

Dysfunctional call bell system and inadequate management of resident at high risk of falls at aged care facility

1. On 24 April 2022, the Health and Disability Commissioner (HDC) received a complaint from Ms A about the care provided to her mother, Mrs B, by Ultimate Care Oakland (UCO; trading as Alden Ultimate Care – Oakland) in Tauranga. The complaint concerned the lack of a functioning call bell system and UCO's poor management of Mrs B's high falls risk. Mrs B had experienced numerous falls and was reported as crawling down hallways seeking the assistance of staff.

Information gathered

Background

2. Mrs B, a Māori kuia, was 77 years old at the time of events. She was admitted to UCO from Tauranga Hospital on 6 April 2022 for hospital-level care after a stroke that left her with left-sided weakness. Her medical history included an internal carotid artery aneurysm,¹ migraines, stroke, and vascular dementia.
3. On admission, Mrs B was noted to be a high falls risk, and a care plan was completed with Mrs B's younger daughter, who is also her Enduring Power of Attorney (EPOA). It was noted that Mrs B required carer assistance to reposition, mobilise (particularly with mobilising to the toilet at night), and meet her personal care requirements. It was also documented that Mrs B had a cognitive impairment, with issues around her memory.

Call bell system

4. Ms A told HDC that when her mother was admitted to UCO there was no functioning call bell system to alert carers when residents needed help and that Mrs B was advised to 'bang on the walls' or 'yell for staff' to come and help her, and this led to her experiencing multiple falls (discussed further below).
5. An external certification audit completed in November 2021, some five months before this complaint, identified issues within UCO's call bell system; in particular, it noted that 'some resident room call bells were not functioning' (despite battery replacement and an external contractor visiting) and that UCO was awaiting either repair or replacement of the call bell system. The audit noted that call bell system failure had not been reported to the Ministry of Health | Manatū Hauora and outlined two corrective actions to be completed within 30 days:
 - Ensure that correct routine testing and maintenance of the call bell system is maintained, results are reported to management, and that repairs or replacement are actioned in an urgent manner.

¹ A bulge in the internal carotid artery that can pose serious health risks, including the potential for rupture and stroke.

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Ensure that failures in the call bell system are reported to the District Health Board and Ministry of Health | Manatū Hauora as required under Section 31 of the Health and Disability Services (Safety) Act 2001.²
6. UCO acknowledged that there were ‘intermittent faults’ with the call bell system at the time of Mrs B’s admission and that some residents’ call bells did not always work properly at first attempt. UCO told HDC that a hazard/risk alert form was completed in its eCase (a web-based client management system) in January 2022, and three related helpdesk notifications were submitted but also acknowledged that the hazard alert did not include a management plan and there was no follow-up or evidence of communication with relevant stakeholders to ensure the issue was addressed.
 7. UCO stated that alternative strategies were used in response to the call bell faults, which included increased frequency of visual safety checks and that whistles were provided to residents with which to call staff. It is unclear whether UCO had a call bell policy in place at the time.

Falls management

8. Over the course of around two weeks after Mrs B’s admission to UCO, she experienced six falls. Concerns have been raised about the identification and management of Mrs B’s falls risk. It is also worth noting that Mrs B’s falls risk was in the context of UCO having a dysfunctional system for ensuring its residents could readily seek the assistance of staff as required.
9. On admission, Mrs B was assessed as a high falls risk according to UCO’s ‘Falls Assessment and Management’ policy (January 2022) (‘the falls policy’). The falls policy stipulates that when a falls risk is identified, a registered nurse (RN) is to complete a care plan that outlines the immediate management and interventions to be followed to mitigate the risk. Mrs B was provided with equipment, including a call bell and a ‘Steady Eddy’ (mobility aid), physio-prescribed exercises and information to help mitigate her falls risk.³ UCO stated that, because of her cognitive impairment, Mrs B may not remember some of the advice given or to use her call bell and so staff utilised a ‘sensor mat’ that triggers a signal to a carer when it is stepped on.
10. On 6 April 2022, at approximately 3.30pm, Mrs B was found lying on the floor of her bedroom, conscious and responsive, following an unwitnessed fall. Clinical notes outline that Mrs B was hoisted off the floor and back into bed, although it is unclear whether a post-falls assessment occurred first. The falls policy requires that an RN is to complete a post-falls assessment to assess the resident for injuries and that the resident should not be moved before this assessment. According to UCO, Mrs B was unsure whether she had hit her head, and UCO told HDC that, although neurological observations were commenced, they were

² Section 31 of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about specific incidents that may affect the health and safety of individuals receiving services.

³ The falls policy requires that ‘individual causative factors’ be identified and appropriate equipment be available for the resident to use to minimise the risk of falls.

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

not continued as per the falls policy.⁴ An incident form was completed, but whether Mrs B's EPOA was contacted as required by the falls policy is not documented.⁵

11. On 8 April 2022, at approximately 9.26pm, Mrs B was found lying on the floor next to her bed after an unwitnessed fall. According to UCO, the call bell was activated but did not work. A post-fall assessment was undertaken, Mrs B was settled back to bed, neurological observations were commenced, and an incident form was completed.
12. UCO said that, at 9.39pm, Mrs B's daughter was informed of this fall (although this was not documented) and she reportedly expressed concern that there had been two falls since Mrs B's admission. UCO told HDC that this 'seems to show awareness of the fall on 6 April,' although it is unclear whether staff called the daughter who has EPOA or Ms A (the complainant). UCO stated that Mrs B's daughter expressed concerns regarding the call bell system. UCO said they told her that a new system was to be installed the following week; however, this was delayed because of a COVID-19 outbreak at the care home.
13. That same evening (8 April), at approximately 9.43pm, Mrs B was again found on the floor by her door. Clinical notes outline that Mrs B was again settled back into bed and that the bed was lowered and a padded impact mat put on the floor (although it appears this was only discussed and not implemented until 11 April 2022). There is no evidence that an incident form was completed for this second unwitnessed fall on 8 April 2022 or that Mrs B's EPOA was informed. UCO recognised this was a departure from its policy. It is unclear whether an RN assessed Mrs B after this further fall or before being moved back into bed or whether neurological observations were taken.
14. On 9 April 2022, it was documented that Mrs B was 'instructed to use call bell and wait for help prior to getting up in bed or chair' and that visual checks were to occur every 30 minutes. However, nothing is documented in the notes about the call bell system being reviewed after it was found to be not working the previous evening or that 30-minute checks were maintained.
15. On the morning of 16 April 2022, clinical notes show that Mrs B's toilet light was not working properly and that 'a bell or whistle is also needed'.⁶
16. On 17 April 2022, at approximately 3pm, Mrs B was found kneeling on the impact mat beside her bed, although UCO stated it was unclear whether this was the result of a fall. There is no evidence of a post-fall assessment, an incident report being completed, or the EPOA being informed.
17. On 18 April 2022, at approximately 9.30pm, Mrs B sustained another unwitnessed fall. UCO stated that there is no evidence that Mrs B's EPOA was notified of this fall, and, although neurological observations were commenced, only a few entries were documented. It

⁴ The falls policy states that: '**For all unwitnessed falls**, commence with neurological observations; these will be done 1/2 hourly for two (2) hours, these are to be continued 4 hourly for 72 hours.'

⁵ The falls policy requires a falls incident to be completed in eCase and for the RN to notify the whānau.

⁶ The falls policy requires that environments are as safe as possible and that all areas of the facility are well lit to minimise the risk of falls.

appears that an RN completed a post-fall assessment at the time, with a clinical note reporting that Mrs B was very sleepy during the post-fall assessment.

18. On 21 April 2022, at approximately 2.40pm, Mrs B experienced a witnessed fall. An RN assessed her and noted no injuries. An incident report was completed, but there is no evidence that the EPOA was informed of this fall.
19. UCO acknowledged the failure to communicate falls to Mrs B's EPOA, the lack of documentation and follow-up of fall events, and the departures from its policies.

In-house clinical advice

20. In-house clinical advice was provided by RN Jane Ferreira (**Appendix A**), who has extensive aged care nursing experience. She identified a number of issues with the care provided to Mrs B.
21. RN Ferreira advised that UCO's management of the issues with its call bell system was a **moderate to significant departure** from accepted practice standards for the following reasons:
 - A lack of regular communication with residents and their family/whānau regarding the call bell system;
 - No discussion of safety strategies with staff about how to keep all people safe; and
 - No clinical leadership or risk management plan to ensure health and safety needs were met and maintained during this period.
22. RN Ferreira advised that the falls prevention and management strategies offered to Mrs B were a **moderate to significant departure** from accepted practice standards for the following reasons:
 - The care plan did not include a discussion of nursing admission assessments/specific care; safety/monitoring requirements; possible triggers of fall events or relevant prevention strategies; discussion regarding call bell use, access, preferred location, or positioning; frequency of relevant safety checks; pain interventions; smoking cessation advice; or discussion of requirements for room configuration to reduce the risk of falls; and
 - There is no evidence of shift handover communication or a plan for clinical oversight of a resident at high falls risk during their settling-in phase and while managing the associated risks of the faulty call bell system.
23. RN Ferreira advised that the management of Mrs B's falls represented a **moderate to significant departure** from accepted practice standards for the following reasons:
 - Failure to communicate Mrs B's falls to her EPOA;
 - A lack of documentation and follow-up of fall events (including event evaluation, corrective actions, or improvement opportunities); and
 - Inconsistencies in the monitoring, completion and reporting of post-fall observations.

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Changes made

24. UCO reported that the following changes have been introduced since these events:
- The call bell system was replaced in May 2022. An external report from the Ministry of Health | Manatū Hauora indicated that the outstanding audit criteria were assessed as met on 14 September 2022.
 - InterRAI Clinical Assessment Protocol scores were integrated into care plans from 2022 to highlight priority areas requiring attention, such as a resident's falls risk.
 - Falls Management training was completed in 2024. Also in 2024, managers and RNs received formal 'Identify, Situation, Background, Assessment, and Recommendation' (ISBAR) training, which is now an annual training requirement.
 - Its clinical incident management has been strengthened with clear policies and streamlined processes.
 - Following the implementation of its eCase client management system, incident reporting has become more consistent, with managers notified and required to complete timely reviews. National oversight has improved through daily monitoring via the 'Resident of Concern' register.
 - The Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Severity Assessment Code rating and triage tool for adverse event reporting has been implemented to prioritise the completion of adverse event reviews, with all reportable incidents tracked to meet HQSC timelines.

Response to provisional report

25. Ms A was given the opportunity to comment on the 'information gathered' section of the provisional report. Ms A said that UCO is still not providing her mother with an appropriate standard of care.

Decision: UCO – breach

26. This case highlights the importance of appropriate falls risk assessment and management for at-risk consumers. As a healthcare provider, UCO is responsible for providing services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). In reaching this opinion, I have considered the advice provided by RN Ferreira.
27. Mrs B was assessed as a high falls risk and therefore appropriate falls risk strategies, including a detailed care plan, should have been implemented. I accept RN Ferreira's advice that Mrs B's care plan lacked critical information, including (but not limited to) safety and monitoring requirements, triggers to fall events, requirements for room configuration, and discussion regarding call bell use.
28. In addition, I accept RN Ferreira's advice regarding the call bell system and am critical that the intermittent faults were not adequately managed, in particular, that residents' family/whānau were not informed of the issues and that no risk management plan was implemented. Although I appreciate that technological issues do arise, in my view UCO should have done more to mitigate the risks that came with a faulty call bell system, particularly given Mrs B's high falls risk.

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

29. Furthermore, I am critical of UCO's management of Mrs B's falls. As noted by my advisor, 'communication with a resident's nominated representative is a significant part of service provider responsibilities,' and it appears that Mrs B's EPOA was repeatedly not informed of her falls. I am critical that corrective actions were not undertaken after these falls, particularly on 8 April 2022, when Mrs B sustained two falls within a very short period of time for the same reasons (wanting a cigarette), and that incident reports were not consistently completed.
30. UCO is responsible for adhering to specific policies and procedures. In my view, there were multiple deviations from UCO's Falls Assessment and Management policy, including:
- Failure to properly assess Mrs B's falls risk and documenting a thorough falls prevention management plan;
 - Failure to minimise Mrs B's falls risk by not identifying causative factors (such as smoking) or ensuring appropriate equipment was available (the lack of a reliable call bell system, not implementing the impact mat, and not addressing the faulty toilet light sooner);
 - Moving Mrs B before a post-falls assessment was undertaken;
 - Lack of RN assessments after Mrs B's falls;
 - Failure to commence and/or continue neurological observations after the falls;
 - Failure to notify Mrs B's EPOA after each fall; and
 - Failure to complete incident reports.
31. I consider that, following this policy in full would likely have mitigated these events and deficiencies in care. I am therefore of the opinion that UCO is in breach of Right 4(2) of the Code.⁷

Inadequate cultural recognition – other comment

32. I also take this opportunity to highlight the importance of cultural recognition and integration into patient care. As noted by RN Ferreira, the Ngā Paerewa Health and Disability Service Standards (HDSS)⁸ and Age-Related Residential Care (ARRC) Services Agreement require service providers to interact with family/whānau to support effective, consumer-focussed care delivery. Furthermore, the HDSS requires providers to be responsive to consumers' identity and recognise their tino rangatiratanga and Māori mana motuhake.
33. Ms A told HDC that Mrs B is a kuia and advised HDC of her iwi.
34. I am concerned about the minimal acknowledgement of Mrs B's cultural identity and needs as a wahine Māori in her care plan, with no meaningful discussion of a relationship between falls risk, cultural responsibilities, and care outcomes. I am also concerned about the lack of communication between UCO and Mrs B's whānau, not only about the fall events but also

⁷ Right 4(2) of the Code states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

⁸ [NZS-81342021.pdf](#).

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

about the call bell situation. It is important that providers appreciate the significance of family/whānau involvement in residents' care, and I agree with RN Ferreira that this 'presents [an] improvement opportunity.'

Recommendations and follow-up actions

35. I recommend that UCO:
 - Provide a written apology to Mrs B and her whānau for the failings identified in this report. This apology is to be sent to HDC for forwarding to the whānau within three weeks of the date of this report.
 - Audit current compliance with its falls policy and identify areas for improvement. Particular focus should be given to incident reporting, post-falls assessments and EPOA notification. A summary of the audit findings with corrective actions as required is to be provided to HDC within three months of the date of this report.
36. UCO underwent a certification audit by HealthCERT in December 2024. It was certified for three years. A mid-point surveillance audit is due in approximately July 2026. Notwithstanding the passage of time and the remedial actions UCO has implemented in the four years since the complaint was made, HealthCERT will be asked to ensure that the auditors pay particular attention to the deficiencies in care identified by this investigation. If there is non-compliance with the relevant Health and Disability Services Standards, UCO will be required to undertake corrective actions and report their completion to HealthCERT.
37. A copy of this report with details identifying the parties removed, except Ultimate Care Oakland and the clinical advisor on this case, will be sent to HealthCERT at the Ministry of Health | Manatū Hauora and Health NZ Hauora a Toi Bay of Plenty and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall

Deputy Health and Disability Commissioner

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: In-house clinical advice to the Commissioner

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

CLINICAL ADVICE – AGED CARE

CONSUMER : Mrs [B]

PROVIDER : Ultimate Care Oakland

FILE NUMBER : C22HDC00991

DATE : 2 June 2023

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Ultimate Care Oakland. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
2. **Documents reviewed**
 - Letter of complaint received 27 April 2022
 - Provider response dated 15 June 2022
 - Clinical records, including falls risk assessments, care plans, progress notes, neurological observations, physiotherapy records, incident report summary
 - Organisation's Falls Assessment and Management Procedure and Neurological Observations guidelines
 - External certification audit report November 2021 with call bell findings and actions reported as complete 14 September 2022.
3. **Complaint**
[Mrs B]'s daughter has raised concerns regarding issues with the care home's call bell system and impact on her mother's safety between April and May 2022.
4. **Review of clinical records**
For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- The adequacy of steps taken to repair the call bell system and alternatives used when the call bell system was non-functional.
- Falls risk assessments and measures put into place to protect [Mrs B] and whether these were appropriate.
- Whether the actions taken after each of [Mrs B]’s falls were adequate.
- The adequacy of documentation relating to falls.
- Any other comments you wish to make.

Background

[Mrs B] was admitted to the care home at hospital-level care from [a] hospital on 6 April 2022 following a recent stroke with left-sided weakness. According to clinical file records, her medical history included a right terminal internal carotid artery aneurysm, migraines, stroke and vascular dementia. Nursing information indicates [Mrs B] was assessed as a high falls risk and required carer assistance to reposition, mobilise and meet personal care requirements. [Mrs B] experienced five fall events during the timeframe in question, prompting her daughter to raise concerns regarding the care home’s call bell system and impact on [Mrs B]’s care and safety needs.

a) The adequacy of steps taken to repair the call bell system and alternatives used when the call bell system was non-functional.

An external certification audit completed in November 2021 identified issues with the call bell system, with the audit report outlining steps and timeframes for improvement. Section 31 of the Health and Disability Services (Safety) Act 2001 requires all certified providers to notify HealthCert regarding ‘any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided,’ such as issues or outages with call bell systems.

It is unclear from the provider response if a health and safety risk management plan was in place at the time of audit, given the identified concerns. It is also unclear what measures were commenced to ensure the health and safety needs of all residents were maintained while the call bell system was under review, or what organisational communication occurred with resident’s nominated representatives and wider stakeholders about the system issues, which would be accepted practice.

The provider response has discussed concerns with call bell function, noting there were intermittent issues with the existing system at the time of [Mrs B]’s admission in April 2022 and that some resident’s call bells did not always work properly at first attempt. The provider has advised that the usual process for residents to call for assistance is to use a call bell or to stand on a sensor mat. Given the identified issues, it is unclear what information was communicated to [Mrs B] and her family/whānau about call bell use and care and safety needs, or what process was put in place to support [Mrs B] as she orientated to her new environment.

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

The provider has discussed alternative strategies used by the care home team in response to call bell faults in April 2022, which included increased frequency of visual safety checks (intentional rounding) and that whistles were provided to residents to make their needs known to staff. It is unclear what nursing assessment occurred to determine resident ability to safely use the device. While whistles may be used as a signalling tool by people in the case of medical emergency in some settings, preferred practice for call system failures in an aged care setting is the use of hand bells, unless clinically indicated, partnered with a coordinated plan of intentional rounding. Given the extended timeframe of faults or outages, it would be expected that essential equipment was available with a hazard management plan in place to guide duty teams as part of the care home's clinical and operational responsibilities.

It is unclear if the organisation had a call bell policy in place at the time as there does not appear to be supporting information of this within the evidence bundle. Given the potential risk to resident health and safety, it would be expected that a call bell policy provide guidance to staff regarding service responsibilities, such as expected timeframes for responding to calls, pager use and the call escalation process, management of call bell outages with alternative call solutions, maintenance checks, reporting of faults and how to respond to health and safety issues or clinical events. Staff orientation, health and safety training and ongoing education requirements are also indicated areas for policy inclusion to ensure the team hold the necessary skills to keep residents safe. I note from the response that the Head of Resident Care was in the process of considering short-term alternatives for call bell outages, which presents an improvement opportunity.

The provider advised that the call bell system was replaced in May 2022, and an external report reflects that the outstanding audit criteria was assessed as met on 14 September 2022. The provider has commented that 'according to resident, family, manager and staff feedback the new call bell system is working well'; however, there is no evidence supplied to support this in the form of a call bell report depicting response times, an audit tool, letter of communication, survey or meeting minutes, which would be accepted practice for significant event evaluation per quality improvement methodology.

From the information reviewed to respond to this question, it appears there were system and practice concerns at the time. There does not appear to be evidence of regular communication with residents and their family/whānau regarding the call bell system or discussion of safety strategies with staff about how to keep all people safe.

There is no evidence of clinical leadership or a risk management plan to ensure resident and staff health and safety needs were met and maintained during this period. I consider there to be moderate to significant departures from accepted practice standards, and this would be viewed similarly by my peers.

Departure from accepted practice: Moderate to significant

b) Falls risk assessments and measures put into place to protect [Mrs B] and whether these were appropriate

The Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Reducing Harm from Falls programme, quality improvement toolkit, falls resources and Frailty Care Guides are key points of support for service providers when considering falls prevention and management strategies (HQSC, 2019). The organisation's Falls Assessment and Management Procedure (January 2022) provides guidance regarding falls risk assessments and how to respond to fall events (actual or suspected). The document states that falls risk will be assessed on admission using the eCase Mobility and Transfers Assessment to inform the initial care plan, with interventions reviewed within 21 days, six monthly or as indicated.

Admission information in the clinical record states that [Mrs B] was at risk for falls, was able to weight-bear and used a Steady Eddy to transfer with x2 carer assistance but did not mobilise. The entry states an interim care plan was completed with [Mrs B]'s EPOA but there is no discussion of nursing admission assessments or specific care, safety or monitoring requirements commenced at this time. There is no evidence of orientation provided to [Mrs B] or her family/whānau to support her settling-in phase as a new resident to the care home, which would be accepted practice.

The interim care plan refers to a recent falls history while in hospital, reporting a frequency of daily falls. The plan provides information regarding her mobility, transfer and personal care needs but does not provide information about possible triggers to fall events or relevant prevention strategies. There is no discussion of any specific requirements for room configuration or access to meaningful items to reduce the risk of over-reaching or falling from bed given her left-sided weakness and visual impairment. File information indicates that [Mrs B] required the assistance of a call bell to communicate with staff; however, her care plan does not provide discussion of call bell use, access, preferred location or positioning, or frequency of relevant safety checks, with no evidence of monitoring forms provided.

[Mrs B] was seen by a nurse practitioner (NP) on 7 April 2022 as part of the admission process. Consultation notes discuss the recent removal of an indwelling urinary catheter and potential risk of urinary retention with orders to ensure optimum urinary function. There is no evidence that a short-term care plan was commenced to guide continence requirements given her recent stroke, including a fluid balance chart to monitor intake and output supported by a personalised toileting plan. There is no discussion of personal care requirements, potential signs of retention or urinary infection and the relationship to falls risk, prevention and management, which would be accepted practice in the circumstances.

The care plan indicates that [Mrs B] experienced pain but does not discuss location, type, scale, duration or any relevant interventions that may reduce the risk of restlessness, pain or distress. The document refers to [Mrs B]’s daily routine, which included smoke breaks, with a goal to reduce smoking to three per day or less; however, there is no further guidance provided regarding smoking safety, risks with cessation or specific support required to manage unmet needs, which would be accepted practice.

The Falls Risk Assessment Tool (FRAT) shows [Mrs B]’s assessed fall status as high, acknowledging automatic risk factors; however, these do not appear to be well discussed in care planning. The Mobility and Transfer Assessment and care plan summary completed 5 May 2022 reflect InterRAI assessment scores of 30 April 2022, which indicate improvement in mobility and functioning; however, there is no evidence that planned interventions from admission were reviewed and evaluated by the RN team as part of responsibilities to the nursing process per falls policy timeframes. There appear to be discrepancies in reporting, with the falls screening tool recording a history of falls as ‘no’. It is unclear if [Mrs B]’s incident management history was reviewed at this time to inform nursing assessments and care planning. The tool states ‘yes’ to agitated, impulsive, or unpredictable behaviour, and ‘yes’ to overestimate/forget limitations; however, there is no evidence of further analysis or interventions commenced in response to the assessment to support [Mrs B]’s mobility and safety needs.

The falls screening tool asks about a resident’s cultural background, but the significance of this information and relevance to [Mrs B]’s care is unclear. There is minimal acknowledgement of [Mrs B]’s cultural identity and needs as Māori in her care plan, with no meaningful discussion of a relationship between falls risk, cultural responsibilities and care outcomes, which presents improvement opportunity.

It is unclear what information, training and support was provided to the care home team prior to [Mrs B]’s admission to ensure her care, cultural and safety needs were able to be met and maintained. There is no evidence provided of shift handover communication or a plan for clinical oversight of a high-falls risk resident during the settling-in phase, while managing the associated risks of the faulty call bell system.

From the evidence reviewed to respond to this question, I consider the falls prevention and management strategies offered to [Mrs B] to be of the minimum standard of practice under the circumstances. There are opportunities for improvement relating to clinical leadership, care oversight, nursing assessment and care planning, and systems and process standards concerning communication and documentation standards, which would be viewed similarly by my peers.

Departure from accepted practice: Moderate to significant.

c) Whether the actions taken after each of [Mrs B]’s falls were adequate.

The provider response, clinical notes and resident incident report summary reflect that [Mrs B] experienced seven falls (five reported and three unreported fall events) following her admission on 6 April 2022. The provider response has included an event timeline, which outlines the fall events, but the supporting information does not provide discussion of event evaluation, corrective actions or improvement opportunities which would be considered accepted practice as a part of incident management responsibilities.

The organisation’s Falls Assessment and Management Procedure (January 2022) provides guidance for first responders and ongoing care, stating that residents will be assessed for signs of injury before being moved, with escalation steps, which aligns to falls management guidance in the Frailty Care Guides (HQSC, 2019). The Neurological Observations Guidelines discuss related actions and organisational post-fall monitoring for assessed low-grade unwitnessed falls events, with reference to the Falls Assessment and Management Procedure. It may be helpful to consider referencing a moving and handling policy and associated learning material to support staff training or competency requirements.

The record reflects that at 3.30pm on 6 April 2022, staff found [Mrs B] lying on the floor of her bedroom, positioned on her left side, following an unwitnessed fall event. The RN progress note entry states that [Mrs B] was repositioned and hoisted off the floor back onto bed, limbs were checked, able to move all limbs, left arm a bit sore. It is unclear if a primary assessment was completed prior to hoisting [Mrs B] per falls policy guidelines, if her skin integrity was reviewed or a pain assessment completed for the left arm pain, which would be accepted practice in the circumstances. Neurological observations were commenced per unwitnessed fall protocol; however, there appear to be discrepancies in the recorded timeframes. It appears from the incident event record that an incident form was completed; however, there is no record that [Mrs B]’s EPOA was informed as part of service provider responsibilities.

On 7 April, [Mrs B] was seen by the NP and physiotherapist to complete admission documentation and a post-fall assessment, which is accepted practice. Supporting clinical documentation is comprehensive and provides clear guidance regarding [Mrs B]’s ongoing care and safety needs. It is unclear if the interim nursing care plan was updated to reflect revised interventions given the identified falls risk.

At 9pm on 8 April 2022, [Mrs B] was found lying on the floor next to her bed.

File information reflects that [Mrs B] had rolled out of bed and wanted a smoke. A post-fall assessment occurred, [Mrs B] was hoisted back to bed and her EPOA was called about the fall event at 9.39pm; however, there is no evidence of a supporting entry in a family/whānau record, if unmet needs or triggers to restlessness were considered, or an ongoing management plan commenced.

The record shows that [Mrs B] was found half an hour later at 9.30pm by her door, reportedly trying to find a cigarette. File information reflects she was offered a change of environment but chose to return to bed assisted by two staff. Fall prevention interventions are noted with bed lowered and the impact mat in place; however, there is no evidence that [Mrs B]'s call bell was checked, a hand bell offered, a sensor mat introduced to alert staff, or intentional rounding commenced to maintain safety needs. As outlined by the provider, there is no evidence that an incident form was completed for the second event or that [Mrs B]'s EPOA was informed, which was acknowledged as a departure from the organisation's event process, and below accepted practice standards.

A progress note entry on 9 April states that [Mrs B] was found by a carer crawling out of her room. File information states the carer reportedly activated the emergency call bell per falls protocol but that the bell did not appear to be working. The falls policy instructs staff to deal promptly with hazards as they arise. It is unclear if the care home had a health and safety plan in place to guide staff actions given the ongoing concerns with the call bell system, if the manager or maintenance teams were informed, or if an incident report was logged, which would be accepted practice in the circumstances.

File information states that [Mrs B] was able to 'crawl back up to her bed', and that an RN was informed of the event; however, there is no evidence that she was assessed by an RN at the time or over the next 24 hours. This approach would not be considered to be in line with accepted falls management principles or moving and handling guidelines, and would be considered below the accepted standard for delivery of appropriate, dignified and respectful care.

The progress note entry states that [Mrs B] described crawling down the bed to go to the toilet and that she was reminded to call for help prior to moving from bed; however, it is unclear if call bell education was offered or evidence that increased monitoring or a smoking or toileting plan was commenced to support unmet needs.

It appears that an incident form was not completed for an unwitnessed fall event or that [Mrs B]'s EPOA was informed. Progress notes discuss the use of a padded impact mat, but it appears that a sensor mat was only implemented on 11 April as a safety intervention.

On 17 April 2022, [Mrs B] was found kneeling on the impact mat beside her bed. It is unclear if the sensor mat was operational and triggered to alert staff or if it was checked as part of falls investigation responsibilities. There is no evidence that a post-fall nursing assessment was provided, an incident report completed or that the EPOA was informed.

On 18 April 2022, [Mrs B] was found crawling along the corridor in the early morning by staff (event time unclear). She was reportedly 'redirected back to her room and assisted by staff onto her chair.' According to the physiotherapist assessment, mobility and transfer information and progress note entries in the

clinical file, [Mrs B] required the use of a Steady Eddy mobility aid and two staff to assist her to transfer at this time. Again, this approach would not be considered to be in line with accepted falls management principles or moving and handling guidelines, and would be considered below the accepted standard for delivery of appropriate, dignified and respectful care. There is no evidence that a post-fall nursing assessment was completed by an RN or delegated member of the care team. The provider has identified discrepancies with incident documentation and reporting responsibilities, noting that the EPOA was not informed of the event.

A progress note entry at 3.04am on 19 April 2022 reports that [Mrs B] was found lying face down beside her bed at 9pm, but the rationale for delayed reporting is unclear. It appears a post-fall assessment was completed at the time by an RN, with a second progress note entry at 3.36am reporting that [Mrs B] was very sleepy during the post-fall assessment. It appears neurological observations were commenced at 9.30pm on 18 April 2022 and repeated at 10pm, 10.30pm, and 11pm. Neurological observations were recorded once on 19 April at 3.39am, then recommenced on 20 April at 7.05am, 11.10am, 3.24pm, and 7.30pm; however, there is no evidence of RN analysis or neurological observations or further nursing assessment provided within nursing notes. As outlined in the provider response, there is no evidence that an incident report was completed or that her EPOA was informed, which is a departure from accepted practice standards. It is also unclear if the clinical manager and NP were informed of the fall event and guidance sought regarding ongoing care and monitoring requirements given the additional falls and possible head injury.

The resident incident record reflects that, at 2.40pm on 21 April 2022, [Mrs B] experienced a witnessed fall event without injury. Progress notes completed at 2.58pm indicate she was assessed by an RN, but there is no discussion of contributing factors or review of safety measures noted. The provider has confirmed that an incident report was completed; however, it appears the EPOA was not informed of the fall event.

The Ngā Paerewa HDSS and ARRC Services Agreement require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in the resident's health condition or of any adverse event. As outlined in the provider response, it appears that [Mrs B]'s EPOA was not updated regarding the fall events, which is considered accepted practice, as outlined in (13) of 6F3 Falls Assessment and Management Procedure, and Frailty Care Guide flowchart: 'always inform relatives of any falls and record the discussion.' There is no record of communication provided to reflect that [Mrs B]'s nominated representative and primary contact was informed of each fall event, in line with accepted incident management practice standards.

The Frailty Care Guides define a fall as ‘any unintentional change in position where the person ends up on the floor, ground or other lower level; includes falls that occur while being assisted by others’ (HQSC, 2019). The supporting flowchart outlines recommended post-fall assessment actions with clear guidance to inform nursing responsibilities and clinical decision-making. It is unclear from the information reviewed why three fall events were unreported by the care team. The Low Grade Fall Neurological Observation Guide (6F4) outlines the organisation’s expectations and documentation requirements for events where a resident displays known behaviours of placing themselves on the floor. There is no evidence that [Mrs B] was assessed as meeting this criterion. There is no evidence that behaviour charts were commenced in response to the reported events on 8 and 18 April 2022, with no related guidance noted in [Mrs B]’s care planning regarding falls risk versus behavioural criteria or insight to personal safety needs.

[Mrs B]’s daughter and EPOA raised concern regarding [Mrs B]’s swollen ankle and delayed care on 5 May 2022. The care record reflects that [Mrs B] was identified with a swollen left ankle on 10 April 2022. She was assessed by an RN, who reported that the left ankle was slightly swollen with no pain, query oedema. It is unclear if a pain assessment was completed, supportive first aid measures applied, falls history reviewed or concerns escalated to the NP for further assessment. There is no evidence that a short-term care plan was commenced or related communication shared with the EPOA, which would be accepted practice in the circumstances. File information reflects that [Mrs B] had experienced three unwitnessed events between 8 and 9 April 2022 where she was found on the floor.

The Low Grade Fall Neurological Observation Guide (6F4) states that it is the responsibility of each oncoming RN to complete a physical assessment for bruising and pain and one full set of neurological observations per eight hours and handover to the incoming shift. There is limited evidence that nursing assessments were completed per policy over the next shifts, or related care and safety needs reviewed collaboratively by the nursing team. [Mrs B] was seen by a physiotherapist on 11 April, 13 April and 5 May 2022 with comprehensive assessment notes discussing function and range of motion, but it is unclear if this was communicated to [Mrs B]’s EPOA by the RN team, which would be accepted practice.

There is limited evidence of falls analysis completed by the clinical team or a review of strategies to maintain [Mrs B]’s safety needs, as outlined in the Falls Assessment and Management procedure for residents who fall frequently. It is unclear what maintenance checks occurred post-fall to ensure her call bell or sensor mat were operational or if environmental factors such as lighting, flooring or handrails were safe. A progress note entry on 16 April stated that the toilet light was not working properly and that a bell or whistle was needed. It is unclear if [Mrs B] wore hip protectors, if footwear was reviewed, or

alternative strategies such as a mattress perimeter guard, chair-exit sensor or beam were considered as part of responsibilities to the falls review process.

From the evidence reviewed to respond to this question, there appear to be moderate to significant departures from accepted practice standards regarding falls management, effective communication and documentation standards, which would be viewed similarly by my peers. Evidence of communication with a resident's nominated representative is a significant part of service provider responsibilities and a fundamental part of the nursing process. The apparent lack of communication between the care home and [Mrs B]'s EPOA, and related safe documentation and follow-up of fall events presents a serious departure from the accepted standard of care and would be viewed similarly by my peers.

Departure from accepted practice: Moderate to significant

d) The adequacy of documentation relating to falls

The provider response has acknowledged there are identified areas for practice improvement regarding nursing assessment and care planning, incident management, the application of organisational policies or guidelines to practice, communication and documentation standards. As discussed in responses to the above questions, there is room for improvement regarding the timely completion of nursing assessments to identify actual or potential risks to resident health and wellbeing, and the associated responsibilities of the nursing team to collaboratively plan, deliver and evaluate care in both verbal and written form, in partnership with family/whānau.

As identified in the provider response, there are inconsistencies in the monitoring, completion and reporting of post-fall observations. The organisation's Falls Assessment and Management Procedure (8) states that neurological observations will be completed half-hourly for two hours then continued four-hourly for 72 hours for all unwitnessed falls, unless otherwise clinically indicated. However, guidance on the organisation's Neurological Observation Chart states '*Neurological Obs = 15 minutes for first hour then every 30 minutes for 3 hours*', which differs from the Falls procedure and wider recommended approaches to health monitoring (HQSC, 2019). Organisational policies and procedures are implemented to provide guidance to staff regarding actions and expectations for care and service delivery. It is unclear if the care home team had been trained on the care home's policy for falls management, requirements for taking neurological observations, and related post-fall responsibilities, which presents an opportunity for improvement.

The HDSS standards and ARRC contractual responsibilities require service providers to interact with family/whānau to support effective, consumer-focussed care delivery.

There is no evidence of a family/whānau contact record to reflect the frequency of interactions between the parties involved, which is part of service provider responsibilities and accepted documentation standards. It is unclear if meetings

Names have been removed (except Ultimate Care Oakland t/a Alden Ultimate Care – Oakland and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

were held with [Mrs B] and her EPOA in response to concerns raised regarding the call bell system, fall events and care concerns. There is no evidence of meeting minutes outlining corrective actions or an agreed approach toward quality improvement initiatives in the evidence bundle.

From the evidence reviewed to respond to this question, it appears there are departures from accepted standards of practice in the circumstances, with identified opportunities for improvement with complaint management processes, clinical leadership and documentation standards.

Departure from accepted practice: Moderate to significant

5. Clinical advice

I note that the events occurred during the COVID-19 pandemic period of 2020–2022 and would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams and health service providers during this time.

Based on this review, I recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring that changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the family in the resident's clinical record and implementing the use of the ISBAR communication tool to better inform clinical assessments, actions and safe, evidence-based decision-making.

To support this approach, I recommend that the care home team complete the new HDC online modules for further learning -

<https://www.hdc.org.nz/education/online-learning/>

Jane Ferreira, RN, PGDipHC, MHLth

Nurse Advisor (Aged Care)

Health and Disability Commissioner

References

Health and Disability Commissioner. (2022). Online Learning.
<https://www.hdc.org.nz/education/online-learning/>

Health Quality & Safety Commission Te Tāhū Hauora. (2019). Frailty Care Guides. <http://www.hqsc.govt.nz/>