The Cascades Retirement Resort Limited

Healthcare Assistant, Ms C

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01148)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Following a hospital admission in 2016, Mr A was discharged and admitted to hospital-level care at a rest home (the rest home) owned by Cascades Retirement Resort Limited (Cascades). Mr A was noted in the Patient Care Plan and progress notes to have had multiple falls and to be at a high risk of further falls. The progress notes also stated that Mr A required assistance with all cares.

2. On 5 Month2[1], Cascades staff developed Mr A's long-term care plan, which stated that two staff members should be involved for all cares. This Care Plan was not updated during his stay at the rest home.

3. On 29 Month3, 8 Month4, 10 Month4, 17 Month4, and twice on 4 Month5, Mr A suffered falls. Some of the falls were unwitnessed by Cascades staff members. On 3 Month6, Mr A suffered a fall from the toilet when a healthcare assistant left Mr A unattended to look for his clothes. Following Mr A's falls, incident reporting documentation was completed and "actions to prevent recurrence" were recorded. Progress notes after the 8 Month4 fall also stated that a recliner chair would be trialled over the weekend; however, there is no record of an evaluation of the trial. No multidisciplinary meeting was called in accordance with policy.

4. On the occasions when Mr A fell, it is recorded that a member of Mr A's family was informed of his falls. Mr A's family stated that they were unaware that Mr A had hit his head when he fell on 3 Month6, and soon became concerned when they saw damage to the wall. There is no record that the family were informed that Mr A had hit his head. Members of the family also found medication on or around Mr A on a number of occasions and raised concerns about this with Cascades' staff.

5. In 2016, Mr A's family installed a video camera in his room owing to concerns about the care he was receiving. On approximately 11 Month6, video footage shows a woman (identified as Ms C) removing Mr A's bedclothes and throwing them on the floor, calling "[Mr A, Mr A]", slapping Mr A's hip once, followed by five quick slaps or taps on the head. It also shows Ms C dragging Mr A across the bed roughly.

Findings

6. It was found that Ms C's actions towards Mr A, an elderly and vulnerable individual, amounted to a very serious departure from fundamental ethical and legal standards. Accordingly, Ms C breached Right 4(2) of the Code.

7. It was found that Cascades failed to provide services to Mr A with reasonable care and skill in the following areas: care planning, falls prevention, monitoring, incident management, and communication with family. Accordingly, Cascades breached Right 4(1) of the Code.

[1] Relevant months are referred to as Months 1-7 to protect privacy.

Recommendations

8. It was recommended that Ms C and Cascades each provide a letter of apology to Mr A's family. Ms C has since provided a letter of apology to HDC. In accordance with the proposed recommendations in the provisional opinion, Cascades has reviewed the effectiveness of its medication management policy; developed a training schedule for staff on challenging behaviour, de-escalation skills, abuse and neglect; and included in its ongoing refresher training that reporting of concerns is expected and accepted from all staff, techniques to identify personal stress and coping mechanisms, and a process for staff to report such stress, fatigue, and pressures at work. Cascades has also reviewed its incident policy in relation to multiple falls, and has reviewed the process by which information in incident reporting forms is analysed for trends.

9. It is recommended that Cascades review the effectiveness of its processes for assessments of care planning; review the involvement of clinical nurse managers in residents' care; set in place a procedure to ensure that regular family meetings are held; and complete education for all staff on comprehensive documentation. It is also recommended that Cascades conduct an audit of six months' documentation, for a random selection of 10 residents, to ensure that all documentation complies with accepted standards; and that Cascades establish a procedure to ensure that all residents who are serial fallers are referred to an external gerontology nurse specialist.

Complaint and investigation

10. The Commissioner received a complaint from Mr B regarding the care provided to his father, Mr A, at a rest home owned by Cascades Retirement Resort Limited. The following issues were identified for investigation:

- *Whether Ms C provided Mr A with an appropriate standard of care in 2016.*
- *Whether The Cascades Retirement Resort Limited provided Mr A with an appropriate standard of care in 2016.*

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

12. The parties directly involved in the investigation were:

Mrs A	Consumer's wife
Mr B	Consumer's son
Ms C	Provider
The Cascades Retirement Resort Limited	Provider

Also mentioned in this report

Ms D	Mr A's daughter
CNM E	Clinical Nurse Manager
RN G	Registered nurse

RN H	Registered nurse
Ms I	DHB Complaint Service

13. Information was also reviewed from:

The district health board
New Zealand Police
Ministry of Justice

14. Independent expert advice was obtained from registered nurse (RN) Rhonda Sherriff (**Appendix A**).

Information gathered during investigation

Background

15. Mr A (aged in his eighties) had dementia and was living at home with his family. On 23 Month1 he was admitted to the public hospital because he was suffering a lower respiratory tract infection (LRTI). He had also recently had a fall and had extensive bruising over his left hand. He was admitted to the general medicine ward for treatment of the LRTI and assessment for possible increased level of care. The LRTI resolved over the next few days and he remained otherwise medically stable with no further concerns.

16. Mr A's wife had been finding it difficult to care for him at home. At a family meeting it was agreed that Mr A would be assessed by a Needs Assessment and Service Coordination service (NASC).[2] [3]

NASC assessment

17. While Mr A was in hospital, the NASC received a referral to assess Mr A for residential care. On 29 Month1 Mr A was assessed with the following whānau present: Mr A, Mrs A, Mr A's son Mr B, Mr A's daughter-in-law and Mr A's daughter, Ms D.

18. The comments section of the assessment report states that the reason for the assessment was that Mr A had severe dementia, which was contributing to falls because he was unaware of his own limitations and safety. It is noted that Mrs A had been providing full support for her husband, with family assistance as required, and had three hours per week of agency support. The assessment notes that Mrs A and the family were having

[2] NASCs are organisations contracted by the Ministry of Health to work with disabled people and their family, whānau, aiga, or carers, to identify their strengths and support needs, outline what disability support services are available, and determine their eligibility for Ministry-funded support services. NASCs allocate Ministry-funded disability support services and help with accessing other supports. These services are then delivered by service providers.

[3] This is a community-based organisation that provides a needs assessment and service coordination service for people with disabilities. It carries out a comprehensive assessment to determine the person's support needs, and then identifies suitable support services, arranges them, and reviews whether the arrangement is working for the client.

difficulty managing the 24-hour care that Mr A required, and were "reluctantly requesting Residential Care".

19. The assessment report states that Mr A's speech was limited, he was unable to make any requests, and he could answer only "yes" or "no" to questions. He was not able to express how he was feeling or any discomfort. The assessment report states that Mr A was totally dependent for all meals, household tasks, finances, medications, stairs, and shopping. It notes that he required two-person transfer using a transfer belt onto a commode chair in order to be showered, and states: "Must not be left alone in the shower." When walking, he required assistance from two people and was unsteady on his feet. He required a wheelchair for his mobility and someone to propel the wheelchair.

20. The assessment report notes that Mr A's comorbidities were:

- Severe dementia
- Diabetes mellitus type 2
- LRTI resolving
- Fast atrial fibrillation4

21. At the time of assessment, Mr A had no enduring power of attorney (EPOA) or welfare guardian.

22. The assessor recommended that Mr A be authorised for hospital/continuing level of care. Mr A's family decided that he would be moved to the rest home[5]

Admission to the rest home

23. Mr A was discharged from the public hospital on 2 Month2. The discharge plan was:

- Continuation of medications
- Hospital level placement
- General practitioner (GP) to follow up with ongoing medical needs
- Requirement for one person to assist Mr A when mobilising

24. Mr A's discharge medications were frusemide,[6] aspirin, metoprolol CR,[7] and gliclazide.[8] The nursing transfer letter noted that Mr A required 1–2 assistants, needed full cares, and was to be monitored two-hourly. The letter states that he was at a high risk of falls and that his bed was to be placed at the lowest level with a bell nearby.

[4] An irregular and rapid heart rhythm.
[5] The Cascades Retirement Resort (Cascades) has 74 beds and provides rest home, geriatric, and medical care. At the time of these events it was owned and operated by The Cascades Retirement Resort Ltd.
[6] Frusemide is a diuretic (ie, it increases the volume of urine output and therefore removes extra fluid from the body).
[7] Metoprolol CR is a beta blocker type of medication that relaxes blood vessels and slows the heart rate. It can be used to treat chest pain (angina), heart failure, and high blood pressure. The tablets should be swallowed whole and not chewed, crushed, split or broken before consumption, to prevent the entire drug from being released at one time.
[8] Gliclazide is used for the control of blood glucose in people with type 2 diabetes.

25. At 11.10am on 3 Month2 Mr A arrived by ambulance at the rest home. He was accompanied by his wife and daughter-in-law and was reviewed by the facility's general practitioner (GP).

26. On 3 Month2, Mrs A signed a resident admission agreement for Mr A to receive hospital-level care at a daily rate (exclusive of the government subsidy) of $230.90. Also on 3 Month2, Mrs A signed a "physical restraint/enabler consent form" which states that Mrs A consented to the use of bedsides. The form refers to "a bedside preventing them from leaving bed unaided or falling out of bed and sustaining injury to themselves or others". Mrs A also signed an informed consent form as next of kin/ representative/whānau.

27. Mr A was noted in the Patient Care Plan and progress notes to have had multiple falls and to be at a high risk of further falls. At the time of admission, Mr A had a wound on his left heel and left forearm, and plaster on his left arm due to a fractured wrist. The progress notes state that Mr A required assistance with all cares.

28. The admission form notes that the first contact person was Mr A's daughter, Ms D, and the second contact person was his son, Mr B.

Care planning

29. On 3 Month2, an RN completed an initial nursing care plan. The plan includes: "Respect [Mr A's] privacy and perform cares professionally." A care plan was completed on 5 Month2, and notes that Mr A was very hard of hearing but would respond if spoken to loudly into his right ear. The care plan states that Mr A required full assistance with his personal cares. With regard to mobility, the care plan states that Mr A required two-person assistance, with use of a standing hoist.

30. The care plan states: "Family have requested for [Mr A] to have bedrails up as he has a history of falling out of bed. Restraint form signed by family. To be seen by physiotherapist [to] maintain his degree of mobility as long as possible." The care plan was signed on 5 Month2 and counter-signed by Mrs A. Subsequently it was not updated.

Assessments

31. Mr A was weighed in Month2, Month3, Month4, and Month6. His weight varied from 62.7kg to 67.6kg. Mr A's vital signs were recorded monthly between Month2 and Month6.

4 Month2 to 24 Month3

32. On 4 Month2, Mr A was seen by a physiotherapist. At that stage, Mr A was unable to pull himself to standing. The physiotherapist noted that Mr A was to be showered in a shower chair and not to be left unattended. She also noted that he mobilised with two assistants.

33. On 5 Month2, Mr A was found with blood on his face, shirt, and hand. The blood had come from his nose. An RN noted that Mr A had been checked, and that no cut was found inside his nose. The RN queried whether Mr A had hit his face on the bedside

rails and recorded that she had advised the staff to use bedside covers and that the next of kin should be informed. An incident form was completed.

34. On 23 Month2, Mr A was again reviewed by the physiotherapist, and it is noted that he was to be managed by two carers for all transfers, and staff were to use a lifting belt. If Mr A was unable to weight bear, staff were to use a standing lifter.

35. On 16 Month3, Mr A's family visited in the evening and asked to see his medication signing sheet for the previous month. On the morning of 22 Month3, Mr B requested that Mr A wear a singlet and socks each day, and enquired whether he was having his medication daily. The progress notes state that Mr B was reassured.

36. Also on 22 Month3, Clinical Nurse Manager (CNM) E noted that Mr B said that on two occasions he had found that the side rails of Mr A's bed were covered with faecal matter. CNM E recorded that she assured Mr B that all concerns would be raised with the care team and addressed appropriately, and that Mr A reported that he was happy with the care being provided.

37. On 23 Month3, a skin tear/cut was found on the sole of Mr A's right foot, which was dressed. On 24 Month3, Mr A had a further episode of bleeding from his nose. His vital signs were recorded, and he was positioned in a left lateral position to prevent aspiration.

38. On 25 Month3 at 2.30pm, Mr A had a further nosebleed while his family were present. The progress notes state that the family were found to be changing Mr A's top because his nose was bleeding. At 10.55pm, Mr A refused his dinner-time medications and spat them out.

Fall 29 Month3

39. At 10.00am on 29 Month3, an RN found Mr A in the dining hall, lying on the floor, 15 feet away from his wheelchair. The incident form states that one of the other residents said that Mr A appeared to be bending to pick up something from the floor, lost his balance, and fell on the floor. The incident form states that Mr A was attended by two registered nurses and two healthcare assistants (HCAs), who put him back in the wheelchair.

40. Mr A had suffered bruises on his left forearm and right arm, but no skin tears. The RN assessed Mr A and took his observations. The actions to prevent a recurrence are stated to be:

> "[Mr A] is placed in an area with high traffic of RNs and HCAs passing by so that he will be monitored all the time. Lap belt recommended."

41. Ms D was advised of the fall at 2.15pm. There is no record of any consideration of use of a lap belt. Cascades said that the use of a lap belt was discussed with the GP, but it was not discussed with Mr A's family and that the GP and the CNM "deemed that the use of a lap belt would increase the level of frustration, agitation and potential harm to [Mr A]".

Complaint 30 Month3

42. The progress notes state that on 30 Month3 Mr B came to visit and complained that nothing had been documented in Mr A's turning chart. The progress notes state that staff went to apologise but were unable to do so because Mr B had left.

Fall 8 Month4

43. An HCA completed an incident form on 8 Month4 stating that, at 1.40pm, a visitor rang the emergency bell and reported that a resident had fallen. Care staff found Mr A sitting on the floor with his wheelchair tipped over. He was assessed by an RN who found no apparent injury. The contributing factor was recorded to be Mr A trying to walk without assistance. The action to prevent a recurrence was recorded as: "Staff to ensure not to leave [Mr A] on his wheelchair. He should be sitting in a more stable chair. If unsettled to monitor usually every hour to ensure safety." The incident form notes that Mr B was informed of the incident at 2pm.

44. At 3.30pm on 8 Month4, Mr A was reviewed by the RN who found him to be very unsettled and trying to get up. The progress notes state that a recliner chair would be trialled over the weekend to evaluate whether the wheelchair was the cause of Mr A's restlessness. There is no record in the progress notes of an evaluation of the trial. Care staff were instructed to toilet Mr A regularly to avoid restlessness. In response to the provisional opinion, Cascades said that Mr A was put in a recliner chair, but fell out, so this was not considered successful.

Medication found

45. At 3pm on 9 Month4, Mrs A found a white tablet on Mr A's chair. The progress notes state that it was not known which medication it was or where it was from.

Fall 10 Month4

46. On 10 Month4 at 8.10pm, an RN found Mr A in the lounge on the floor beside a recliner chair. The RN recorded on the incident form that she heard the portable sensor mat beep and, by the time she reached the lounge, Mr A had fallen. She recorded: "Unsure if hit his head, no apparent injuries and [complaint of] pain noted and at the lifting belt and three assist [used to] transfer him back to the lazy boy chair." Post-fall assessments were completed, including a Glasgow Coma Score (GCS),[9] and the actions to prevent an occurrence were recorded as: "To commence half hourly observations on [Mr A]." Ms D was advised of the incident on 11 Month4 at 9.40am.

Fall 17 Month4

47. On 17 Month4 at 3.15pm, Mr A had a further fall. An HCA recorded on the incident form that she heard the sensor mat alarm and found Mr A in the lounge on the floor trying to get up. Mr A had sustained a skin tear to his left elbow. Neurological recordings were commenced, with no abnormality detected, and the wound was dressed. The actions to prevent a recurrence were recorded as: "Inform staff to immediately

[9] An objective way of recording the initial and subsequent level of consciousness in a person after a head injury.

attend to the sound of the sensor mat [placed under Mr A's] wheelchair or lazy boy." Mrs A was advised of the fall at 8pm.

Falls 4 Month5

48. On 4 Month5 at 3.10pm, RN H found Mr A sitting on the floor in front of his wheelchair. He was returned to the wheelchair and, two minutes later, he tried to get up again and was again found on the floor in front of the wheelchair. There were no apparent injuries. Actions to prevent a recurrence were recorded on the incident form as: "Staff reminded to provide therapeutic distractions such as walks (assisted), newspaper, objects etc." The incident form states: "Daughter [Ms C] phoned & informed. [Nil] concerns."

6 Month5 to 8 Month5

49. On 6 Month5, Mr A was provided with a "fiddle box" to distract him and prevent him from standing and falling. The progress notes state that nursing staff were to place Mr A into his rocker recliner at 9am each morning with a table in front of him, and diversional therapy staff were to arrange activities to keep him occupied.

50. That day, HCA Ms C recorded that two-person assistance was required to transfer Mr A. Later on 6 Month5, Mrs A became upset with staff because they had put Mr A to bed at 6.30pm instead of 8pm. RN H completed an incident form noting that the healthcare assistant reported that Mrs A was very upset and speaking aggressively. RN H recorded that she apologised to Mrs A and attempted to de-escalate the situation by offering to assist Mr A to get out of bed until 8pm, but Mrs A did not agree to that action. RN H recorded that her apology was not accepted.

Welfare guardian

51. On 13 Month5, the forms were completed in order for Mrs A to make an application to be appointed as Mr A's welfare guardian.

Medication found

52. On 18 Month5, Mr B showed CNM E two tablets that he had found down the side of Mr A's wheelchair. The tablets were identified as aspirin and metoprolol. The actions to prevent a recurrence are recorded as: "Provide sufficient fluids during administration of medications or assess for 'crush' tablets [tablets that can be crushed before administration] sooner."

53. A multidisciplinary meeting was initiated with Mr A's family present, on 25 Month5. HDC was told: "This meeting was called to try to defuse an escalating situation and while we discussed issues of concern to the family, we also discussed all the positive things we had put in place like music therapy." However, the outcomes of the meeting are not documented.

54. On 27 Month5 at 10.20am, Mr B approached CNM E and produced two tablets (aspirin and gliclazide). CNM E noted that Mr B said: "Was not the RN meant to watch [Mr A] while he takes his medication and that [Mr A] could die from not having his tablets. I thought you fixed this."

55. CNM E recorded that she told Mr B that the matter had been discussed with the registered nurses the previous week, but that aspirin was not a medication that could be cut. Another staff member noted that it was explained to the family that Mr A still had rights even though he had dementia, and that if he wanted to spit out his tablets they would not force him to take the medication. Mr B again expressed concern that this was the second time he had found tablets under his father's wheelchair cushion. CNM E noted:

> "Medi Map[10] has been checked and appropriate medication changes had already been made with the GP and [a] note placed on [Mr A's] file to crush all medications. This has since been further outlined on the front page for all medications to be crushed except the enteric coated and monitored for appropriate administration."

Fall 3 Month6

56. On 3 Month6, an HCA recorded on an incident form that at 7.30am she had sat Mr A on a commode and gone to look for his clothes. She noted that he had got off the commode and walked to the hallway in the bedroom, and had fallen over, hitting the back of his head on the wall. The incident form states that Mr A had a right knee skin tear and bruising. RN G recorded that she had applied a protective dressing to the graze and had assessed Mr A, who had a bruise on the back of his head.

57. The actions to prevent a recurrence were recorded as: "Staff to closely monitor and not leave him during morning cares or whenever he is sitting alone in his room." Neurological observations were commenced at 9.30am and taken every 15 minutes for the first hour, half hourly until 3pm, and then four hourly until 2pm the following day. The neurological recordings were normal. HDC was told that the reason the neurological observations did not begin immediately was that RN G placed priority on the medication round that was in progress, and did not think to delegate the neurological observations to another staff member or seek support from the team leader. An RN told HDC that she informed Ms D "of the fall". The progress notes and incident form do not record that Ms D was told that Mr A had hit his head.

58. Mr B told HDC that when the family next visited Mr A they found that there was a hole the size of a bread plate in the wall of his room. Mr B said that each family member was told a different story by a different staff member about what had happened. In response to the provisional opinion, Cascades submitted that there was an "indentation" in the wall.

Assessment at the public hospital, 11 Month6

59. On 11 Month6, Mr A's family took him to the public hospital. The public hospital recorded that Mr A attended the Emergency Department because he had an altered level of consciousness. His family reported that he was drowsy following a fall and had nose pain and swelling. The initial hospital record states that the fall had occurred the previous night, but this was corrected in the medical assessment to having been seven or eight days earlier. There was a differential diagnosis of a subdural bleed, which was ruled out by CT imaging, as were any fractures. Mr A's other investigations were

[10] Medi-Map is medication management software.

normal, and there is no mention of concerns regarding nutrition or hydration. The attending emergency physician completed an ACC form and Mr A was discharged, and he returned to the rest home.

60. On 12 Month6 at 7.30pm, RN H recorded on an incident form that she had found a public hospital tag on Mr A's wrist dated 11 Month6. She recorded on the incident form that the family had not reported that they had taken Mr A to hospital, and that she asked Mrs A why they had done so.

61. Mrs A said that they were concerned about Mr A after his fall on 3 Month6, and that the family was not properly informed regarding the incident. Mrs A said that she was concerned after seeing that there was a hole in the wall. She claimed that the family did not know that her husband had hit his head.

Response to falls

62. Mr B said that he asked to see the incident report but a staff member refused to allow him to see it. He said that a week later he obtained the incident report from a nurse.

63. On 13 Month6, a file note was made that Mr A's family had come and asked to see a copy of the incident report regarding Mr A's fall on 3 Month6. It was recorded that the incident report and progress notes were given to the family and that: "Their behaviour is aggressive & bullying towards staff to the point where staff are terrified of them. I have asked them to find accommodation elsewhere for their father."

64. Cascades told HDC that initially Mr B's request was refused because he was not Mr A's welfare guardian or appointed under an EPOA. Cascades said that Mrs A was asked for her consent as next of kin, and then gave Mr B the report and a copy of the progress notes.

65. HDC was told that RN G was requested to update and complete Mr A's care plan detailing the high number of falls, and to obtain additional information about the interventions in response to the falls and the requirement for review and updating. The date on which this request was made was not specified. HDC was told:

> "This did not happen and I acknowledge that further formal follow-up did not occur. Whilst there was in place a system whereby the Quality Co-ordinator audited files monthly to ensure they were up to date, unfortunately she only did a random number of files and did not pick up the failure to update [Mr A's] file."

66. HDC was told that the clinical team and the CNM were aware of the frequency of Mr A's falls and had put in place measures to address this, but that: "We do however acknowledge, that the measures discussed and implemented were not always reflected in the appropriate documentation." HDC was told that Mr A was put in a wheelchair in order to be the correct height to be seated at the dining room table, and also because his family took him out frequently; however, at times he was seated in a recliner chair.

Family concerns and videotape

67. Mr B stated that from late Month2 the family became suspicious about Mr A's treatment because, when they visited him, he would cover his head and say, "Don't hit me, please don't hit me, yes I am dumb, I am dumb," and he stopped singing, talking and whistling. Mr B said that, as a result of their concerns, in Month4 the family bought a digital clock with a camera that had a motion sensor.

68. Mr B stated that around 11 Month6, they viewed the video footage and saw their father being hit by a healthcare assistant. HDC was supplied with a copy of the video footage. It is undated, so it is unclear exactly when the incident occurred. Cascades told HDC that it believes the incident occurred on 11 Month6 between 7.30am and 8am.

69. The video footage shows a woman (identified as Ms C) removing Mr A's bedclothes and throwing them on the floor, calling "[Mr A Mr A]", slapping Mr A's hip once, followed by five quick slaps or taps on the head. It also shows Ms C dragging Mr A across the bed roughly.

70. On 14 Month6, Ms I of the DHB's complaint resolution service met with Mr B, Mr A's daughter-in-law, and Mr B's brother-in-law. Mr A's family discussed the events that they were concerned about and showed Ms I the video. Ms I recorded that the caregiver was openly slapping Mr A.

71. Mr A's family told Ms I that they wanted to take their father home and care for him themselves. Ms I suggested that she would ring the NASC to arrange for the continuation of funding and possible services to assist the family. She recorded that she contacted the NASC, who were concerned about the move and the high level of care needed by Mr A, but said that they would give support. The NASC stated that Cascades had to be given 21 days' notice of Mr A's removal.

72. Ms I then arranged for the family to meet with a representative of Cascades. Mr B said that on 14 Month6, he and Mrs A spoke with them about their concerns with Mr A's care, and showed the video footage of Mr A being hit and manhandled.

73. After discussion, it was agreed that the 21-day notice contractual arrangement would be waived, and that assistance would be given to train Mr B and his wife about the safe handling of Mr A and his lifting, showering, and toileting.

Ms C

74. Cascades advised that the healthcare assistant shown in the video was Ms C. Cascades said that Ms C's qualifications were certificates in three areas not related to health. Cascades stated that Ms C was first interviewed in 2015 and, as she had not worked as a caregiver previously, she was asked to undertake voluntary work to ascertain whether she was capable and suited to caregiving. Ms C carried out voluntary work on two occasions and the feedback from the staff with whom she worked was very positive.

75. A reference check was conducted with Ms C's previous employer where Ms C had worked for four months on a part-time contract. No concerns were raised. Cascades

carried out a Police check on Ms C, which returned no results. Ms C was employed at Cascades until 11 Month7.

Ms C — training

76. Cascades provided HDC with Ms C's staff education attendance record. Ms C underwent orientation and attended the following training:

- Emergency and Fire Safety
- End of Life Care
- Moving and Handling
- Restraint
- Cultural Awareness/Māori Health
- IFC Standard Precautions and MROs
- Nutrition and Hydration
- Documentation/reporting/communication
- Falls Prevention and Management
- Code of Rights and Advocacy
- Behaviours that Challenge
- Emergency and Fire Safety
- Foot and Nail Care
- Moving and Handling

77. Ms C had attended a number of staff meetings. Her staff training record does not state that she attended training on abuse and neglect, delirium, or dementia. However, Cascades provided an attendance record showing that Ms C had training on abuse and neglect.

Discussion of incident

78. On 11 Month7, Cascades representatives met with Ms C. Ms C declined the opportunity to watch the video. She was told that the family had informed the Police of her assault of their father. Ms C stated that she had "told other people that [Mr A] was heavy and difficult to do and always spoke with her [buddy] informing them of what she is doing or who she is doing".

79. Ms C told the Cascades representatives that she was stressed at that time. She stated that it was very rushed in the mornings as there were a certain number of residents who needed to get up before breakfast. However, she had never told the CNM of any concerns.

80. Cascades had previously provided a reference for Ms C to support her application to commence nursing training. Ms C was advised that Cascades would contact the tertiary institute and notify them of these events. Ms C resigned from Cascades that day.

Descriptions and explanations of incident

81. On 14 Month7, CNM E wrote to the tertiary institute and described the incident as follows:

"The inappropriate care that was delivered included throwing bed linens across the bed onto the floor, manhandling the resident in an attempt to get him out of bed, when in fact he was a 2 person assist due to the complexity of his medical care and care needs as well as slapping him on the bottom and hip, as well as face to awaken."

82. On 28 August 2016, Cascades told HDC:

"While a tapping on the face may be an acceptable way of trying to wake or rouse a resident, the force used by the caregiver appears to go beyond that. [Mr A's] care plan required that he be handled by two caregivers. The caregiver was keen to get the residents ready on time for breakfast and made a start to prepare [Mr A] while her caregiver buddy finished off attending to the last resident that they had both just worked on."

83. On 21 July 2017, Cascades told HDC that it supports its staff to interact verbally with every resident and explain what they are doing before commencing an activity. Cascades said it believes that the video footage shows that Ms C attempted to wake or rouse Mr A by initially calling out to him and then by "tapping" on his face. Cascades stated: "This was a rapid action with about 3 taps." Cascades said that Mr A was very difficult to rouse in the morning and did not easily respond to verbal communication alone. It stated that the other action was "[t]apping on the hip — on investigation, Ms C advised that when she was unable to rouse or wake [Mr A] by tapping him on the face, she tapped him on the hip".

84. Cascades acknowledged that Ms C dragged Mr A forcibly across the bed. It said that it is of note that Mr A's family had set an expectation that Mr A would be ready for them to pick up that morning, and that Ms C commenced the care alone in order to meet the required timeframe. Cascades stated:

"[Ms C] reported that she realised that she was unable to complete this task alone, so she put the bedrails back in situ and went to find her buddy. We acknowledge that this was completely unacceptable practice and did not meet the requirements of [Mr A's] care plan (which documented all care was to be completed by two caregivers), nor did it meet Cascades policies, procedures or standards. We apologise unreservedly for these actions."

85. Ms C told HDC that she tried changing Mr A that morning and found that he was very stiff and was not moving or helping. She said that she went out of the room to call her buddy for assistance, but her buddy was busy with her own residents, as she had to complete her list of residents as well. Ms C said that she looked around for help but everyone was busy, so she went back to her buddy, an Enrolled Nurse (EN), to explain that she could not find help, and the EN said that she should start Mr A's cares by herself.

86. Ms C said that she went back to the room to do Mr A's cares and, "because he was too stiff and wasn't cooperating I tapped on [Mr A's] face and called out his name multiple times to get his attention/response so he can assist me, but I didn't get his response".

Prosecution

87. Subsequently, Ms C was charged with assault pursuant to section 196 of the Crimes Act 1961. She was interviewed by the Police. Ms C told the Police that she was in charge of training new staff and responsible for residents as well. She stated that, in addition, she helped with organised activities and orientated new student nurses.

88. Ms C told the Police that when doing daily cares like washing, showering or getting Mr A dressed, just one person was required, but when Mr A was transferred, two people were required.

89. Ms C told the Police that because Mr A did not respond to her when she was trying to call him, she tapped him on the face. She stated: "It wasn't my intention to hurt him or anything." She said that she thought she tapped his bottom and tried to grab him and was trying to help him sit up, but was not able to do so because Mr A was very stiff. She stated that she went outside to get help but could not find anyone to help her, and so she went back into the room and tried again by herself. She said that eventually her buddy arrived to help her.

90. Ms C stated that it is common practice to tap residents on the face to get a response. She said that she tapped Mr A twice on his bottom to see whether he would talk to her, and did not intend to smack him.

91. The Police then showed Ms C the video clips, and she stated that she tapped Mr A on the face to tell him to help her, and struck him on the leg because he was not helping. She again stated that it was not a smack.

92. Ms C pleaded guilty to a charge of assault. She appeared in the District Court for sentencing, where the Judge considered her application for a discharge without conviction pursuant to section 106 of the Sentencing Act 2002. In his ruling, the Judge noted that Ms C had pleaded guilty to one charge of assault, which he found related to events that occurred between 9 Month6 and 11 Month6.

93. The Judge said that he had viewed the video footage and described the events as follows:

> "[I]t is very clear to me that the victim is in bed and while you are trying to change him and roll him over, the first thing that you do is you apply what I consider to be a forceful slap to his hip. You could hear it and I describe it as forceful because it involved you having to swing your hand down onto his hip. It was not a tap. There was however no response from the victim. A few minutes later when you are trying to turn him over and you are facing him and you are trying to push him away from you again, still attempting to change him you give five quick fire taps to the side of his face. I consider the degree of force then to be less than the slap to the hip but again there was no response from the victim. It is clear to me also that despite your best endeavours for reasons completely out of his control the victim was unable to comply with your attempts to roll over so that he could be changed."

94. His Honour stated that Mr A was clearly vulnerable, and the offending was moderately serious. The Judge stated that it is simply unacceptable to hit a patient in any way, shape or form. Ms C was convicted of a charge of assault and discharged.

Policies

Staff Code of Conduct

95. Cascades' "Staff Code of Conduct" provides that the dignity and privacy of the resident must be respected. Principle 3 requires that a safe environment is maintained, including that the environment minimises the incidence of accidents. It requires that staff protect residents from harm by following policies and procedures. The policy does not refer to abuse.

Falls policy

96. Cascades' "Policy on Resident Falls" includes: In order to minimise the risk of residents falling, "ONGOING STAFF TRAINING TO SUPERVISE RESIDENTS AND NOT LEAVE VULNERABLE RESIDENTS UNATTENDED … IF WE IDENTIFY A TREND AROUND FALLS A PHYSIOTHERAPIST WILL BE INVITED TO ASSIST US IN DEVELOPING A FURTHER PROGRAMME THAT PROMOTES SAFE MOBILITY AND TRANSFERS" (emphasis in original).

97. Under the heading "Management of Falls", the policy states that the objective is that, in the case of a fall, a systematic assessment will take place prior to transferring the person, to ensure that no further harm will result from the move. Following a fall, the registered nurse/senior staff on duty must be notified and, if appropriate, the senior staff member may notify the manager and also the relatives and doctor. An incident form and a falls management investigation post-falls tool must be completed. The policy states that if a resident falls frequently (more than twice a month) a complete multidisciplinary review must be carried out, which includes:

- Medical review
- Falls assessment
- Medication review
- Physiotherapist review
- Nursing review
- External advice when indicated

Residents' safety and abuse prevention and security policy

98. The policy "Residents' safety and abuse prevention and security" states that "any behaviour which causes harm to an older person is abuse". The types of abuse listed include, "pushing, grabbing, shoving, pinching, slapping or hitting".

99. The policy states that abuse is part of a response to a stressful work situation, and adds that management are to be caring and supportive of staff, helping to raise staff self-esteem. Management will provide training and in-service education about management of difficult behaviour, and caregivers are to have input and involvement in developing care plans for residents. The policy states that every incident of abuse must be reported on an incident form and investigated.

100. The Cascades house rules set out its operating procedures and standards. They apply to all employees. Section 4 contains the Disciplinary Code and Procedure and states that serious misconduct includes "anything that may affect the health and welfare of residents, and others". It also states that serious misconduct includes "assault or verbal abuse of another employee, supplier, resident or any other party associated with our activities at the work place or at employer functions".

The DHB

101. On the advice of Age Concern, Mr A's daughter-in-law made a verbal complaint to the DHB on Mrs A's behalf, alleging assault and that poor care had been provided to Mr A while he resided at the rest home.

102. Following an investigation, on 12 Month8, the DHB advised Mr A's daughter-in-law that it agreed that the caregiver's actions were unacceptable. The DHB found that Cascades was in substantial breach of its duty of care as required by its aged/related residential care agreement with the DHB, which required the provision of safe, resident-centred care. The corrective actions required by the DHB included:

- Cascades to provide a copy of its grounds for employee dismissal, and confirm that they were followed in this instance and, if not, provide an explanation.
- Cascades to review its manual handling training for all care staff and provide confirmation that all staff are compliant with the required policy and procedures.
- The DHB would arrange for its clinical gerontology specialist nursing team to conduct a random review of a selection of six current hospital level of care residents at Cascades to ensure that:
  a) The care plan was appropriate for the resident's identified risks;
  b) The care plan was being followed and amended as necessary;
  c) The staff carrying out the care plan were competent to deliver the care required;
  d) The staff carrying out the care plan were following procedures that reflect best practice; and
  e) There was regular and ongoing monitoring of staff performance in the delivery of the care plan.

103. With regard to staff failing to notice that Mr A had not taken his medication, the DHB found that there was no documentation to show that the facility's procedure for safe medication administration had been followed. Cascades was to provide a corrective action plan to address the identified medication management compliance issues.

104. With regard to mobility practice, Cascades was to undertake an internal review of all documentation related to a resident's specific mobility/exercise/etc programme and ensure that all staff were compliant with the required signing procedures, and that the documentation was fit for purpose and allowed adequate information about resident participation to be reviewed.

105. With regard to Mr A's fall on 3 Month6, the DHB's corrective action was that the DHB would ask the clinical gerontology specialist nursing team to conduct a clinical review of Mr A's clinical notes from 3 Month6 to 18 Month6, to determine whether there were any gaps in how Mr A's fall was documented, followed up, and managed.

106. Cascades was to provide weight charts for the duration of Mr A's stay.

107. Falls risk, management of falls, and identification and management of malnourishment were to be included in the random review of six current hospital care residents.

108. The DHB told Mr A's daughter-in-law that it would conduct ongoing monitoring of Cascades and bring the corrective actions to the attention of HealthCERT so that the next certification audit scrutinised performance in the specific areas of medication management, compliance with resident care plans, manual handling, manual handling training, and staff competency.

109. The DHB required a full response to the corrective actions from Cascades by 31 August 2016. The DHB followed up with an unannounced audit in March 2017, which "came back clear" apart from one area of continuous improvement.

Further events

110. Mr A was cared for at home by his family until he passed away.

Ms C — further information

111. Ms C stated that she was stressed and overworked and had worked approximately 11–12 shifts in a row, owing to the rest home frequently being short staffed. She said that before the day of the incident she had completed an afternoon shift from 3.30pm until midnight, and had started work again at 7.00am.

112. Ms C stated that the incident took place between 7.30am and 8.00am. She said that morning shifts were usually very busy, and she had to get approximately three hospital-level care residents up and ready for breakfast within 45 minutes in order to stay on time to complete all her other tasks. Ms C stated that a lack of interpersonal support resulted in a sense of isolation, which caused this incident to occur.

113. Ms C said that she could not do Mr A's cares after breakfast because his family had told all care staff that they wanted him to be dressed for breakfast every morning.

114. Ms C said that the video shows her speaking to the EN who was her buddy that morning. Ms C said that the EN told her that she would start providing cares to her resident while Ms C started the cares for Mr A, and she would join Ms C once she had finished with her resident's care.

115. Ms C said she knows that her effort to move Mr A across the bed sideways by his arm was very poor and not safe. She stated:

> "I had no intention to hurt or cause harm to [Mr A]. Nor, I have done something like these before. I would like to assure you this was a one time off and won't happen again in near future. I am a very professional person and value my work a lot. I have an

excellent performances record since I was employed in the company and it saddens me that I have caused a mar in my record. I'm regretting what I have done and the pain I have caused the family."

Cascades — further information

116. Cascades told HDC that Ms C was rostered on duty from 7am to 3.30pm on 2–7 Month6 inclusive and 11–14 Month6 inclusive.

117. Cascades stated that it undertook a thorough review of the incident and, as part of the review, recognised that carer stress could be a contributing factor. Cascades stated that in response to the review it has:

- Reviewed the way in which care is organised to ensure that all care that requires two persons is only carried out by two persons. This has included altering the team leader's position description so that she now works on the floor with the care team in the mornings to mentor and coach care staff and support them where necessary.
- Put in place a quality system whereby the quality co-ordinator undertakes a random check across the facility on a weekly basis to ensure that residents' rights are maintained, care meets the standard expected, and the overall care provided to all residents is optimised.
- Included the Code of Rights and Cascades' vision, mission, and values as part of the orientation programme for all staff before they commence any duties.
- Made education on abuse and neglect compulsory for all staff and highlighted the policy of zero tolerance. Individual recognition of stress as a factor is highlighted, and techniques to manage this are discussed at meetings.
- Reviewed the number of shifts that any carer works to ensure that stress and fatigue is not a factor.
- Undertaken specific carer education on stress.
- Put in place clinical supervision to support the clinical manager, who in turn supports the staff across the facility.
- Encouraged staff, residents, and families to raise issues early so that they can be managed proactively.

118. The rest home continues to be owned and operated by Cascades Retirement Resort Ltd. On 4 January 2017, after these events, the shares in Cascades Retirement Resort Ltd were purchased by a new company. Cascades stated that the added support of the national care organisation and regular meetings provides more opportunity to network and discuss proactive management. A national network of clinical managers meets regularly to discuss clinical issues that arise and proactively develop solutions. New policies, procedures, standards, and resources have been provided, which confirm a policy of zero tolerance of abuse and neglect.

119. Cascades said that, in addition, it has introduced a new preceptor (training) role for senior healthcare assistants to provide peer support and mentoring within the healthcare

assistant team. It has also recently implemented a workplace communication course because it identified gaps in verbal and written communication.

120. Cascades stated:

> "Overall we acknowledge that this was a terrible incident and understand that it will have had a deep impact on [Mr A's] family. For this, we unreservedly apologise."

Responses to provisional opinion

121. The family was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. Mr B stated that he was concerned that there was not a second person assisting Ms C with helping his father out of his bed and during other activities, including showering and toileting.

122. Ms C was provided with an opportunity to respond to the relevant sections of the provisional opinion. Ms C provided a letter of apology to Mr A's family for her breach of the Code, and this has been forwarded.

123. Cascades was provided with an opportunity to respond to the provisional opinion. In their response, it was stated that analysis and discussion of Mr A's falls took place, but acknowledged that there is "little documentation to support this analysis and these discussions". It was also stated that Mr A's "falls and measures to prevent recurrence were discussed at the monthly Quality meetings".

124. Cascades also told HDC that since this incident, and as a result of the new management in place at Cascades, a number of changes have been made, including that a full-time Village Manager has been employed, new policies have been put in place, and "[a]n Employee Assistance Programme and specific access to the Whistle-blower hotline is available to all staff".

Opinion: Ms C — breach

125. The core issue in this case is Ms C's treatment of Mr A one morning between 9 Month6 and 11 Month6. The events as recorded on the video footage are that Mr A was in bed and, while trying to provide his cares, Ms C dragged him roughly across the bed, slapped his hip, and tapped him five times on the side of his face. As stated above, Ms C later pleaded guilty to a charge of assault against Mr A between 9–11 Month6.

126. My expert nursing advisor, RN Rhonda Sherriff, advised:

> "[Mr A] was very poorly manhandled the morning of the incident where caregiver [Ms C] is videoed attempting to waken him, to dress him, and move him out of bed. It was unacceptable practice to tap/slap [Mr A] on the face or hip in an effort to awaken [Mr A], and would be seen clearly as resident physical abuse, and would also be considered unacceptable practice by Aged Care industry leaders."

127. RN Sherriff also advised that pulling Mr A by his arm in order to move him across the bed was poor and dangerous practice because the risk of injuring Mr A was extremely high. She stated that this action would also be seen as physical abuse by her peers. RN Sherriff noted that Ms C was an experienced caregiver and was aware that Mr A required two staff for all cares, as was shown by Ms C having recorded that requirement in Mr A's progress notes. RN Sherriff said:

> "[Ms C] clearly did not follow [Mr A's] care plan instructions, written by the Registered Nurse, or follow the guidelines written by the Physiotherapist, on that morning, and [her actions] would be considered a significant departure from accepted practice."

128. I agree with RN Sherriff's advice. In addition, RN Sherriff also noted that the video shows that Ms C threw the bed linen onto the floor, which would not be accepted as good hygiene or infection control practices.

129. This Office has repeatedly stated: "[I]t is … plainly unprofessional to physically assault a patient. This is so fundamental that it requires little further comment."[11] Furthermore, the Health and Disability Services (Core) Standards[12] place an obligation on providers to ensure that "[c]onsumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect".

130. Ms C said that morning shifts were usually very busy, and that having to meet deadlines on the day of this incident was making her feel stressed, rushed, and under pressure. Ms C said that Mr A's family's insistence that he be out of bed and dressed for breakfast every morning contributed to this. However, I note that Ms C did not report her tiredness or stress to management. In my view, these factors do not excuse her having struck Mr A, her rough handling of Mr A, and her lack of compliance with good hygiene practices.

131. I acknowledge that working with elderly residents can be challenging. However, the use of unreasonable force is completely unacceptable — whatever the circumstances. Furthermore, there was a marked imbalance of power between Mr A, who was an elderly dementia patient, and Ms C, an experienced healthcare assistant. People with dementia can be particularly vulnerable to abuse, and the fact that the person has dementia can make it harder to establish whether abuse is taking place, and by whom.

132. Ms C's response to the situation was clearly inappropriate. To act in this way towards an elderly and vulnerable resident is a very serious departure from fundamental ethical and legal standards, and is clearly unacceptable. Accordingly, Ms C breached Right 4(2) of the Code.

Opinion: The Cascades Retirement Resort Limited — breach

[11] 05HDC13588, reiterated in 07HDC20395,12HDC01008,13HDC01495, available at www.hdc.org.nz.
[12] NZS 8134:2008.

133. Mr A resided at the rest home from 3 Month2 until Month6. During that period, his family expressed concerns about his medication management, he was abused by a staff member, and he had a number of falls — some resulting in injury.

134. Cascades had a duty to provide Mr A with services of an appropriate standard. I have concerns about the services provided to Mr A by multiple Cascades' staff members, as discussed below.

Care planning

135. The Age-Related Residential Care Services Agreement (AARC) provides that at the time of admission an initial care plan must be developed and documented based on information from the resident's most recent interRAI home care assessment, and on any other relevant information. The AARC also provides that a long-term care plan is to be developed, documented, and evaluated by a registered nurse, and informed by the interRAI, within 21 days of admission.

136. Mr A's long-term care plan was developed on 5 Month2, three days after he was admitted to the rest home. RN Sherriff advised that that was insufficient time after admission to know and understand a resident's care needs well and to be able to personalise the resident's care requirements in a long-term care plan. She stated that the plans can be commenced early and added to within the 21-day time frame, as the needs become more fully understood.

137. RN Sherriff was also critical that Mr A's plan was fully completed in one day and never updated further. She stated that the plan has very basic information and does not reflect Mr A's personalised care needs well. For example, the section on mobility identifies him as a "high falls risk" with a Coombs assessment rating of 16. However, there are no further updates in the care plan itself despite Mr A having suffered a large number of falls. RN Sherriff advised:

> "[G]ood practice would be to update the care plan with different strategies of managing the ongoing high falls risk and evaluations of how successful these strategies were at minimising the falls. The standards and AARC contract state a resident's status must be reviewed at a minimum of every 6 months but if clinically indicated (as was the case with [Mr A]) this should occur as the resident's care needs change, or he is identified as a serial faller (more than 2 a month)."

138. HDC was told that RN G was asked to update and complete Mr A's care plan detailing the high number of falls, and to obtain additional information about the interventions in response to the falls and the requirement for review and updating. However, that did not happen, and the Quality Coordinator did not detect that Mr A's file had not been updated.

139. In my view, Mr A's care planning was superficial and did not reflect his changing needs.

Falls management and prevention

140. On 29 Month3, Mr A fell from his wheelchair. The actions to prevent a recurrence of the incident included "lap belt recommended"; however, there is no record of any action to implement that recommendation. HDC was told that the use of a lap belt was discussed with the GP who, together with the CNM, decided that "the use of a lap belt would increase the level of frustration, agitation and potential harm to [Mr A]". The use of a lap belt was not discussed with Mr A's family.

141. Mr A fell from his wheelchair again on 8 Month4 and, on that occasion, the incident form stated that Mr A should not be left in his wheelchair and should be sitting in a more stable chair. However, although the progress notes state that a recliner chair would be trialled over the weekend to evaluate whether the wheelchair was the cause of Mr A's restlessness, there is no record of any assessment of his seating having taken place. HDC was told that Mr A was put in a wheelchair in order to be the correct height to be seated at the dining room table, and because his family took him out frequently, but that at times he was seated in a recliner chair. HDC was also told that Mr A was put in a recliner chair, but fell out, so this was not considered successful.

142. RN Sherriff was critical that although a staff member had suggested that Mr A be put in a more suitable recliner chair rather than his wheelchair, there are continuing references to his having fallen from the wheelchair. RN Sherriff stated: "Good practice would be to have [Mr A's] seating assessed and determine what type of chair would minimise his discomfort and restlessness, thereby preventing falls." She noted that if the family had requested that Mr A be in the wheelchair in order for them to take him out for walks, staff could have transferred him from a more suitable recliner chair to the wheelchair when required.

143. Mr A fell again on 10 Month4, and the noted action to prevent a recurrence was to commence half-hourly observations. A sensor mat was placed under the cushion of Mr A's wheelchair when he was in the lounge, to alert staff if he stood up. The sensor mat had a speaker box that alerted when pressure was released from the sensor pad. This was to indicate to staff that Mr A was attempting to stand up.

144. Mr A fell again on 17 Month4, and the action to prevent recurrence was to require staff to immediately attend to the sound of the sensor mat. Mr A then fell from a wheelchair twice on 4 Month5.

145. RN Sherriff stated that although the use of a sensor mat was good practice, by the time the sensor mat alarmed, Mr A had already fallen.

146. HDC was told that Mr A was provided with a fiddle box that at the time had been made specifically for him to provide cognitive stimulation and distraction for him. HDC was told that the clinical team and the CNM were aware of the frequency of Mr A's falls and had put in place measures to address this and that: "We do however acknowledge, that the measures discussed and implemented were not always reflected in the appropriate documentation."

147. RN Sherriff was critical that Mr A's falls did not appear to have been reviewed either by the primary care nurse or a senior nursing clinician, and appropriate recommendations made to prevent further falls.

148. The falls policy states that if a resident fell more than twice in a month there should be a comprehensive multidisciplinary meeting to determine actions to prevent or minimise any potential falls. This did not happen in Mr A's case. A multidisciplinary meeting with Mr A's family present took place on 25 Month5, but it focussed on the family's escalating concerns, rather than the falls and their prevention.

149. I also note that most of Mr A's falls were unwitnessed, which suggests that there was no staff member present in the lounge at the time. RN Sherriff stated that it would have been good practice to have nursing staff or an activities staff member present in the lounge when a serial faller was present.

150. Furthermore, Mr A was reviewed by the physiotherapist on 8 Month6, and a new walking plan was put in place because his mobility had increased and he was walking well with a gutter frame. However, the records indicate that Mr A was assisted to walk only short distances twice daily. RN Sherriff advised that good practice would have been to recognise that Mr A was walking well with the frame and to ensure that he was walked frequently each day by care staff and toileted to reduce his restlessness and his inclination to get out of his chair. RN Sherriff advised: "Referring [Mr A] to an external Gerontology Nurse Specialist who had expertise managing residents who were serial fallers, would also have been beneficial, for advice and strategies on how to manage his ongoing care needs."

151. RN Sherriff advised that the management of Mr A's falls was a moderate departure from accepted practice. I accept this advice.

Fall 3 Month6

152. I am particularly concerned about the events surrounding Mr A's fall on 3 Month6. That day, an HCA left Mr A on the toilet and went to look for his clothes. Although the HCA did not see the fall, she recorded that Mr A got up off the commode and walked to the hallway in the bedroom and fell over, hitting the back of his head on the wall.

153. Mr A's physiotherapist assessment of 4 Month2, and his individualised care plan dated 5 Month2, state that he was at a high risk of falling. Furthermore, the care plan states that Mr A required two staff members for all cares. On 3 Month6, those instructions were not followed by care staff, which contributed to Mr A's fall.

154. RN Sherriff advised that this was a clear deviation from the expected standard of care for Mr A in relation to this incident. She said that expected practice would be to gather the clothing and necessary equipment prior to toileting Mr A, and to have this ready to dress him when he was finished. RN Sherriff stated: "One staff member should have been present during his toileting to ensure he stayed safe."

155. Following the fall, Mr A was assessed by a registered nurse. However, neurological recordings were not commenced until 9.30am, two hours after the fall. HDC was told that RN G placed priority on the medication round that was in progress, and did not

think to delegate the neurological observations to another staff member or seek support from the team leader.

156. RN Sherriff stated that it would be expected practice to commence neurological recordings immediately after a fall that involved a potential head injury, so the neurological recordings should have started between 7.30am and 7.45am. She stated that initially the fall was not given the importance it required.

157. Furthermore, RN Sherriff stated that the facts of the fall should have been recorded in the progress notes, including a full description of what had occurred at the time of the fall. This was important because the incident report would not stay with the notes but was likely to be submitted to the CNM. As a result, the unit staff would have had little information to refer to if Mr A deteriorated following the fall or required further follow-up.

158. RN Sherriff also stated:

> "[T]he lack of detail in the resident's progress notes was unacceptable, as this information could have assisted staff when they were conversing with [the family] about the fall. This lack of detail also contributed to why [the family] felt they had not been adequately informed by [the RN]."

159. RN Sherriff advised that the management of this fall was a moderate departure from accepted practice. I agree with her advice. I consider it unsatisfactory that Mr A was left unattended, which contributed to the fall, and that there was a delay in monitoring him after his fall, the fall was not recorded in the progress notes, and his family were not fully informed about what had occurred.

Falls policy

160. RN Sherriff advised that as Cascades' policy required that residents have a multidisciplinary review after two falls, it should have a process in place that flagged when a resident had fallen twice to ensure that the primary care nurse activated a multidisciplinary meeting.

161. RN Sherriff also noted that the policy does not require the clinical nurse manager's involvement, overview, or supervision of clinical incidents, and the review process is undertaken by the registered nurse. RN Sherriff stated:

> "Aged Sector expectations would be, that the responsibility of analysing the clinical incident data for trends would be the responsibility of the Clinical Nurse Manager (CNM), who would then liaise with the Registered Staff on directives to minimise further incidents/accidents. This process should be put in place to ensure incidents are not overlooked and [are] managed appropriately."

162. RN Sherriff noted that it is usual for facilities to have policies that the data and information from incident reports will be analysed for trends and corrective actions implemented by senior clinicians or clinical managers in conjunction with registered staff. I agree with this advice.

163. Overall I am very critical about the management of Mr A's falls risk, including falls prevention, assessment, and management. I also have concerns about the adequacy of Cascades' falls policy. I consider that the follow-up after the falls was insufficient, and put Mr A at risk of further falls.

Communication

164. Mr A's family became increasingly concerned about his care. This concern was exacerbated by a number of occasions on which medication was found or documentation was incomplete. Communication between Mr A's family and Cascades staff appears to have become dysfunctional. I am concerned that Mr A's family became so worried about his care that they felt it necessary to install a hidden camera rather than raising their concerns with Cascades.

165. Mrs A and Mr B said that they did not know that Mr A had hit his head when he fell on 3 Month6, and later became concerned when they saw the hole in the wall. There is no documentation to establish that Mr A's family were told that he had hit his head in the fall. The incident form states only that the family were notified of the fall, and the time of notification. An RN said that she informed the family of the fall. I find it more likely than not that Mr A's family were not told that he had hit his head during the fall. It is of concern that family members were given differing accounts of what had occurred, and it is understandable that they were concerned when they saw the damage to the wall.

166. Although the family's anger was upsetting for staff, it is also understandable that the family felt let down by Cascades.

167. RN Sherriff advised that communication can be enhanced by ensuring that there are meetings with family members within a reasonable timeframe following the resident's admission, rather than waiting for concerns to be brought to management's attention. She suggested that an appropriate timeframe would be within the first three months. RN Sherriff stated: "This process can be reviewed also to ensure that family members are happy with the care. The primary nurse responsible for the resident can meet with the resident's family members to ensure they are content with the care."

168. The family were very concerned about Mr A and wanted to be informed and involved in decisions about his care. I consider it unfortunate that Cascades was unable to manage its interactions with Mr A's family in a more constructive manner.

Conclusions

169. Aged care facilities are responsible for the operation of the clinical services they provide, and can be held responsible for any service failures. In my view, it was the responsibility of Cascades to have in place adequate systems and appropriate oversight of the rest home staff in order to ensure that Mr A received appropriate care. It is also responsible for the actions of its staff.

170. In my view, the failures by Cascades staff, summarised in the categories outlined below, demonstrate a pattern of suboptimal care. Accordingly, I consider those failures of the staff to be service failures that are directly attributable to Cascades. In my view, Cascades failed to provide services to Mr A with reasonable care and skill in the following areas:

- Care planning
- Falls prevention
- Monitoring
- Incident management
- Communication with family

171. Accordingly, I find that Cascades Retirement Resort Ltd breached Right 4(1) of the Code.

Recommendations

172. In accordance with the proposed recommendations in my provisional opinion, Cascades Retirement Resort Ltd has undertaken the following and reported back to HDC:

a) Reviewed the effectiveness of its processes for medication management.

b) Developed a training schedule to ensure that all care staff and nurses receive regular ongoing training on challenging behaviour, de-escalation skills, abuse and neglect.

c) Included in its ongoing refresher training for all staff, information that the practice at Cascades is that asking of questions and the reporting of concerns is expected and accepted from all staff.

d) Reviewed the process by which data and information from incident reports is analysed for trends and corrective actions.

e) Included in staff training techniques to identify personal stress and coping mechanisms, and put in place a process that facilitates and supports staff to report stress, fatigue, and pressure of work to management.

f) Reviewed the roles and responsibilities of clinical nurse managers.

173. I recommend that within three months of the date of this opinion, the Cascades Retirement Resort Ltd undertake the following and report back to HDC on the outcome:

a) Review the effectiveness of its processes for assessments of care planning.

b) Review the involvement of the clinical nurse manager in residents' care.

c) Set in place a procedure to ensure that regular family meetings are held, commencing within the first three months following admission.

d) Complete education for all staff on comprehensive documentation, including individualised care planning, comprehensive progress notes, and informative incident reports.

e) Conduct an audit of six months' documentation for a random selection of 10 residents to ensure that all documentation complies with accepted standards.

f) Establish a procedure to ensure that residents who are serial fallers are referred to an external gerontology nurse specialist.

g) Review its falls policy to put in place processes to ensure that if a resident has fallen twice in a month, the primary care nurse activates a multidisciplinary review.

174. In the provisional opinion it was recommended that Ms C apologise to the family for her breach of the Code, with the apology letter to be sent to HDC for forwarding to the parties. This letter of apology has since been provided to HDC.

175. I recommend that The Cascades Retirement Resort Ltd apologise to the family for its breach of the Code, with the apology letter to be sent to HDC for forwarding to the parties within three weeks of the date of this opinion.

Follow-up actions

176. Ms C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

177. A partially anonymised copy of this report, naming The Cascades Retirement Resort Ltd and the expert who advised HDC on this case, will be sent to the DHB, and it will be advised of Ms C's name in covering correspondence.

178. A partially anonymised copy of this report, naming The Cascades Retirement Resort Ltd and the expert who advised HDC on this case, will be sent to the Nursing Council of New Zealand and HealthCERT (Ministry of Health), and will be placed on the HDC website (www.hdc.org.nz) for educational purposes.

Addendum

The Director of Proceedings decided to take a restorative approach in this case.

Appendix A: Independent nursing advice to the Commissioner

The following expert advice was obtained from Rhonda Sherriff, a registered general and obstetric nurse with 38 years of nursing practice, including 25 years of aged care experience in a variety of roles including quality coordination, aged care facility management, and operational management:

> "The Health and Disability Commissioner has requested R Sherriff to undertake a review of the Care provided to [Mr A] at Cascades Retirement Resort Ltd in 2016, and provide expert advice/opinion on the following:
>
> Regarding the care provided at Cascades Retirement Resort Ltd:
>
> 1) With reference to relevant standards and policies and the videos supplied by [the family], please comment on the adequacy and appropriateness of the care of [Ms C] and other healthcare assistants provided [to] [Mr A] in [Month6]. Please include specific comment regarding [Ms C's] actions when she attempted to get [Mr A] out of bed.
>
> 2) With reference to relevant standards and documentation including [Mr A's] care plan, please comment on the adequacy and appropriateness of the steps taken on 3 [Month6]:
>
>   - [Mr A] was toileted and left unattended.
>   - The steps taken to manage his head injury following his fall.
>   - The appropriateness of the incident report and subsequent documentation.
>
> 3) The adequacy and appropriateness of the nursing care provided to [Mr A] at the Cascades Retirement Resort Limited including but not limited to:
>
>   - The standard of [Mr A's] care plan and whether it was updated appropriately in light of his falls.
>   - The appropriateness of the steps taken following [Mr A's] falls. Please include comment regarding whether incident forms and relevant policies and procedures were correctly completed/followed and whether appropriate actions were taken to minimalize future falls.
>   - Any other matter relating to the nursing care provided to [Mr A] you consider relevant to comment on.
>
> 4) Whether any systems issues or organization factors at the Cascades Retirement Resort Limited contributed to the standard of care provided to [Mr A]. When answering this question please address the adequacy and appropriateness of relevant policies and procedures in force at the time of these events.
>
> 5) The adequacy and appropriateness of the actions taken by the Cascades Retirement Resort Limited subsequent to these events including any changes to practice.
>
> 6) Any other matter you consider clinically relevant to comment on.

Documents from Cascades Retirement Resort Limited have been reviewed as follows:

- Letter of complaint and copy of video taken by [the family]
- Record of phone conversations between HDC and [Mr B]
- Cascade Retirement Resort Limited response ([date]) and attachments
- Cascade Retirement Resort Limited response ([date])
- [Ms C's] response received 13th July 2017
- [The DHB's] response dated ([date]) and attachments
- [The DHB's] response dated 5th July 2017 and attachments
- Clinical Notes including short and long term care plan, progress notes, medications charts, health monitoring recordings
- Cascade relevant policies

Client: [Mr A]
[DOB]
[NHI]

Summary: Client [Mr A] was admitted to Cascades Retirement [Resort] on the 3rd [Month2] following an admission to the public hospital for a chest infection. He had previously been living at home and was being cared for by his wife and family, but whilst in hospital was assessed as requiring hospital level residential care.

[Mr A's] diagnosis at time of admission to Cascades were:

- *Vascular Dementia with decreased cognitive functioning*
- *Type II Diabetes*
- *Hypertensive disease*
- *Atrial Fibrillation*

Overview:

03 [Month2] [Mr A] was admitted to Cascades Retirement [Resort] with a history of atrial fibrillation, hypertensive disease, type 2 diabetes and dementia.

His admission progress notes identify [Mr A] as a high falls risk, due to a history of multiple falls.

Coombs assessment is 16.

Family (wife and son) request [Mr A] has bedrails at night (restraint) as he is prone to falling out of bed.

He is admitted with a pressure area on his left heel.

He is deemed to require full assistance with all cares, and two caregivers at all times.

04 [Month2] [Mr A] is weighed and is 65 kilograms Blood Pressure is 140/85
He is seen by [the physiotherapist] for an admission physical assessment and this clearly states he is not to be left unattended when showering. It also states he must have 1–2 care assistants for cares.

05 [Month2] [Mr A] has an episode of epistaxis (nose bleed) and staff question whether [Mr A] has hit his face on the bed rails causing the nose bleed. Corrective action is to place bed rail covers over the rails for safety.

22 [Month2] Progress notes state that family have said they are happy with [Mr A's] cares.

23 [Month2] [Mr A] is reviewed again by the Physiotherapist and his notes state he has had an assisted walk with the gutter frame. He is to be managed by two carers for all transfers and staff are to use a lifting belt. If [Mr A] is unable to weight bear then staff are to use the Cubro standing lifter.

29 [Month2] [Ms C] (Caregiver) enters in the progress notes that 2 carers are present for all cares.

22 [Month3] [Mr B and his wife] met with [Clinical Nurse Manager] and concerns were raised regarding medication administration, [Mr A] wearing singlet and sox every day, and faeces found on bedrail covers.

23 [Month3] Skin Tear found on [Mr A's] right foot (on the sole).

24 [Month3] [Mr A] has another episode of epistaxis B/P 110/60.

29 [Month3] Found [Mr A] lying on the floor in the dining room. He was witnessed by another resident bending down to pick something off the floor, and lost his balance, falling.

30 [Month3] [Mr A's] (son) points out to staff that his father's turning chart has not been kept up to date. Staff are reminded to keep this completed accurately.

08 [Month4] Unwitnessed fall in the lounge. He is found sitting on the floor by his wheelchair. The incident form states a corrective action should be that he is sat in a better chair.
He is identified as being very unsettled in the progress notes and staff are directed to toilet [Mr A] more frequently in an effort to settle him.

09 [Month4] Mrs A (wife) finds medications (1 white tablet) on [Mr A's] chair.

10 [Month4] [Mr A] found on the floor in the lounge at 2010 hours. B/P 120/75. Half hourly neurological recordings are commenced.

17 [Month4] Fall is documented at 1525 hours. He is seated back in his wheelchair. [Mr A] has sustained a skin tear (1.5x2cm) wound on his left elbow. Neurological recordings are commenced with no abnormality detected.

27 [Month4] Wound documented as almost healed on elbow.

04 [Month5] [Mr A] found sitting upright on the floor in front of his wheelchair. He is put back into his chair and 3 minutes later stands and falls again.

06 [Month5] [Mr A] is given a 'fiddle box' (activity box) to keep him occupied when seated in the lounge.

06 [Month5] [Mrs A] is upset and verbally aggressive towards staff for putting [Mr A] to bed too early at 1830 hours. His normal bed time is 2000 hours. Staff apologize and suggest getting [Mr A] back up, but [Mrs A] says this is too late and to leave him in bed.

03 [Month6] [Mr A] sustains a fall after having been left unattended on the toilet whilst a caregiver goes to get his clothes (as per the incident form), but there is little documentation in the progress notes to substantiate the events that took place. The first entry referencing this event is written into the progress notes at 1430 hours. Entry states that [Mr A] sustained bruising and a graze to his right knee and neurological recordings are commenced due to head hitting the wall.

The neurological form evidences that the neurological recordings were commenced at 0930 hours and taken every 15 minutes for the first hour, half hourly until 1500 hours, then 4 hourly until 1400 hours the next day. The extension of time to continue taking recordings is on the recommendation of the Nurse Practitioner who reviews [Mr A] on the day of the fall.

There are no abnormalities detected in the neurological recordings.

The fall occurred at 0730 hours according to the incident report and yet the neurological recordings were not commenced until 2 hours later at 0930 hours.

The incident form states the injury (bruising and skin tear) to [Mr A's] right knee, and then underneath this entry, states he hit the back of his head — no bumps.

The corrective action on this incident form states he is not to be left unattended, but this is already a directive.

08 [Month6] [Mr A] is seen by the Physiotherapist at staff's recommendation due to his restlessness and self-mobilizing. The physiotherapist comments that he is walking well with a gutter frame and there is a new walking plan in place.

11 [Month6] [Mr B], [Mrs A] and Daughter-in-law demand to know what really happened when [Mr A] fell on the 3rd [Month6] and ask to see the incident report. They are told by the staff the incident form is not in his notes. They state that they believe the fall was witnessed. They also state they were not properly informed of what happened at the time.

[Mr B] (son) takes [Mr A] to [the emergency department at the public hospital] to have him checked following his fall on the 3rd [Month6].

12 [Month6] Staff write an incident report stating they have found a [DHB] bracelet on [Mr A] when completing cares, and that the Registered Nurse was not made aware that they had taken him to the hospital for a review yesterday.

[Mr B] states he has a video of [Mr A] being assaulted by [Ms C] (Care giver employed at Cascades Retirement [Resort]) 12 [Month6]

17 [Month6] [The family] remove [Mr A] from Cascades Retirement [Resort] and take him home to provide care after discussions with [Clinical Nurse Manager].

Expert Advice:

1) **With reference to relevant standards and policies and the videos supplied by [the family], please comment on the adequacy and appropriateness of the care of [Ms C] and other healthcare assistants provided [to] [Mr A] in [Month6]. Please include specific comment regarding [Ms C's] actions when she attempted to get [Mr A] out of bed.**

Video footage: *The video shows [Mr A] being changed by night staff (assumed as the light is being put on and off each time staff attend to [Mr A]) a number of times on the video (3) where he is respectfully treated, turned for pressure relief with the aid of a turning sheet, and his pad is changed due to incontinence. He appears to be left comfortable and settled following the cares. The night staff appeared caring and considerate by talking to him during the procedure, as well as to each other. It is clear via the video footage that [Mr A] requires two staff for all cares as he is relatively immobile and difficult to move about in the bed.*

When [Ms C] appears on the video she looks at her watch on entry to the room, and then proceeds to roughly throw the bedclothes back off [Mr A], and onto the floor. She is talking to other (unseen) staff as she proceeds to get the equipment and clothing ready. She manhandles [Mr A] roughly, pulling him down the bed and proceeds to try and put his underpants and trousers on. She is witnessed slapping [Mr A] on the hip (once) in an attempt to get him to cooperate. She walks around the bed and taps/slaps [Mr A] several times on the side of his face to get a response. She pulls [Mr A] down the bed and then sideways by his arm roughly, then appears to push him back, and leaves him to get assistance.

[Mr A] was very poorly manhandled the morning of the incident where caregiver [Ms C] is videoed attempting to waken him, to dress him, and move him out of bed. It was unacceptable practice to tap/slap [Mr A] on the face or hip in an effort to awaken [Mr A], and would be seen clearly as resident physical abuse, and would also be considered unacceptable practice by aged care industry leaders.

Pulling [Mr A] by his arm in an effort to move him across the bed is also poor/dangerous practice as the risk of injuring [Mr A] was extremely high, and would be viewed as physical abuse by my peers.

[Ms C] was an experienced caregiver who had worked at Cascades [since 2015], and had attended to [Mr A] on many occasions during his residency at Cascades Retirement [Resort], as evidenced by her entries into his progress notes. She was well aware that [Mr A] required two staff for all cares, as she had documented this practice as occurring during the delivery of cares, when making numerous entries into his progress notes. She clearly did not follow [Mr A's] care plan instructions written by the Registered Nurse or follow the guidelines written by the Physiotherapist, on that morning and [this] would be considered a significant departure from accepted practice.

The video also demonstrates that [Ms C] was extremely rough by the way she threw bed linen on the floor and this would not be accepted as good hygiene or infection control practices.

Annual staff education on elder abuse cannot be evidenced in the documents supplied, but it would be an expectation that [Ms C] would have attended at least one compulsory session during her employment at Cascades, on what constitutes elder abuse. She would also be expected to have a full understanding of what expected care standards, compassion, and care delivery would encompass.

Cascades employment documents clearly outline the code of conduct, what constitutes abuse, and what is expected of staff who work there. The staff member would have been expected to have read this and signed to say she understood the code of conduct.

Departure from accepted practice — maximum (high level of departure).

2) With reference to relevant standards and documentation including [Mr A's] care plan, please comment on adequacy and appropriateness of the steps taken on 3 [Month6]:

- **A. [Mr A] was toileted and left unattended.**
- **B. The steps taken to manage his head injury following his fall.**
- **C. The appropriateness of the incident report and subsequent documentation.**

[Mr A] was left unattended on the toilet in the en-suite whilst the caregiver went to find [Mr A's] clothes to dress him. It clearly stated in [Mr A's] physiotherapist assessment dated the 4th [Month2], and his individualized Care Plan dated the 5th [Month2], that he was a high falls risk…. The care plan identified that [Mr A] required two care staff for all cares. These instructions were not followed by the care staff and contributed to [Mr A's] fall that morning, and were a clear deviation from the expected standard of care for [Mr A].

Expected practice would be to gather clothing and all necessary equipment prior to toileting [Mr A] and have this ready to dress [Mr A] when he was finished, as it was clearly documented he was not able to be left unattended. One staff member should have been present during his toileting to ensure he remained safe.

Registered Staff attended [Mr A] and examined him following the fall for injuries as stated in the incident form.

[Mr A] was checked physically as per the Incident/Accident Cascade policy guidelines, however, neurological recordings were not commenced until 0930 hours (2 hours after the fall) as per policy for a head injury. I would question whether it was established initially that he had hit his head at the time of the fall, and whether it was identified some time afterwards (between 0730–0930 hours) when the wall damage was noticed.

It would be expected practice to commence neurological recordings immediately after a fall that involved a potential head injury, so the neurological recordings should have started immediately between 0730–0745 hours.

He was later assessed by the visiting Nurse Practitioner who advised to continue the neurological recordings for a further 24 hours. These showed no neurological deficit whilst being completed over the 29 hour timeframe the recordings were taken.

The progress notes are insufficiently updated at the time of the actual events and only outline that an incident report had been developed and family notified. This is not an acceptable standard of documentation and the notes should have had a full description of what had occurred at the time of the fall.

The incident report does not initially stay with the notes, but is usually submitted to the Clinical Nurse Manager for her information and follow-up, so the unit staff would have had little information to relate back to, in the event that [Mr A] deteriorated following the fall or required further follow up. The lack of detail in the resident's progress notes was unacceptable, as this information could have assisted the staff when they were conversing with [the family] about the fall. This lack of detail also contributed to why [the family] felt they had not been adequately informed by [the Registered Nurse].

The Incident report was completed and stated that [Mr A] had an unwitnessed fall (having taken some steps) then fallen. I question how staff knew he had taken some steps if the fall was unwitnessed, apart from the distance from the toilet where he fell.

The potential head injury does not have the priority on the incident form injury section, but rather the knee graze and bruising, and looks more of an afterthought written on the incident form (potentially written when the staff realized that he may have hit the wall with his head), when the wall damage was noticed. I would suggest that the fall was not given the importance it required initially.

[Mr B] (son) stated that they had not been given the full/correct information when informed of the fall in relation to his father's head hitting the wall. There is no written documentation to evidence that the family were told [Mr A] had hit his head in the fall in either the progress notes or the incident form. The incident form only states the family were notified of the fall and what time.

Recommended Improvement: That staff document clearly in the progress notes all information regarding any incident/accident that occurs and what outcomes resulted.

That staff fully document in the progress notes and/or on the family contact sheet, what was discussed with the family when they were notified of any incident.

Departure from accepted practice — moderate.

3) The adequacy and appropriateness of the nursing care provided to [Mr A] at the Cascades Retirement Resort Limited including but not limited to:

- **The standard of [Mr A's] care plan and whether it was updated appropriately in light of his falls.**
- **The appropriateness of the steps taken following [Mr A's] falls. Please include comment regarding whether incident forms and relevant policies and procedures were correctly completed/followed and whether appropriate actions were taken to minimalize future falls.**
- **Any other matter relating to the nursing care provided to [Mr A] you consider relevant to comment on.**

[Mr A's] long term care plan was developed on the 5th [Month2], three days after his admission to Cascades Retirement [Resort]. This is insufficient time after an admission in my clinical opinion to know and understand the resident care needs well, and be able to personalize the resident's care requirements fully in the long term care plan.

The standards state that aged care facilities have 21 days to develop a long term care plan that is personalized to the resident's individual care needs. Plans can be commenced early, and added to in this 21 day time frame, as the resident's needs are more fully understood, but [Mr A's] plan was completed (according to the dates on the long term care plan) in total on the one day and not updated further at any time following the 5th [Month2].

It had very basic information written into each section and was not accurately reflecting [Mr A's] personalized care needs well. The section on mobility identified him as a 'high falls risk' from the information gathered on admission, and it stated a Coombs assessment completed identified a rating of 16 (validating the 'high' score).

There were no further updates/entries/evaluations into the long term care plan itself, even after a substantial number of falls had occurred. Good practice would be to update the care plan with different strategies on managing the ongoing high falls risk and evaluations on how successful these strategies were at minimizing the falls. The standards and ARRC contract state a resident status must be reviewed at a minimum of every six months, but if clinically indicated (as was the case with [Mr A]) this should occur as the resident's care needs change or he is identified as a serial faller (more than 2 a month). There was opportunity for the primary care Registered nurse and the CNM to evaluate the care plan on a number of dates, and add information and strategies to manage [Mr A's] fall.

[Mr A] fell in the lounge a number of times. He had a sensor mat placed in front of his wheelchair to alert staff when he stood up on it, and there was the potential for him to fall. By the time the sensor mat alarmed, [Mr A] had fallen. In an early Incident form a staff member makes the suggestion (corrective action) of putting [Mr A] into a more suitable recliner chair rather than his wheelchair to minimize his falls, but this is not followed up on, nor occurs, as there are continued references to him falling from the wheelchair. Good Practice would be to have his seating assessed and determine what type of chair would minimize his discomfort and restlessness, thereby preventing falls.

It is unclear in the notes provided whether the family requested that [Mr A] was to remain in the wheelchair at all times, as they often took him out for walks in the wheelchair. Staff could have transferred him from a more suitable recliner chair to the wheelchair for outings, if this was the case.

There was a summary provided of all of the incident reports relating to [Mr A's] numerous falls and incidents with [the family], but I question whether the falls were reviewed by either the primary care nurse, or a senior nursing clinician (CNM, or the Nurse Practitioner), and recommendations made on the prevention of further falls. The use of the sensor mat by the wheelchair in the lounge was good practice, however, asking nursing or activities staff members to be present in the lounge when a serial faller was present, would also have been good practice.

Most falls were unwitnessed, which evidences there was no staff present in the lounge at the time of the documented falls. There is one recorded incident form documenting another resident witnessed [Mr A] falling after attempting to pick something up from the floor.

[Mr A] fell frequently and was referred to, and reassessed by the Physiotherapist for restlessness and self-mobilizing on the 8th [Month6]. Her assessment resulted in a new walking plan being put into place, due to his increased mobility, and comments stated that he walked well with the Gutter Frame.

Good practice would have been to recognize that [Mr A] was now walking well with the frame, and to ensure he was frequently walked each duty by care staff, and toileted to reduce his restlessness. There was a walking plan in place (recommended by the Physiotherapist) but on review he was walked reasonably short distances twice a duty. Providing [Mr A] with a fiddle box of activities helped keep him less restless, but walking and toileting him on a regular basis would also have reduced his restlessness and inclination to get up from his seat.

Referring [Mr A] to an external Gerontology Nurse Specialist who had expertise in managing residents who were serial fallers, would also have been beneficial, for advice and strategies on how to manage his ongoing care needs.

Departure from accepted practice — Moderate.

4) Whether any systems issues or organization factors at the Cascades Retirement Resort Limited contributed to the standard of care provided to [Mr A]. When answering this question please address the adequacy and appropriateness of relevant policies and procedures in force at the time of these events.

[The incident policy] states that when a resident falls more than twice within a month there will be a comprehensive multi-disciplinary meeting to determine actions to prevent or minimize any potential resident's falls. This did not appear to have happened in [Mr A's] case. There does not appear to be any meeting minutes that evidence the multi-disciplinary meeting occurred either in the progress notes or any meeting minutes.

Multi-disciplinary reviews are where the nursing staff, clinical manager, General practitioner, Physiotherapist, Diversional Therapist, and any other specialist input can discuss the resident's care needs, and determine an improved plan for their care.

Cascades should ensure that residents are multi-disciplinarily reviewed as per their policy, and have a process in place that flags when a resident has fallen twice, to ensure this is activated by the primary care nurse (R/N).

There is also no reference to the Clinical Nurse Manager's involvement, overview or supervision of clinical incidents in the Cascades Incident policy. [The policy] states the review process is undertaken by the Registered Nurse. Aged Sector expectations would be, that the responsibility of analysing the clinical incident data for trends would be the responsibility of the Clinical Nurse Manager (CNM), who would then liaise with the Registered Staff on directives to minimize further ongoing incidents/accidents. This process should be put in place to ensure incidents are not overlooked and [are] managed appropriately.

The only evidence of any multi-disciplinary involvement was the physiotherapist's reassessment of [Mr A's] mobility and it is not clear when this review was requested, or by whom?

Policies and processes need to be followed when they are documented. I would question where the CNM's involvement in this process occurs as there is not much evidence or documentation to substantiate that there is? I.e. no entries into [Mr A's] notes by the CNM.

Most facilities have written into their policies that the data and information from incident reports will be analyzed for trends and corrective actions implemented by senior clinicians or clinical managers in conjunction with Registered Staff.

Communication can be enhanced by ensuring family members are met with, in a reasonable time frame following the resident's admission (within the first three months), rather than waiting for their concerns to be brought to management's attention. This process can be reviewed also to ensure that family members are happy with the care. The primary nurse responsible for the resident can meet with the resident's family members to ensure they are content with the care.

Departure from accepted practice — Moderate.

5) The adequacy and appropriateness of the actions taken by the Cascades Retirement Resort Limited subsequent to these events including any changes to practice.

Cascades management reacted to the situation by meeting with [the family], admitted to being shocked and saddened by their staff member's actions, acknowledged their concerns and failings, and offered assistance to maintain [Mr A] at home with support.

The staff member [Ms C] was interviewed on her return from annual leave by senior Cascades Management and chose to immediately resign from her position as caregiver

once informed of the alleged offences, acknowledging that this was unacceptable practice. She stated she had been under pressure to get [Mr A] up and ready for the morning but did not advise this to senior staff.

Police had already been informed by family members of the physical abuse and were in the process of charging the staff member with assault, but it would be expected that police be notified of an instance of physical abuse by a staff member.

[The staff conduct expectations policy] was clearly articulated, and highlighted abuse as an unacceptable practice. Improvements to the policy document could include further information on stress, outlining who to report stress or pressure of work to, and expected time frames for this to occur.

It is difficult to ascertain from the information provided whether staff felt comfortable in the Cascade Retirement Village [Resort] environment reporting stress, fatigue and pressure of work to management. The staff member identified as [Ms C] could have chosen to report that she was feeling under pressure that morning to senior staff, but chose not to do so. Her physical management of [Mr A] was rough, abusive and lacked any compassion. The video clip showed her looking at her watch, talking to someone outside of the room who was unidentifiable, and performing the tasks of getting [Mr A] ready by herself. Whether she negotiated her work load with other staff is unable to be ascertained.

Cascade staff member completed a Section 31 to notify the Ministry of Health about the incident (abuse), and liaised with District Health Board planning and funding representatives during the management of the incident. This is expected actions following an incident of this nature.

Management maintained an open and honest continuing dialogue with the MOH/DHB following this incident, as evidenced by the correspondence reviewed.

Cascade management had also undertaken screening of staff prior to employment which met expected guidelines/practice and there was no suggestion or evidence that [Ms C] would offend in the abusive manner, captured on the video at the time of the incident from her references.

Cascade management also held education sessions for all staff following this incident to reinforce the unacceptance of elder abuse on site at Cascade Retirement Village [Resort]. This would be an expected Corrective action that was undertaken.

Recommendation: Education be completed on comprehensive documentation — individualized care planning, comprehensive progress notes, informative incident reports, etc, this should be considered for Registered Nurses to ensure that all documentation contains more relative information and is highly informative.

Departure from accepted practice — minimum.

6) Any other matter you consider clinically relevant to comment on.

Staff member [Ms C] stated she was stressed and unable to find a work colleague to help her the morning when the physical abuse incident occurred. She is observed talking with someone outside [Mr A's] room on the video just after she has entered, and is organizing her equipment and [Mr A's] clothing. On the video she is also seen looking at her watch on entry into the room, obviously determining time constraints. From the outset of her arrival into the room she is observed as rough and negligent. Was the person she was talking with (observed on the video), another staff member she could have asked for assistance?

Were other staff aware of how rough this caregiver was, having worked previously with her, and were other staff interviewed as part of the investigative process to determine this? There are no investigative notes from other staff interviews supplied to evidence this process was undertaken.

[Ms C] was well aware of the care plan specifications that identify [Mr A] requiring two carers for all cares, as she has been responsible for his cares in the past months (this is evidenced by her entries into his progress notes) and yet she proceeds to undertake his cares on her own.

Her behaviour and attitude are less than optimal (as viewed on the video) and this puts [Mr A] at significant physical and mental risk. On the video, other staff who have provided his care prior to this incident, appear to be calm, attentive and meet [Mr A's] care needs, abiding by the 2 care staff to be present guidelines.

When educating staff on elder abuse, staff should also be taught identification of personal stress and coping mechanisms, such as to identify their own personal stress levels and to walk away when they are in stressed situations.

The Clinical Nurse Manager's role and responsibilities could benefit from a review, and clarification to ensure that there is involvement in the oversight and individualized care planning for residents with complex care needs, and to also ensure that facility policies are followed by all staff.

Rhonda Sherriff
Friday 25th August 2017."