst night staff are kept busy attending to their needs and preparing for the changeover of shifts. However, it is identified that residents at a high risk of falls are most likely to have challenges at this time of day and staff should view these residents needs as a high priority.

Staff identified through engagement, that [Mrs A] was mobilising early on 2 [Month6]. CCTV footage identifies [Mrs A's] continence product required changing. However, staff in attendance did not complete personal cares at the time of engagement to meet [Mrs A's] hygiene and comfort needs. Meeting these needs and providing food or fluids, may have settled [Mrs A] and produced a diversion. Therefore, staff may have missed an opportunity to respond to [Mrs A's] discomfort and meet her hygiene needs as identified in her plan of care. Potentially, this and other staff support, could have prevented her from being unsettled and moving to the room next door.

The care provided following her unwitnessed fall;

Tamahere Eventide is required (H&DSS) to provide up to date policy, staff orientation and training on emergency situations including staff response to unwitnessed falls. There must be staff on each shift who are trained to provide basic first aid and follow the organisation's policy and procedures to ensure the safe management of unexpected events.

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Documentation, including staff records of [Mrs A's] fall, identified a failure to follow basic first aid (level 2) and complete a head to toe assessment before any further action was taken.

Care provided to [Mrs A], should have included a basic first aid response with timely assessment for level of consciousness and injury. [Mrs A] should have been left on the floor, with support to ensure her comfort, until it was established that it was appropriate to move her.

Actions by staff to move [Mrs A] without completing an assessment, assist stand, followed by an assist walk to a bathroom, would not meet appropriate standards of response to the event. Continuing to shower [Mrs A] whilst she was standing was also inappropriate.

In summary, the sequential actions taken by staff attending [Mrs A] following her unwitnessed fall was not in keeping with the expected standard of care. Therefore, the care provided to [Mrs A] fell short of industry expectations in this event.

The appropriateness of the compliance and management by Tamahere Eventide staff in relation to the hourly checklist

Tamahere Eventide staff identified that completion of [Mrs A's] hourly check list was inaccurate following the complaint received by [the family]. An internal response was initiated and completed. Tamahere Eventide management have identified areas for improvement and completed corrective action. It is acknowledged by the writer that the falsified records identified fell short of the required standard of documentation required and the organisation's expectations. However, Tamahere Eventide have completed a review of this aspect of the complaint, and have worked with individuals and others to ensure improvement has been made. Internal disciplinary processes have been completed.

Ongoing oversight of HCAs by RNs and management will support accurate completion of documentation, including the hourly checklist, in the future. Regular training to include hourly checklist documentation requirements, will improve the quality of documentation completed.

No recommendations for improvement have been identified related to completion or management of the hourly checklist.

In response to Question 1:

What is the standard of care/expected practice? Was there a departure from the expected standard of care or accepted practice?

I believe there was a moderate departure from expected care related to [Mrs A's] fall, regarding the risk of falls assessment and care planning required.

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Additionally, there appears to be a lack of personal care support provided to [Mrs A] on the morning of [Month6] the 2nd. This is identified as a moderate departure from expected practice.

There is also a departure from practice related to the care provided following [Mrs A's] fall in relation to an initial assessment and management of her unwitnessed fall. In this case, the departure from practice was significant.

There is a minimal departure from practice identified, related to completion of documentation in particular the hourly checklist.

How this would be viewed by your peers?

I consider my peers would not accept that the care provided to [Mrs A] met current standards of care.

Recommendations for improvement that may help a similar situation occurring in the future.

Recommendations for improvement include enhanced staff training, competency assessment and clinical oversight to include managing risk and prevention of falls alongside emergency management of witnessed and unwitnessed falls.

2. Care provided by the following individuals and comment on any care considered a departure from expected standard of care.

[EN C];

The care provided by [EN C] fell short of the required standard. By her own admission she reflected she would do things differently if the situation occurred again. Internal management of this issue has been completed. However, these actions represent a significant departure from the expected standard of care.

[RN D];

The care provided by [RN D] fell short of the required standard expected. [RN D] did not stay with [Mrs A] when summoned by care staff and/or complete a head-to-toe assessment. Additionally, [RN D] did not provide appropriate direction to staff regarding the safe and appropriate management of [Mrs A] as a priority. However, [RN D] provided attention and vital sign assessment, summoned medical support to [Mrs A] following the morning medication round. Through the statements provided, it is evidenced [RN D] has been supported to grow knowledge related to the management of falls/unwitnessed falls and complete further training. [RN D] has engaged in reflective practice. However, the actions around the event involving [Mrs A], evidence a significant departure from expected practice.

Any health care assistant(s)

The HCAs always work under direction of the RNs. HCAs must also follow first aid training requirements (if they are trained in first aid) and the organisation's policies and

procedures. The Tamahere Eventide policy related to head injury states: "In case of a fall: visual check first before moving. If fall is unwitnessed: complete neuro observations as you don't know if the resident has banged their head (follow RN instructions for time and frequency)."

The HCAs may not have acted as required in this event however they will always require oversight and direction from RNs and/or management. In this case the EN in attendance fell short of appropriate knowledge and competency to manage the situation safely in the first instance.

What is the standard of care/expected practice?

There is an expectation that staff in leadership positions will have sufficient knowledge, skill and competency to deliver care and provide direction to other staff.

Was there a departure from the expected standard of care or accepted practice?

In this instance there was a significant departure from practice when neither the EN nor RN attending [Mrs A] provided appropriate care or direction to others.

How this would be viewed by your peers?

It is my opinion that this would not be viewed as appropriate clinical response by my peers.

Recommendations for improvement that may help a similar situation occurring in the future.

Ensuring staff have the appropriate skills and competency, oversight and clinical capability is reached through ongoing, frequent and industry guided training/education. Competency assessment will ensure staff have access to support to maintain appropriate clinical competencies. Policies that reflect best practice, and are clear and easy to follow will also support staff to provide the best care.

3. Consideration of the issues identified (above) to be systemic issues at Tamahere Home or whether it was more attributable to an individual, or both.

There is evidence that policy documents related to this event could have been clearer. There is also evidence to consider [RN D] and [EN C] were not confident or competent when managing this fall. This could relate to their training, knowledge and skill level, the responsibility of the organisation in particular their competency. The reflective practice completed by staff, indicates personal responsibility was identified.

A blend of individual responsibility coupled with areas of improvement related to training, policy and oversight is most likely.

What is the standard of care/expected practice?

Care should be provided by staff who feel confident and competent to deliver care to meet both Health and Disability Sector Standards, policies, and procedures to meet best practice guidelines.

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Was there a departure from the expected standard of care or accepted practice?

In this event, staff did not follow policy, first aid training requirements nor did they meet best practice guidelines requirements for post fall care. This was a significant departure from practice.

How this would be viewed by your peers?

It is my opinion that my peers would see this as a significant departure from expected practice.

Recommendations for improvement that may help a similar situation occurring in the future.

Frequent internal training, assessment education including risk of falls assessment, increased clinical oversight/access to senior clinical staff, case study review, access to external training related to falls management and emergency management of falls injury would be areas of improvement identified.

<u>4. The appropriateness of the training at Tamahere Home to its staff</u>

There are guidelines related to the frequency and content of mandatory training in the aged care sector. Every organisation must ensure adequate training is provided to meet these requirements and make every effort to follow up on staff who miss out on group training. In this instance not all training was up to date and refresher training was completed as part of corrective action.

Competency is also required. Training provided and competency assessed within the facility.

What is the standard of care/expected practice?

Orientation, training, competency assessment and education should be completed to ensure staff are confident to provide appropriate care.

Was there a departure from the expected standard of care or accepted practice?

Not all required training had been completed for all staff.

How this would be viewed by your peers?

Staff training is the cornerstone of clinical care provision. My peers would believe staff would not feel confident if training was not always completed as required and their competency regularly assessed.

Recommendations for improvement that may help a similar situation occurring in the future.

Ensure all staff are training to meet requirements, their competency assessed regularly and demonstrate confidence in their ability to provide clinical care. That direction and delegation training is provided and competed by all RNs.

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5. The appropriateness of the policies provided by Tamahere Home.

Review of the policy considers that it should be internally reviewed to separate information and develop two policies; a policy related to head injury and another related to the management of an unwitnessed fall. In my opinion, the current policy does not provide enough clear sequential information to the user for the management of head injury and unwitnessed/witnessed falls and the difference in managing these.

The Head Injury policy in use at that time, states neurological observations should be completed under instruction of the RN. This relies on the RN's knowledge of neurological observation requirements for residents who have an unwitnessed fall. In my opinion, the requirements should be included in policy/procedure providing greater clarity for staff.

6. Any other matters that warrant comment.

There are no other matters identified that require further comment.

Megan Sendall RN'

The following subsequent advice was obtained from RN Sendall:

'Re: 20HDC01252

Response to clinical advice from Tamahere Eventide Home — 16 December 2021

Re: Falls assessment

Noted. However, no changes made to the original advice provided.

Re: Delay in care provision

Noted. However, no changes made to the original advice provided.

Re: Post fall assessment

Noted. I acknowledge there was competing tasks and responsibilities for staff responding to [Mrs A] at the time of her event. I considered the nature and response for these competing responsibilities when providing the original advice. However, there was no way of knowing [Mrs A's] condition other than completing the required post fall clinical assessment.

Therefore, my original advice remains unchanged.

Re: Clinical documentation

Noted. However, no change made to the original advice.

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Re: Appropriate care or direction to care staff from [EN C] and [RN D] following the event

The Tamahere Eventide Home provided a statement "This event does not reflect entirely their overall competence" referring to [EN C] and [RN D].

My statement referred to the provision of appropriate care to [Mrs A] following her fall and direction to care staff following [Mrs A's] fall. In this instance competent care provision, clinical decision making, and oversight was not demonstrated by the staff involved.

I was requested to review the event in question only therefore, my original advice remains unchanged.

Re: Clinical competence — [EN C] and [RN D] responding to the event with [Mrs A].

The advice provided in the first instance, reflected the clinical response by staff for this event only. The actions of both staff members directly involved did not meet requirements for safe resident care or demonstrate competent nursing practice for appropriate post fall management. Confidence and competence to prioritise a range of competing clinical requirements effectively, ensure due process/policy is followed in order of clinical priority alongside the provision of appropriate oversight of others, was not demonstrated by [EN C] and [RN D] in this instance.

Therefore, my original advice remains unchanged.

Re: Staff training

I appreciate that Tamahere Eventide Home managers, report challenges related to staff training compliance. They documented actions that were undertaken by the organisation to improve this. Completion of staff training does, however, remain the foundation of ensuring up to date staff knowledge and skills are maintained to ensure the provision of safe care. I note the organisation reports progress following the event to support [RN D's] professional development including completion of clinical assessment and decision making education. However, at the time of the event, staff education/training was not up to date and not all staff had completed the education/training required. Therefore, the advice provided related to the time of [Mrs A's] event remains unchanged.

8. Re: Head injury management — documentation.

It is pleasing to read Tamahere Eventide Home have completed a documentation review which resulted in changes to the Tamahere Eventide Home head injury management document and the development of a falls prevention policy (QAN47). However, the advice provided related to documentation available to staff at the time. Therefore, my original advice remains unchanged.

9/10 Additional comments from Tamahere Eventide Home

No further comment.

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My additional comment:

I reviewed all documentation provided including the statement from [RN D] dated 11 December 2021. I found [the] response insightful. Although [RN D] initially reported [that the response had been competent], on reflection [RN D] described [current thinking in detail], the reasons/rationale for [the] change of view, and identified [personal] competency gaps related to the event.

This presents as an honest reflection of [RN D's] practice, and I endorse [RN D's] accurate assessment of competency improvement identified. [RN D] additionally documents current employment activities and the scope of practice [currently working within]. I find [RN D's] ability to reflect on this event accurately and professionally is positive.

Yours sincerely,

Megan Sendall RN'

The following subsequent advice was obtained from RN Sendall:

'**Please review the 2016 First aid policy, and comment on whether it changes your previous advice at all? Please also comment if you see any difference/improvement in their current 2022 First aid policy?**

Response Tamahere Advice

August 14 2023

Megan Sendall

I compared the 2016 First Aid Policy with the 2020 Policy and did not find practice variation. Both policies are consistent with safe practice.

The 2022 First aid Policy provides the same information as the 2016 and 2020 alongside however additional templates for Burns and Bleeding situations are included. I believe these are an improvement and would support the user to provide informed response.

Of note: the policies (2016, 2020, and 2022) do not provide information related to cardiac arrest in an unwitnessed fall.

This is not seen as a deficit. I'm thinking it is implied through the outcome of the assessment process that the need for Cardiopulmonary Resuscitation CPR is provided as required. Noting a training First Aider is required on every shift for this purpose.

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Please clarify whether you identified mild departures for the hourly checklist and the failure to perform physical hourly checks? Would you be able to comment on whether the mild departure you identified, was only for the completion of the hourly checklist (documentation) or, that your intention was that there was a mild departure for the completion of the hourly checklist and a mild departure for the failure to perform hourly checks?

The mild departure described was not clear I agree.

To Clarify further the hourly checks are physical checks in the room with the resident using observation and clinical measurements (ie blood pressure recording).

My intention was to identify the hourly checklist documentation was not completed in keeping with policy requirements.

The purpose of the checklist requirements was to physically check the resident at no less than hourly intervals, record the outcome, ensure any deterioration was identified and should this happen, an escalation pathway would be followed.

Commonly staff will report residents were checked after a fall. However, documentation doesn't always support this. Reasons given are time related with staff shortages and/or competing demands for staff care.

In this instance my understanding is some checks were completed and others were not. Therefore, some physical assessment was completed and documented, however not all as required indicating a partially completed process. I relate to a mild departure from practice.

Therefore, your interpretation of "a mild departure for the completion of the hourly checklist which I thought would also mean you were critical that the hourly checks were not done" is correct.

The hourly checklist is documenting physical assessment completed remembering that assessments may have been completed without completing documentation.'

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