

Failings in managing acute post-fall deterioration in aged care resident with dementia

Executive summary

1. Mrs A was a resident at Athenree Life Limited (Athenree; part of Sound Care Group Limited) and was receiving dementia care. On 30 October 2022, Mrs A's husband, Mr A, complained to the Health and Disability Commissioner (HDC) in relation to the management of a urinary tract infection (UTI) Mrs A had in September 2022 and the lack of escalation of her care between 10 and 16 October 2022 when she experienced multiple falls and a rapid deterioration in her health and mobility.
2. This investigation focuses on the care provided to Mrs A between 3 September and 16 October 2022, specifically clinical oversight, falls management, recognition and escalation of health decline and delayed treatment, which resulted in significant unwellness that required admission to hospital.
3. I find Athenree in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services to Mrs A with reasonable care and skill.

Recommendations

4. Athenree advised HDC that it has reflected on the care provided to Mrs A and implemented the following changes since these events:
 - Staff use the ISBAR¹ tool for acute and three-monthly reviews of residents' health.
 - A clinical records audit of all resident files was completed, including dementia-specific documentation, to ensure that all requirements of the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (the Standard) and the Age-Related Residential Care (ARRC)² contract are met.
 - The complaint was discussed during a regular staff meeting on 21 October 2022. Staff were reminded to do appropriate assessments and intervene when residents had acute deterioration or other reversible conditions, such as dehydration, delirium, UTIs or other infections. Staff were also reminded to use food and fluid charts when residents show signs of dehydration or are susceptible to UTIs and to ensure that progress notes and documentation are clear.
 - The importance of communication during handovers on both the general and the secure units has been reiterated during regular staff meetings.

¹ A structured communication tool used in healthcare settings.

² A contract with Health New Zealand | Te Whatu Ora to provide aged residential care services.

5. I acknowledge and support these changes. In addition, I recommend that Athenree:
- a) Provide a written apology to Mr and Mrs A's whānau for the breach of the Code identified. This apology is to be sent to HDC for forwarding within three weeks of this report.
 - b) Provide training to staff at Athenree on recognising and responding to acute deterioration in residents. Training should include the use of the STOP and WATCH³ tool and other indicators of deterioration to look for beyond vital signs, particularly for residents with dementia who may not be able to verbally communicate changes in their health.
 - c) Provide education to staff on falls prevention and management. Training should include requirements for documentation and post-fall monitoring and review.

Athenree is to provide evidence of education occurring on these topics as per paragraphs b and c, to HDC in the form of education materials and staff attendance records, including the percentage of staff who have attended the training sessions. Training is to be completed, and the relevant evidence forwarded to HDC, within six months of the date of this report.

- d) Three months after the completion of training on the use of the STOP and WATCH tool, complete an audit of the use of the tool in cases where a resident's health deteriorates.
- e) Three months after the completion of training on falls prevention and management, complete an audit of compliance against falls prevention interventions included in long-term care plans for residents.

A summary of the audit findings as per paragraphs d and e, are to be sent to HDC within nine months of the date of this report.

Background

- 6. Mrs A, who was aged 69 at the time of the events, had been living at Athenree since August 2022 and received dementia care. She had been diagnosed with advanced dementia/mate wareware, including behavioural and psychological symptoms of dementia (BPSD).⁴ She also had a history of recurrent UTIs and vaginal prolapse (bladder and bowel).⁵
- 7. Mrs A was prescribed several medications to manage her BPSD, particularly 'sundowning', a symptom of dementia that causes increased agitation in the late afternoon. These

³ STOP and WATCH stands for: S – Seems different than usual, T – Talks or communicates less, O – overall needs help, P – participates less in activities, A – ate less, difficulty swallowing medication, N – No bowel motion >3 days, diarrhoea, D – Drank less, W – Weight change, A – Agitated or more nervous than usual, T – Tired, weak, confused or drowsy, C – change in skin colour or condition, H – More help walking, transferring, toileting.

⁴ BPSD symptoms include aggression, agitation, anxiety, depression, hallucinations and disturbed sleep.

⁵ A condition where the bladder and bowel bulge into the vagina because of a weakened pelvic floor.

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medications included clonazepam, which Athenree staff could give Mrs A if she became agitated or aggressive after lunch, as well as quetiapine and risperidone.

8. Mrs A was admitted to the local public hospital from Athenree on 16 October 2022. She was treated for pneumonia⁶ in both lungs, a UTI and acute kidney injury⁷ and hypernatremia⁸ caused by dehydration. She was discharged on 31 October 2022 to another aged care provider for ongoing care.

Clinical oversight and management of Mrs A's UTI in September 2022

9. In their response to HDC, Athenree stated that, in early September 2022, Mrs A began to display increased physical and verbal aggression and confusion and experienced hallucinations. This is reflected in progress notes, which record instances where Mrs A pushed or hit staff and regularly appeared confused. Athenree advised that a urine dipstick test was done on 3 September 2022 to rule out a UTI as the cause of Mrs A's behaviour change.
10. General practitioner (GP) records indicate that Athenree staff contacted the GP practice via fax regarding Mrs A's condition on Saturday 3 September 2022, when the GP practice was closed for the weekend. The fax was seen on Monday 5 September 2022 by Dr C, another GP at the practice who provided services to Athenree when Athenree's GP, Dr B, was on leave. In her response to HDC, Dr B noted that Athenree usually contacted the GP practice by email or fax but that staff had been instructed to call the practice if they required urgent support. Dr B stated that Athenree staff did not call the practice.
11. The fax sent by Athenree on 3 September 2022 stated that Mrs A had been more aggressive, including hitting staff, over the previous three days. A urine dipstick test⁹ showed high levels of leukocytes, suggesting a potential UTI.
12. Dr C prescribed a five-day course of antibiotics (trimethoprim) for Mrs A on 5 September 2022. Dr C also requested that Athenree staff do another urine dipstick test in one week's time to check whether Mrs A's UTI had resolved.
13. Medimap¹⁰ records show that Mrs A was given her first dose of trimethoprim on 6 September 2022 at 4pm.
14. A registered nurse (RN) developed a short-term care plan for Mrs A's UTI on 7 September 2022. Nursing actions included in the short-term care plan were to perform a urine dipstick test, instruct healthcare assistants (HCAs) to encourage fluid intake of two litres per day and

⁶ An infection that inflames the air sacs of the lungs.

⁷ A sudden decrease in kidney function that can range from minor loss of kidney function to complete kidney failure

⁸ Elevated levels of sodium in the blood.

⁹ A test where a small plastic strip with chemicals on it is inserted into urine. The chemicals on the stick change colour if certain substances are detected.

¹⁰ Medication management software.

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report anything abnormal, administer antibiotics and refer back to the GP if the UTI and symptoms did not resolve.

15. There appears to have been some delay in Athenree staff completing a follow-up urine dipstick test, with the short-term care plan noting on 11 September 2022 that nursing staff were unable to take a urine sample. A urine dipstick test was completed on 17 September 2022, and this was negative for leukocytes. Progress notes state that Mr A requested a urine sample be sent to the lab. A midstream urine sample (MSU)¹¹ was sent to the lab on 19 September 2022.
16. The results of the MSU were sent to the GP practice on 20 September 2022 and indicated that Mrs A no longer had a UTI. The lab report noted that a culture was not taken from the urine sample because the results showed that a UTI was unlikely. The short-term care plan was not updated to reflect these results.

Falls management

17. In their response to HDC, Athenree provided comment on falls that occurred on 11 and 14 October, confirming that incident report forms were completed in both cases. Athenree also said that, as part of the falls management plan, staff closely monitored Mrs A and a sensor mat and landing mattress were put beside her bed. Mrs A was scheduled to be reviewed by the GP when they next visited Athenree, but she was transferred to hospital before this occurred.
18. Mrs A was independently mobile and did not use any mobility aids. She required one person to assist her with all activities of daily living.
19. A Coombe Assessment was done when Mrs A was admitted to Athenree in August 2022, and she was assessed as being at low risk of falls. However, a long-term care plan dated 12 September 2022 noted that her mobility was expected to decline over time and care needed to be taken to minimise falls and related injuries. Her risk of falls also increased when she was prescribed clonazepam on 5 September 2022 because of the medication's side effects, including drowsiness, potential unsteadiness, poor coordination, and dizziness.
20. To manage a decline in mobility and risk of falls, the long-term care plan noted that staff were to report any decline in mobility to an RN, who could put interventions in place, including minimising immediate risks and reviewing transfer and mobility plans. Other interventions included maintaining a clutter-free environment, a walking chart to monitor progress, ruling out acute illnesses such as UTIs as a cause of decline in mobility, referral to the GP or physiotherapist, and review of medications if required.
21. A warning for staff to be aware of Mrs A's heightened risk of falls when taking clonazepam was also included in Medimap.

¹¹ A urine sample is taken mid-flow to prevent contamination of the sample by skin cells.

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22. Mrs A's long-term care plan stated that if more than two falls occurred in one month, a high fall risk minimisation plan would be put in place. This plan included a crash mat and bell mat being used in Mrs A's room and GP involvement if required.

Unwitnessed falls on 11, 12, and 14 October 2022

23. Progress notes state that, at 11pm on 11 October 2022, an HCA found Mrs A sleeping on her back on the floor of her room. When HCAs repositioned Mrs A in bed, they noticed she had a small scrape on the bridge of her nose, which did not require a dressing. A physical assessment was completed, and no other injuries were noted. Mrs A's vital signs were taken and considered normal. A note was made to inform Mr A of Mrs A's suspected fall the next day.
24. An incident report form was completed for the fall on 11 October 2022. Contributing factors for the fall were listed as confusion, dementia, and Mrs A possibly standing up on her own and lying down on the floor. Frequent checks and a bell mat being placed by Mrs A's bed were recommended to prevent future falls.
25. No wound management plan was completed for the scrape Mrs A sustained on the bridge of her nose.
26. Progress notes state that, at 9.30pm on 12 October 2022, an HCA found Mrs A on the floor. There was blood on the floor, and Mrs A had a laceration on her forehead, which was cleaned and dressed. Her vital signs were all normal, her pupils were equally reactive to light, and no weakness or clumsiness was noted.
27. No incident report form was completed, and no wound management plan was developed for the cut on Mrs A's forehead.
28. After Mrs A's fall on 12 October 2022, a note was made in the progress notes to not give her clonazepam drops if she appeared sleepy. However, Medimap records show that Mrs A continued to be given three drops of clonazepam each day on 13, 14, and 15 October 2022, despite being noted as sleepy on those days.
29. On 14 October 2022, Mrs A had another fall. An HCA found her on the floor in the lounge at 12.15pm. Progress notes state that Mrs A was pushed by another resident after she accidentally stepped on their foot while wandering. No injuries were noted, but she was given Panadol for anticipated pain.
30. An incident report form was completed for Mrs A's fall on 14 October 2022. The form lists Mrs A's sleepiness as a potential contributing factor to her fall and notes that she was assessed by the clinical manager, observations were taken, and a head-to-toe assessment was completed. The incident report form also notes that Mrs A's fall was preventable and that frequent checks were required to prevent a re-occurrence.
31. Neurological observations were completed every 15 minutes for the first hour after Mrs A's fall on 14 October. After this, the neurological observation form states that observations are

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to be made every half hour for four hours as clinically required. Observations were made half-hourly from 1pm to 3pm but then less frequently, at 4pm, 5pm, and 9pm.

Management of deterioration between 10 and 16 October 2022

32. Progress notes recorded between 10 and 16 October 2022 show that Mrs A was experiencing excessive sleepiness, cold symptoms – including a productive cough with green phlegm – and a decline in her mobility. Mrs A was observed crawling on the floor on 16 October 2022, and Mr A stated in his complaint that she was unable to stand.
33. Throughout the week of 10 October 2022, Mrs A's food and fluid intake was noted in progress notes to be 'fair'. However, the food intake and fluid balance charts show that, over this period, Mrs A was regularly refusing meals and only consuming between 210ml and 550ml of fluid each day, which is low. Mr A also observed her having difficulty eating her lunch on 16 October 2022.
34. Mrs A's deterioration culminated in her family asking an RN to call an ambulance for her on 16 October 2022.
35. The RN caring for Mrs A on 16 October 2022 provided a statement to HDC. She said that, after she had attended to another resident, Mr A asked her to assess Mrs A, who appeared 'sleepy and lethargic'. Mrs A's daughter instructed the RN to transfer Mrs A to hospital. The RN took Mrs A's vital signs and considered them within the normal range. In her statement, the RN says she told Mrs A's family that she needed to discuss the situation with the clinical manager. Mr A stated that the RN told them that the clinical manager was not working that day, although Athenree's response suggests the RN may have spoken to an on-call manager. The RN came back to Mrs A and her family, and Mrs A's daughter expressed that she felt the RN disagreed with her about transferring Mrs A to hospital. The RN responded that she would transfer Mrs A to hospital as her family requested. The RN has stated that she called an ambulance for Mrs A and apologised to Mr A and Mrs A's daughter for the misunderstanding. Conversely, Mr A stated that no apology was made after the ambulance was contacted.

Responses to provisional opinion

36. Mr A was given an opportunity to comment on the 'background' section of the provisional opinion. His comments have been incorporated into the report where relevant.
37. Athenree was given an opportunity to comment on the provisional opinion and advised that they had no comments to make.

Analysis

Athenree – breach

38. As a healthcare provider, Athenree is responsible for providing services in accordance with the Code. In finding that Athenree breached the Code, I have relied on advice from in-house aged care advisor, RN Jane Ferreira (see **Appendix A**).

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Clinical oversight and management of UTI in September 2022

39. RN Ferreira advised that there was a mild to moderate departure from accepted practice in relation to oversight and management of Mrs A's UTI in September 2022. She noted that:

'... it appears that the care provided to [Mrs A] met the minimum standard of practice in the circumstances. While there is discussion of clinical concern and escalation to the GP with related care planning commenced, there are identified areas for improvement regarding communication with nominated representatives and the care team, and standards of accurate reporting.'

40. I accept RN Ferreira's advice. I am critical that there were delays in documenting a short-term care plan and implementing the steps outlined in the plan. Although a fax was sent to the GP practice on 3 September 2022 and Dr C prescribed antibiotics for Mrs A's suspected UTI on 5 September 2022, the short-term care plan was not documented until 7 September 2022. Mrs A was also not given her first dose of antibiotics until 6 September 2022, the day after they were prescribed. In addition, when Mrs A's UTI appears to have been resolved on 20 September 2022, the short-term care plan was not updated.
41. I am also critical of aspects of Athenree staff's communication with the GP practice on this issue. The fax sent to the GP practice on 3 September 2022 noted the changes in Mrs A's behaviour and the results of a urine dipstick suggesting a UTI, but there is little information regarding any other symptoms that could support the GP in understanding Mrs A's overall condition. Despite the fax being sent outside of the GP practice's usual hours, staff did not follow up with the practice when it opened after the weekend to ensure the fax was received.
42. Communication with Mrs A's family about her condition over this period is also not well-documented, and there may have been some miscommunication, with Mr A stating that the clinical manager told him Athenree could not be sure that the UTI Mrs A had in September had been resolved because a culture had not been taken. However, results from the MSU reported on 20 September 2022 showed that a UTI was unlikely and that this was the reason a culture was not taken from the sample.

Falls management

43. RN Ferreira advised that:

'... it appears that falls prevention and management strategies were not well managed by the clinical team. There are identified concerns with post-fall assessment steps, including the completion of neurological observations, event analysis, communication, and reporting processes ... I consider there are **moderate to significant** deviations from accepted practice standards.' [Emphasis added]

44. I accept RN Ferreira's advice and am critical that oversight of Mrs A following falls on 11, 12, and 14 October 2022, including wound management, recording neurological observations, escalation of clinical concerns to an RN and seeking GP input, was inconsistent or at times not done at all. I am particularly critical that no incident report form or monitoring was completed when Mrs A fell on 12 October 2022 and sustained a cut to her forehead.

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45. I am also critical that staff continued to administer clonazepam to Mrs A on 13, 14, and 15 October 2022 despite being instructed not to do so if she appeared sleepy and having been advised that clonazepam increases the risk of falls.

Management of deterioration between 10 and 16 October 2022

46. RN Ferreira advised that:

‘... it appears the nursing team did not recognise signs of decline and act in a timely way. There are identified concerns regarding clinical oversight, nursing assessment, communication and documentation standards which would be considered as **serious** departures from accepted practice standards ...’ [Emphasis added]

47. RN Ferreira referred to the Health Quality & Safety Commission Te Tāhū Hauora 2023 frailty care guides¹² in her advice. In the section on acute deterioration, the STOP and WATCH tool is recommended as widely used for identifying acute deterioration. The frailty care guides also note that changes in health can often occur before changes in vital signs are observed and that vital signs may be a late indicator of deterioration.
48. I accept RN Ferreira’s advice. I am critical that there was no documented evidence of the RN caring for Mrs A on 16 October 2022 using the STOP and WATCH tool, despite it being available for staff to use, or carrying out a further assessment of Mrs A for signs of acute deterioration beyond taking her vital signs. Although I acknowledge that the RN did transfer Mrs A to hospital on 16 October 2022, where she received necessary treatment, this was largely done at the insistence of Mrs A’s family and not as a result of appropriate clinical assessment and decision-making.

Conclusion

49. For the reasons outlined above, I consider that Athenree has not provided services to Mrs A with reasonable care and skill. Accordingly, I find Athenree in breach of Right 4(1) of the Code.

Distribution

50. A copy of the final report with details identifying the parties removed, except Athenree Life Limited and the clinical advisor, will be sent to HealthCERT at the Ministry of Health | Manatū Hauora and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall

Deputy Health and Disability Commissioner

¹² [Frailty care guides Aotearoa New Zealand | Health Quality & Safety Commission Te Tāhū Hauora](https://www.hdc.org.nz/About-Us/Health-Resources/Frailty-care-guides-Aotearoa-New-Zealand).

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Appendix A: In-house clinical advice to the Commissioner

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

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Athenree Lifecare. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Documents reviewed

- Letter of complaint received 31 October 2022
- Provider response received 17 June 2022
- Clinical records, including nursing assessments, care plans, progress notes, monitoring forms, medical records, health information,
- Organisational policies, file audits, meeting minutes

3. Complaint

[Mr A] has expressed concern regarding the care provided to his wife while resident at the care home between 9 August and 16 October 2022. His concerns relate to clinical oversight, recognition of health decline, falls management, medication management and delayed treatment, which resulted in significant unwellness, requiring hospital admission for further care.

4. Review of clinical records

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

- Clinical leadership and care oversight, recognition of unwellness and management of resident stress and distress
- Falls prevention and management, Infection prevention and control
- Communication and documentation standards
- Evidence of case review and quality improvement initiatives

Background

[Mrs A] was admitted to the care home on 9 August 2022 at dementia-level care. Prior to admission, she lived at home with her husband. Her medical history included advanced dementia/mild dementia with BPSD, uterine prolapse, and recurrent UTIs. File information

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states that [Mrs A] was independently mobile on admission and required carer supervision with activities of daily living. [Mrs A] presented with signs of increasing agitation between August and September 2022 and received antibiotic therapy for a suspected urinary infection. She continued to present with signs of functional decline post-treatment, and experienced two fall events. On 16 October 2022, [Mrs A]’s whānau expressed concern about her health and wellbeing and requested transfer to hospital for further assessment. [Mrs A] was admitted for treatment of bilateral lower lobe pneumonia, delirium and urosepsis, with acute kidney injury and hyponatremia related to dehydration. She was later discharged to another provider for ongoing care.

a) Do you consider the clinical oversight in relation to the initial presentation of urinary tract infection, communication with the GP and the ongoing monitoring of these symptoms to be within expected nursing standards of care?

Preadmission health information states that [Mrs A] had a history of recurrent UTIs. The initial nursing care plan states that [Mrs A] was continent of bowel and bladder and required supervision with personal care requirements. While an InterRAI assessment was not submitted, the long-term nursing care plan outlines interventions in response to an identified infection but does not discuss proactive or precautionary measures to reduce the risk of UTI. Medical notes state that [Mrs A] had been commenced on medication for a prolapse, which also aimed to reduce the risk of urinary infections; however, this does not appear to be reflected in care planning.

Clinical records indicate that [Mrs A] presented with escalating signs of distress through August 2022. Concerns were reported to the medical practice on 3 September 2022; however, treatment delays occurred as discussed in question (b). I note there is no corresponding entry in progress notes regarding nursing assessment provided to [Mrs A] on 3 September, discussion of a urine sample and dipstick analysis, or escalation of concern via email to the GP. There is no indication that the RN suspected a urine infection, no request for further RN follow up with the GP, and no guidance provided for carers regarding comfort measures or supportive interventions at this time, which would be considered accepted practice.

Medical records show that antibiotic therapy (trimethoprim) was prescribed by the GP in response to care concerns on 5 September 2022; however, there appears to be a delay with administration by the care home team. Short-course administration records indicate treatment only commenced on 6 September with five doses of medication given (6, 7, 9, 10, 11 September). It is unclear why the prescribed dose was missed on 8 September, with no discussion of RN follow-up in progress notes or that an incident report was completed for a missed dose, in line with organisational policy.

I note a short-term care plan was commenced for the UTI on 7 September to guide care responsibilities and provides evidence of evaluation on 11 September. GP notes request follow-up urinalysis one week later. Laboratory results 20 September indicate that a urine infection was unlikely; however, this information is not reflected within the contemporaneous nursing record.

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On 5 September 2022, a progress note entry by the clinical nurse manager (CNM) has outlined a discussion held with [Mrs A]’s daughter regarding urine dipstick results, medication changes, and referred to a proposed ‘roadmap’ of care. Family/whānau communication records were not included in the evidence bundle to reflect informed consent and care partnership. There is no evidence provided of handover records, meeting minutes or short-term nursing documentation to guide the proposed plan while meeting [Mrs A]’s care and safety needs as she recovered from her UTI. The CNM has referred to daily follow up but it is unclear what was to be assessed. There is no reference made to GP orders, plans for follow up or requests for involvement from other health professionals, such as mental health services, for additional support at this time, which may have been a valuable resource to assist the care home team.

From the evidence reviewed to respond to this question, it appears that the care provided to [Mrs A] met the minimum standard of practice in the circumstances. While there is discussion of clinical concern, and escalation to the GP with related care planning commenced, there are identified areas for improvement regarding communication with nominated representatives and the care team, and standards of accurate reporting, which would be viewed similarly by my peers.

- Departure from accepted practice: Mild to moderate

b) Please comment on the communication with the GP and whether this is within accepted standards of care?

The provider has submitted organisational policies, which outline responsibilities of contracted medical service providers, nursing responsibilities to resident care, including processes for identification and escalation of resident health concerns.

Clinical file information reflects fax/email communications occurred between the care home and GP practice during [Mrs A]’s admission. The GP has advised that the care home sent an email to the practice on Saturday 3 September 2022, which was outside of business hours and subsequently not seen until the practice opened on Monday 5 September 2022. The email outlined concern with [Mrs A]’s wellbeing describing displays of distress, with urine dipstick test results, and a request for a medication review, which appears appropriate in the circumstances. Recommended practice would be to also include discussion of vital sign recordings and to provide an indication of clinical priority for the GP.

It is unclear whether the duty team were aware of the GP’s after-hours process or on-call service. The GP has advised there was no record of a telephone call made to the practice by the care home regarding [Mrs A]’s health concerns. Given the raised concerns, it is unclear why the duty RN or RNs on the incoming shifts did not follow up with the on-call medical team to seek support for [Mrs A]. It is unclear whether vital information was handed over to the next shift for follow up, in line with professional nursing responsibilities to direction and delegation. It is unclear if the duty RN sought guidance from the care home’s on-call clinical leaders, which would be considered recommended practice in the circumstances. Additionally, as outlined in question (a), there is no discussion of these actions recorded in

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[Mrs A]'s progress notes nor evidence of communication with whānau, which would be considered below accepted practice standards.

[Mrs A] was seen by her GP on 8 September regarding the UTI and wellbeing concerns. Progress notes and medical records reflect medication changes, including a plan of care for a prolapse. There is no evidence that care planning was revised to reflect these changes or guidance provided regarding specific care requirements, which would be considered accepted practice in the circumstances.

From the evidence reviewed to respond to this question, it appears that, although communication occurred between the care home and GP practice, there was a lack of proactive, timely follow-up by the RN team, which resulted in delayed treatment for [Mrs A]. I am also concerned about standards of communication and documentation in line with professional nursing responsibilities and the associated risks to compromised resident safety and staff practice. I consider this lack of information a moderate to significant deviation from practice standards, and this would be viewed similarly by my peers.

- Departure from accepted practice. Moderate to significant.

c) Please advise whether documentation would indicate senior clinical oversight to be of an acceptable nursing standard and in line with Ministry of Health guidelines.

Progress note entries reflect involvement by the CNM in [Mrs A]'s care. Although an interRAI assessment was not included in the submitted evidence, the long-term nursing care plan was completed by the CNM on 12 September 2022 and provides comprehensive guidance about [Mrs A]'s care requirements. However, it is unclear what nursing assessment data was used to inform the long-term care plan given the organisational policy states an interRAI assessment will be completed within 21 days of admission, which is in line with contractual requirements under the ARRC service agreement. Preadmission information included an interRAI Home Care assessment, which would be considered a valuable tool to inform the interRAI long-term care facility assessment, which is required for use in aged residential care.

Clinical oversight of new admissions, monitoring of RN engagement in the resident admission process, and timely completion of related documentation is a significant part of CNM role responsibilities. As outlined in this review, there appear to be delays in reviewing nursing risk assessments in response to [Mrs A]'s changing health, completion of relevant care plans and use of monitoring forms in line with accepted practice standards. It is unclear what clinical systems were in place at the time of [Mrs A]'s admission to ensure that nursing assessments and care plans were completed in line with contractual requirements. The provider appears to have acknowledged concerns with record-keeping and has submitted evidence of clinical audits and meeting minutes, which refer to clinical responsibilities.

- Departure from accepted practice: Mild to moderate.

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d) Please comment on the post-fall management for [Mrs A] and whether the oversight provided following the fall and injury to her nasal bridge was in line with policy and of an acceptable nursing standard.

[Mrs A] was assessed on admission using the Coombes Falls risk assessment, with a score of (8), indicating she was at low risk of falls. The long-term care plan, 12 September 2022, states that [Mrs A] was at risk of falls related to prescribed medications and required a clutter-free environment, noting fall and pain assessments will be completed six monthly or sooner if clinically indicated. As noted above, an interRAI assessment was not included in the submitted evidence to inform further comment regarding the assessment process.

The care plan states that, if a decline in mobility is observed, to report to the RN for interventions. The RN will review the mobility plan, eliminate acute illness such as UTI as a cause for decline, and seek physiotherapy or GP input. It does not appear that [Mrs A]’s falls risk was reviewed when she commenced new medications or post-fall as part of incident management principles, following fall events 11–14 October 2022. File evidence does not reflect physiotherapist assessment or involvement. Incident reports and progress notes do not indicate a request for post-fall assessment by the GP, which is in line with the GP’s letter of response.

The incident report for the fall event on 11 October 2022 states that [Mrs A] was found lying behind a bedroom door at 11pm. She was assessed by an RN who has reported completing a physical assessment, which identified a superficial nasal bridge abrasion, which reportedly did not require a dressing. There is no evidence of a wound management plan commenced to acknowledge the breach in skin integrity. One set of vital signs was reported; however, it appears that neurological observations were not completed following this unwitnessed fall event, despite evidence of a facial contusion. Accepted falls management practice for unwitnessed fall events, even with minor injury, recommends nursing observations for 24–72 hours and GP involvement in post-fall reviews (HQSC, 2022; HQSC, 2023). The supporting progress note entry states that [Mrs A] had cough/cold symptoms, but it is unclear if the team considered unwellness as a contributing factor to the fall event. An entry on the morning shift of 12 October has reported a bruise on [Mrs A]’s right shoulder, but there is no evidence of RN involvement to complete a post-fall skin assessment or that the incident form was updated to reflect that further nursing assessment had occurred, which would be considered accepted practice.

A progress note entry at 9.30pm on 12 October states that [Mrs A] was found on the floor and had sustained a laceration to her forehead. Wound care was provided, vital signs recorded and she was assisted back to bed. Progress notes continue to refer to a sleepy presentation, with cough/cold symptoms. It appears that neurological observations were completed at the scene, with discussion of physical function and pupil reactivity. There is no reference to completion of an incident report, ongoing recording of neurological observations, or escalation to the CNM to facilitate a GP review, given this was a second unwitnessed fall event within 24 hours. Progress notes refer to EPOA notification the following morning; however, communication records were not submitted in the evidence bundle to confirm this.

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The incident report and progress note documentation on 14 October state that [Mrs A] was found on the floor in the lounge and had been 'pushed by a peer'. The incident report states she was assessed by the CNM, with no identified injuries at the time. Neurological observations were completed from the time of the fall until 9pm; however, there is limited discussion of analysis, post-fall assessment, consideration of contributing factors, particularly given [Mrs A] had allegedly been pushed by a peer, or indications for GP review. There is no evidence that falls risk was reviewed or additional falls minimisation strategies were implemented. Progress notes indicate that [Mrs A] was unwell and had declined significantly from her admission baseline. As discussed in question (e), it is unclear why an urgent GP assessment was not considered relevant by the clinical team during the timeframe in question.

From the evidence reviewed to respond to this question, it appears that falls prevention and management strategies were not well managed by the clinical team. There are identified concerns with post-fall assessment steps, including the completion of neurological observations, event analysis, communication, and reporting processes. The case review indicates a lack of holistic nursing assessment and recognition of resident decline, with delayed escalation to the GP for clinical guidance, which impacted the delivery of safe and appropriate care to [Mrs A]. I consider there are moderate to significant deviations from accepted practice standards, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to Significant

e) Do you consider the escalation of [Mrs A]'s unwellness to the GP and hospital in light of decline in functional capacity to be within expected timeframes and within acceptable nursing standards of care?

Given [Mrs A] had experienced a urinary infection in September 2022, with changes made at that time to prescribed medications, accepted practice would be to monitor her vital signs, oral intake, and behaviour and observe for signs such as nausea or other extrapyramidal side effects of new medicines to inform clinical decisions regarding her care. There is no evidence that a short-term care plan was commenced to guide the process, with no monitoring strategies put in place to identify potential dehydration, weight loss, infection, or nutritional risk. There is limited discussion of RN evaluation of medicine effectiveness or frequency of PRN doses, use of non-pharmacological strategies, health assessment or updates provided to the GP, which would be considered accepted practice in the circumstances.

Entries in October indicate that [Mrs A] was unwell and experiencing visual hallucinations and coordination difficulties, with accounts of her found crawling on the floor. Progress notes describe changes in mood and behaviour, report a reduced oral intake, and drowsy presentation with difficulty responding to spoken word. Incident reports show that [Mrs A] experienced fall events on 11 and 14 October. Progress notes describe a fall event on 12 October, but there is no evidence of a supporting incident form. The entry states to inform the EPOA the next day; however, communication records were not included in submitted records to evidence contact.

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There is discussion of post-fall assessment by RNs and completion of neurological observations, but it appears that contributing factors to the fall events were not widely considered. Progress notes refer to withholding clonazepam due to sleepiness and falls risk, but there does not appear to be evidence of holistic nursing assessment or escalation of concern to the GP for consultation.

[Mrs A]'s care plan states that the RN will identify and respond to signs of acute health change. It is unclear if the RN team considered factors such as an underlying or unresolved urinary infection, chest infection (given the accounts of a cough with stained sputum), medication involvement, delirium, or possible signs of sepsis. As outlined in the Frailty Care Guides, delirium in older adults is considered a medical emergency, as is sepsis, requiring prompt intervention (HQSC, 2023).

Health records reflect that [Mrs A] was last seen by her GP on 15 September for a medication review. The provider has advised that [Mrs A] was on the GP list for an upcoming monthly consultation; however, given weekly GP services were provided to the care home, it is unclear why the clinical manager or RN team did not seek GP guidance or request medical assessment sooner. Progress note entries reflect that family raised concerns with [Mrs A]'s health and wellbeing during her admission, but it appears from the submitted evidence that feedback was not acted on by the care home leaders in line with organisational policies.

From the clinical information reviewed to respond to this question, it appears the nursing team did not recognise signs of decline and act in a timely way. There are identified concerns regarding clinical oversight, nursing assessment, communication and documentation standards which would be considered as serious departures from accepted practice standards by my peers.

- Departure from accepted practice: Significant

f) Please comment on whether behaviour management is evidenced as in line with policy and expected nursing standards of care to ensure the best management of [Mrs A]'s safety, health, and wellbeing.

The Challenging Behaviour Management policy (December 2020) outlines causes and approaches to caring for residents who are experiencing signs of stress or distress. The policy refers to the use of a challenging behaviour assessment tool and behaviour monitoring form, but the policy does not appear to provide guidance about how to utilise or analyse these forms, which presents an improvement opportunity.

Preadmission interRAI information, 13 July 2022, outlined [Mrs A]'s level of function, daily living requirements and assessed criteria for dementia-level care. The initial care plan, completed 19 August 2022, states that [Mrs A] was inclined to wander; however, risk factors or supporting strategies were not discussed. There is no indication that a short-term care plan was commenced to support her care and safety requirements during the settling-in phase, which, as outlined in the ARRC agreement, would be considered accepted practice.

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The Resident Admission's policy (December 2020) states that a comprehensive InterRAI assessment will be completed within 21 days of admission, in line with contractual timeframes. The policy outlines responsibilities to holistic nursing assessments, short- and long-term care plans, noting the documentation will be completed in conjunction with the resident, relatives, and nursing staff. Although some admission nursing assessments were provided, file information indicates that an InterRAI assessment was not completed for [Mrs A], which would be considered a deviation from nursing responsibilities and accepted practice standards. Nursing assessments are used to develop personalised care plans, which provide essential information to the care team to guide resident care. This is particularly important when caring for vulnerable residents who may not be able to express their needs or provide care consent.

The long-term care plan from 12 September 2022 refers to interventions to support [Mrs A]'s mood and behaviour, including the use of behaviour monitoring forms for pattern identification and event reporting. Progress notes reviewed across [Mrs A]'s admission provide regular discussion of displays of distressed behaviour. Entries describe observed restlessness with episodes of aggression and altercations involving other residents and team members in the dementia community. Recommended practice would be to complete an incident form for these events as part of service provider responsibilities; however, it is unclear from the submitted evidence if reporting occurred. There is no evidence provided of senior nurse assessment, post-event monitoring of care and safety needs, or involvement of care home leaders in event analysis, which would be considered accepted practice. The submitted challenging behaviour assessment and related behaviour monitoring forms from [Mrs A]'s admission are incomplete, with only four entries recorded (2, 8, 13, 15 September) and no evidence of thematic analysis. Entries describe the type of behaviour observed but do not appear to consider involvement of unmet needs as triggers to the events. There is no evidence of nursing assessment provided by the RN team such as vital signs or pain, or consideration of factors such as hunger, thirst, elimination needs, boredom, or loneliness.

Progress notes indicate that [Mrs A] was reluctant to accept assistance with personal care requirements. Comments discuss meal refusal, restlessness, searching or exit-seeking, and carer difficulties in redirecting her. The care plan refers to continence management and toileting needs, noting nursing responsibilities to observe for signs of UTI. Given [Mrs A]'s medical history, it would be considered recommended practice to discuss precautionary measures or proactive strategies to reduce the risk of UTI recurrence in partnership with the GP and [Mrs A]'s whānau, respecting their knowledge and skills as her previous primary carers.

It is unclear whether the RN team considered pain as a contributing factor to displays of resident distress. The initial care plan states that [Mrs A] had a history of migraines and arthritis. The care plan states that verbal and non-verbal pain assessments will be completed and the GP informed regarding management strategies. GP notes refer to signs of pain and a prescription of regular paracetamol, but it appears that only one pain assessment was completed by nurses, during admission (11 August 2022). There is no evidence of pain assessments completed post-fall or part of a nursing assessment when considering signs of health decline in October 2022.

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File information indicates that prescribed medications were reviewed by the GP in response to a request from [Mrs A]’s family, with changes made to regular and PRN [as needed] antipsychotics (haloperidol, quetiapine, risperidone) and benzodiazepines (clonazepam) on 9 September 2022. RN progress notes state to ‘*observe for effect*’, but there is no guidance provided about monitoring requirements or use of nursing documentation. Recommended practice would be to commence a short-term care plan to guide care and safety requirements, including relevant monitoring of vital signs, behaviour, nutrition, and elimination to inform evidence-based evaluation and clinical decision-making.

Medication administration records were only provided for October 2022, but progress notes discuss the use of PRN prescribed medications to manage agitation and aggression. An RN entry on 5 September 2022 states, ‘*instructed HCA’s may give quetiapine for anxiety or clonazepam drops for aggression*’ and ‘*to closely monitor*’, but there is no further guidance provided regarding observing or reporting responsibilities.

Progress notes discuss the covert administration of clonazepam drops given in cordial.

Carer entries in progress notes report that clonazepam drops were given as advised by the CNM, but there is no corresponding entry on behaviour charts to indicate the rationale for the administration of the additional medication, nor evidence of consultation and follow up by the CMN or a delegated RN representative. I note there appears to be limited discussion of non-pharmacological strategies provided to [Mrs A]. Recommended practice would be to administer medication as a last resort. The Medicine Management policy provides clear guidance about charting and safe administration of medicines, the consent process for covert administration, and states that the care plan will reflect specific details. It is unclear whether [Mr A], as [Mrs A]’s nominated representative and EPOA, had provided consent as there is limited evidence of family/whānau communication records or meeting minutes in the submitted information and limited discussion of the same in nursing notes.

From the evidence reviewed to respond to this question, it appears that the nursing care provided to [Mrs A] was below the standard of accepted practice in the circumstances. There is limited evidence of senior nurse oversight, nursing assessment and care evaluation, with apparent delays in recognition of resident decline, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

g) Please comment on whether you consider Athenree Lifecare’s reflection of the concerns raised by [Mrs A]’s family to be considered and evidencing adequate corrective actions to mitigate further incidence of the same nature?

Progress note entries indicate that the care home team received expressions of concern from [Mrs A]’s whānau about her health and wellbeing, including care and treatment, during her stay. The provider has stated that a letter of response regarding raised concerns was completed; however, there is no supporting evidence of correspondence shared with the consumer. Submitted meeting minutes refer to event discussion at staff meetings with evidence of clinical audits completed in response to record-keeping concerns; however,

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there is no evidence of a corrective action plan developed in response to learnings from this complaint to inform further comment at this time.

5. Clinical advice

As outlined in the Frailty Guide resources, RNs have an obligation to assess issues raised by the care team or whānau/family and initiate a timely and appropriate response (HQSC, 2023). Findings from this review indicate there are further opportunities for improvement in clinical leadership, teamwork, falls preventions and management, neurological observations, recognition of decline and escalation, communication, and documentation responsibilities.

Based on this review, I recommend the care home team complete additional education on communication with and about older people and their whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend the care home team complete additional education on person-centred care and effective communication with health consumers. I recommend the provider implements the STOP and WATCH and ISBAR communication tool to better inform clinical assessments, nursing actions, and safe, evidence-based decision-making.

To support this approach, I recommend that the care home team complete the HDC online modules for further learning: <https://www.hdc.org.nz/education/online-learning/>

Jane Ferreira, RN, PGDipHC, MHIth

Nurse Advisor (Aged Care)

Health and Disability Commissioner

References

Health Quality & Safety Commission Te Tāhū Hauora. (2023). Frailty Care Guides. <http://www.hqsc.govt.nz/>

Health Quality & Safety Commission Te Tāhū Hauora. (2022). Falls prevention. 10 topics. <http://www.hqsc.govt.nz/our-work/system-safety/reducing-harm/falls/10-topics/>

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