Rest Home

Registered Nurse, RN C

Registered Nurse, RN D

Registered Nurse, RN E

Registered Nurse, RN F

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC01545)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman following two falls while she was a resident at a rest home — in particular the failure to perform neurological observations for an appropriate length of time after each fall, and the management of her condition following the falls. The report also concerns the adverse event management by the Facility Manager.

2. The report highlights the importance of conducting neurological observations following a fall that involves injury to the head — and the importance of continuing the observations when a resident is asleep — and of having in place adequate policies and training for staff on neurological observations and falls.

Findings summary

3. The Deputy Commissioner found the rest home in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). The policy on neurological observations did not align with the rest home's Neurological Observations Sheet, and its policy did not include guidance on best practice standards for the frequency of neurological observations. The Deputy Commissioner was critical that staff members had not been trained on the rest home's policy and requirements for undertaking neurological observations following a fall, and concluded that the failure to conduct adequate neurological observations was attributable to systemic issues at the rest home.

4. The Deputy Commissioner found three nurses in breach of Right 4(1) of the Code, primarily for the deficiencies in the care they provided to the woman following her falls.

5. The Deputy Commissioner also criticised one nurse's adverse event management.

Recommendations

6. The Deputy Commissioner recommended that the nurses apologise to the family, and undertake further training on falls and neurological observations.

7. The Deputy Commissioner recommended that the rest home: (a) apologise to the family; (b) review its Neurological Recordings Policy and Neurological Observations Sheet, arrange training for its staff on the updated Neurological Recordings Policy, and audit its compliance with the Neurological Recordings Policy; (c) report back to HDC on the outcome of its consultation with an external consultant; and (d) ensure that the advice and recommendations from HDC's expert have been addressed fully.

Complaint and investigation

8. The Commissioner received a complaint from Ms B about the services provided to her aunt, Ms A (deceased), by the rest home. The following issues were identified for investigation:

- *Whether the rest home provided Ms A with an appropriate standard of care in 2017.*
- *Whether RN C provided Ms A with an appropriate standard of care in 2017.*
- *Whether RN D provided Ms A with an appropriate standard of care in 2017.*
- *Whether RN E provided Ms A with an appropriate standard of care in 2017.*
- *Whether RN F provided Ms A with an appropriate standard of care in 2017.*

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

10. The parties directly involved in the investigation were:

Ms A	Consumer
Ms B	Complainant
Rest home	Provider
RN C	Registered nurse
RN D	Registered nurse
RN E	Registered nurse
RN F	Facility Manager

11. Further information was received from:

Dr H	General practitioner
Ambulance service	

12. Also mentioned in this report:

RN G	Registered nurse
RN I	Registered nurse

13. Independent expert advice was obtained from Registered Nurse (RN) Sheryl Lilly, and is included as Appendix A.

Information gathered during investigation

Introduction

14. On 14 Month1,[1] Ms A was admitted to a rest home and hospital[2] (the rest home) for long-term care. Ms A had been diagnosed with Alzheimer's disease and dementia.

15. This investigation concerns the care Ms A received at the rest home — in particular, the frequency of neurological observations by the nursing staff following falls on 26 Month1 and 1 Month2, and the communication with the ambulance service following the fall on 1 Month2 and subsequent management of the adverse events.

Falls risk — admission assessment

16. At the time of her admission, Ms A's Coombe Assessment for Prediction of Falls Risk[3] was calculated at 21, indicating that she had a high risk of falls. A long-term care plan was prepared, which noted Ms A's high falls risk and that more monitoring and assistance was required when Ms A moved. A short-term care plan was also prepared, which noted Ms A's high falls risk and that more monitoring of her movement was required, and that her environment was to be clutter free. A Mobility Support Guide[4] was completed.

Fall on 26 Month1

17. At 2.20pm on 26 Month1, Ms A had an unwitnessed fall. She was found by RN G (who was on duty from 7am to 3pm). RN G checked Ms A's vital signs and condition and noted that there was some swelling around the back of Ms A's head. RN G recorded the incident in the progress notes and completed an adverse event form, which noted: "[F]ound [Ms A] on the floor. Lying back [and] head down." The Facility Manager was informed, and neurological observations were started at 2.30pm. A Glasgow Coma Scale (GCS) examination[5] was conducted but no GCS scores were calculated, and the Neurological Observations Sheet notes the GCS examination as "stable".

18. RN G completed neurological observations at 3pm (at the end of her shift), and noted these on the Neurological Observations Sheet. The observations remained stable but no GCS scores were calculated. RN G told HDC that she "verbally handed over to the evening [nurse] [RN C] who started at [3pm] on 26 [Month1], to continue monitoring neurological observations".

19. At 3.30pm, RN C (who was on duty from 3pm to 11pm) contacted Ms B regarding the fall, and this was noted in the Family Contact Sheet. He completed further neurological observations at 3.30pm, 4.30pm, and at 8.30pm, and noted these on the Neurological

[1] Relevant months are referred to as Months 1–3 to protect privacy.
[2] The facility has over 50 beds and offers dementia care.
[3] A tool for predicting falls risk: risk level 5–9 = low/no risk, 10–15 = medium risk, 16 or more = high risk.
[4] This form identifies when patients require assistance when they move, such as getting into bed or standing up from the bed.
[5] A GCS examination includes checking eye-opening response, verbal response, and motor response. Normally a GCS score is calculated following the examination. The highest score is 15 (fully conscious), and the lowest score is 3 (comatose or dead).

Observations Sheet and recorded that the GCS examination was stable, but did not calculate GCS scores. RN C told HDC:

> "[N]eurological observation was not done after 8.30pm because [Ms A] was already asleep and to wake her up to check her observations would only agitate her and the observations would not be accurate."

20. RN C said that he "realised he should have continued monitoring" Ms A.

21. At 11pm, RN E started her shift (she was on duty from 11pm to 7am). She received a handover from RN C, and said that she was told that "[Ms A] had been stable [and] her usual parameters such as vital signs and neurological observations were stable". RN E did not conduct any neurological observations during her shift. She said that her shift started 8.5 hours after the fall, and that according to the handover from the previous shift, observations were within normal parameters, so she let Ms A sleep. RN E recorded the following in the progress notes at 4.35am:

> "Settled and sleeping most of the shift. Checked regularly. Kept her warm and comfortable. Pad checks done. Nil concerns raised by care staff."

22. RN G commenced her shift at 7am on 27 Month1. At this time there was a regular general practitioner (GP) round visit, and Ms A was reviewed by Dr H. RN G informed Dr H of Ms A's fall the previous day. Dr H said that she reviewed the incident report and the Neurological Observations Sheet, and noted that Ms A's observations had been stable since the fall. Dr H told HDC that she undertook a full body survey and noted that Ms A was not in obvious pain, there was no evidence of a neurological deficit, and there were no bruises anywhere other than a 2cm egg-shaped contusion to the back of her head. These details were also recorded in the Doctors Medical Notes.

23. Dr H said that she discussed with RN G the need to continue neurological observations for a full 24 hours, and that the observations could be stopped if Ms A remained stable. Dr H advised that a restraint should be used, and RN G prepared a care plan for the use of restraint and the care following the fall. Consent for the use of the restraint was obtained from Ms B.

24. RN G completed neurological observations at 7am, 11am, and 2pm, and noted on the Neurological Observations Sheet that the observations were stable. No GCS scores were documented. RN G said that she "continued the neurological observations 4 hourly in [her] shift to complete the 24 hours".

Fall on 1 Month2

RN C's shift (2.30pm to 11pm)

25. At 5.30pm on 1 Month2, Ms A suffered a fall witnessed by RN C, who was on duty at the time. RN C completed an adverse event form and recorded:

> "[Ms A] was agitated, she kept on standing on the wheelchair, her gait was not good … she was made to sit down a couple of times [and] the wheelchair tipped backwards."

26. The form also noted that there was a "lump at the back of her head". RN C also recorded this information in the progress notes, and noted that Ms A's "[next of kin was] informed by phone call". Ms B said that she was called around 8.30pm. No short-term care plan was prepared, and the Facility Manager was not informed. RN C said: "[A]s [Ms A's] neurological observation was stable plus the busy shift, I missed making a short term-care plan and missed informing the on-call manager."

27. RN C started neurological observations at 5.35pm, and further observations were conducted at 6pm, 6.30pm, 7.30pm, and 8.30pm. A GCS examination was noted to be stable, and this was recorded on the Neurological Observations Sheet, but no GCS scores were noted. The Neurological Observations Sheet documented that no observations were taken at 9.30pm and 10.30pm because Ms A was asleep. RN C told HDC:

> "I did the neurological observations, although I stopped at [8.30pm] as [Ms A] was asleep. I was aware of the head injury but because the recording was stable, and the resident was asleep I missed to continue doing it. I realised that I should have continue[d] monitoring and have changed my practice since then …"

28. RN C told the rest home that at 10.45pm he handed over Ms A's care to RN D, and told him that Ms A "had a fall at [5.30pm], has a big lump at the back of her head and she is on neurological observation".

RN D's shift (11 pm, 1 Month2 to 7am, 2 Month2)

29. RN D started his shift at 11pm on 1 Month2. He told the rest home that he "could not recall the handover [he] received on that day".

30. No neurological observations are recorded by RN D on the Neurological Observations Sheet. However, he told HDC that he believes he did complete neurological observations at the commencement of his shift at 11.30pm, but he "wrote them on a piece of paper and did not translate them in to the notes".

31. At 3.20am on 2 Month2, RN D recorded in the progress notes: "[Ms A] slept well, checked her a bit, pad changed, no new concerns." However, RN D told HDC:

> "I wrote notes at 3.20 am indicating that her pad had been changed. The carers would have changed her pad, I would not have attended to it personally … I do not have a recollection why I didn't undertake neurological observations during these times but believe that it is likely I was busy attending to the needs of other residents."

32. RN D told HDC that at the time of his shift on 1–2 Month2, the staff allocation was reduced in Unit 1 to only one healthcare assistant (HCA) rather than two, because one of the units of the hospital had fewer residents than usual. He said that Ms A was in Unit 2, but because there were fewer staff in Unit 1, mainly he based himself there to assist the HCA. RN D stated:

> "I believe that the staffing levels at [the rest home] at the time of [Ms A's] fall meant (particularly on night shift) that it was very difficult for the registered nurses to be as vigilant in attending to the needs of all 50+ residents as they ought to have been."

RN E shift (7am to 3pm 2 Month2)

33. RN E started her shift at 7am on 2 Month2. She told HDC:

> "I received the handover from [RN D] that [Ms A] had a fall at [5.30pm] on 1 [Month2]. But her parameters had been stable and she was in her usual self although she was agitated during the afternoon shift which was her usual self … and neurological observation were okay/within her normal parameters."

34. RN E did not conduct any neurological observations.

35. RN E told the rest home that when she arrived at the unit at 7am, both she and the HCA checked Ms A frequently and found her to be sleeping. RN E said that usually she does not work in the unit where Ms A was staying, and had limited knowledge of the residents. RN E stated that she was advised by the HCA that Ms A had not had enough sleep for the past few days, and so she decided not to wake up Ms A in the morning so that she could have more sleep.

36. RN E told HDC that her shift began 13.5 hours after the fall on 1 Month2, and she had been told at handover that Ms A's neurological observations were stable, so she let Ms A sleep.

37. RN E said that around 12.30pm, she went to wake Ms A as she thought she had been asleep long enough and she needed oral intake. At 1.35pm, RN E retrospectively recorded in the progress notes:

> "At [12.30pm], [Ms A] was found vomited and less responsive. Obs[ervations] taken: [Blood Pressure] 130/90 mmHg, [Pulse] 84 bpm, R[espirations] 24, Temp[erature] 37.2 [degrees Celsius], [Oxygen saturation] 93% on room air and BSL 6.6 mmol/L … hardly responding to verbal stimuli … discussed with [Ms B], niece, regarding [Ms A's] presentation. [Ms B] agreed to send [Ms A] for further investigation treatment … arranged ambulance for [Ms A] to transfer to hospital. Monitor closely."

38. At 1.10pm, RN E called an ambulance. According to the ambulance service's Audio Transcript, RN E told the call handler that Ms A had "dementia but she had a fall and then she became drowsy and less responsive". RN E did not describe the details of the fall or the head injury. The ambulance service told HDC that the call handler checked with RN E that the patient was safe to wait if there was a delay in an ambulance becoming available, to which RN E responded, "Yes." RN E told HDC: "[A]t that time, I felt it was not life threatening although it was urgent."

39. At 1.48pm, the call handler called the rest home to check Ms A's status. The call handler was advised that there were no changes to Ms A's condition. It was not recorded which staff member had this discussion with the call handler.

40. At 2.20pm, RN E made a second call to the ambulance service, as Ms A's condition had deteriorated. The Audio Transcript recorded that the call handler was advised by RN E that Ms A was now unconscious.

41. Ms B said that she was called around 2pm and informed that Ms A was now unconscious and that the ambulance had yet to arrive. Ms B said that she was told that the rest home would call her when the ambulance had left, so that she could go directly to the public hospital.

42. Following RN E's call at 2.20pm, the ambulance service first dispatched a single-crewed ambulance[6] to the rest home at 2.24pm, which arrived at 2.35pm. At 2.37pm, another ambulance was dispatched and it arrived at the rest home at 2.49pm.

43. Ms B said that after she was called around 2pm, she waited for about 40 minutes, and then called the rest home to check on progress. She was advised that "the ambulance had already left", so she went to the hospital immediately.

44. The ambulance arrived at the Emergency Department at 3.31pm. Ms B said that a doctor at the hospital told her that the ambulance staff had not been made aware that Ms A had fallen, and that Ms A had bled in her brain. However, the Ambulance Care Summary noted at 3.48pm states: "[Ms A had] a fall from bed yesterday hit head. Today [patient] becoming increasingly unresponsive during the day to point of unconsciousness." Similarly, this information was noted in the Transfer Information Form to the ambulance staff completed by RN E.

Subsequent events

45. At 9am on 3 Month2, the Facility Manager, RN F, was made aware of Ms A's fall on 1 Month2. RN F did not take any further action at this time.

46. On 21 Month2, Ms B told RN F that she wanted more details about the fall on 1 Month2. On the same day, at 2.10pm, RN F called Ms B to discuss the fall. RN F also filed a Complaints Form to note that Ms B had lodged a complaint. RN F commenced an internal investigation and sought statements from the relevant staff about the fall. She notified HealthCert and updated the adverse event form to note that HealthCert had been notified on this date.

47. On 26 Month2, RN F met with Ms B and her family to discuss the finding of her investigation. On the same day, RN F also sent a letter to Ms B detailing the investigation findings. The letter states:

> "[D]uring this investigation I noticed that, there is a need of in-depth documentation in a timely manner, in regards to the incident in the 'Residents Nursing/Care Progress Notes' … I will also be discussing clinical best practice issues regarding head injuries and the taking of neurological observations. I feel [Ms A] should have been sent to

[6] One paramedic to crew an ambulance.

> hospital after a head injury especially as a lump was evident. The neurological observations should definitely have been continued."

48. On 31 Month2, RN F had a meeting with the registered nurses at the rest home. She said that she "discussed the clinical best practice issues regarding head injuries and the taking of neurological observations during this meeting". The RN Meeting Agenda dated 31 Month2 noted that staff "[r]equired urgent reading and understanding of the following policies — Adverse Event Management Policy and Neurological Recordings Policy", and to report back to the management team by 8 Month3.

49. Ms A passed away a short time later.

50. RN F circulated a memorandum to all registered nurses to sign that they understood the Adverse Event Management Policy and the Neurological Recordings Policy.

Further information received

51. RN F told HDC:

> "I would like to emphasise that, I am very critical of myself, the fact that it took until 21 [Month2] to start an investigation and implement any corrective actions. I am also critical of the fact, that regardless of whatever work practice we were following during that time, I should have still investigated this quickly rather than after 20 days of incident. I fully understand that this was not good enough as a Facility Manager …"

52. The rest home told HDC:

> "[RN F] is aware of the time lapse in dealing with the investigation for this complaint, she has a good understanding of the implications of not addressing this in a timely manner and has made efforts to ensure this does not reoccur, she has taken this most seriously. Whilst I too am critical of her initial management of this complaint, I do have trust and confidence in her moving forward."

53. RN E told HDC:

> "Whilst on duty on 26 [Month1] and 2 [Month2] until [12.30pm], I did not continue neurological observations. However, critically reflecting on my practice, I realised that I would have physically checked and assessed [Ms A] at the beginning of my shift … I would continue neurological observation for at least 24 hours after the head injury … I am sincerely sorry for what happened to the family and [Ms A]."

54. RN D told HDC:

> "I am aware of my mistakes especially with my clinical judgement in deciding not to wake [Ms A] … I realise that this learning took the hard route and I am very sorry for the family and loved ones of [Ms A] …"

55. RN C told HDC:

> "[R]eflecting on the incident, I have realised that there were things that I should have done but missed … My sincere apologies for all the suffering and pain they had to go through. I am terribly sorry for all these."

Orientation and training provided by the rest home

56. The Orientation Programme for registered nurses includes a mandatory checklist for all staff members to complete with a buddy and sign-off once the training has been completed. The programme includes training on "fall prevention — fall risk assessments". Staff members are also required to complete quizzes regarding documentation and the Code of Health and Disability Services Consumers' Rights, which are marked by one of the management staff. The orientation form does not specifically include any training regarding neurological observations. The rest home told HDC that prior to this incident the topic of falls was not addressed as separate training (from the orientation programme).

57. The rest home stated:

> "[A]fter the orientation programme, Registered Nurses and Caregivers are required to complete the competencies annually and as required. Falls prevention and risk assessments are also included in our annual competencies' checklist."

58. The rest home provided HDC with a copy of the signed orientation checklist, completed quizzes, and competencies review form for RN C, RN D, and RN E. The checklist does not include neurological observations specifically.

59. The rest home was asked about the training it provided on falls and neurological observations.

60. RN E told HDC:

> "All RNs required reading the policies and signing on the signing sheet once we read and understand the policies. Also we required to attend monthly RNs meeting to discuss post falls and other incidents at [the rest home]."

61. RN C told HDC: "[The rest home] has regular in-service training and seminars. Falls and neurological observations are included in Falls Prevention in-service which is done yearly now."

62. RN D told HDC: "I recall receiving training at the rest home for Interai, palliative care and first aid. I cannot recall receiving specific training in relation to falls and neurological observations."

63. The rest home also told HDC: "[W]e should ensure RN competencies are being met, rather than being signed off as a 'tick box' requirement."

Policies

64. The Fall Prevention Programme Policy states:

> "Fall Management Plan:
>
> …
>
> 3. In the event of a fall, an Accident and Incident form must be filled out before completion of that duty. The Registered Nurse or Facility Manager will analyse the fall for potential causative factors and will review the management plan accordingly.
> 4. If there is evidence of a blow/knock to the head or suspicion of a head impact with object or other person, the neurological observations policy must be referenced and instigated …
>
> Post falls investigation:
>
> …
>
> 3. Formulate any corrective action plan that is assessed as being appropriate and feasible.
> 4. Formulate a management plan in consultation with the resident, their advocate and Medical Practitioner, Care staff, Diversional Therapist and may also include Physiotherapy assessment and review."

65. The Neurological Recordings Policy states:

> "Procedure:
>
> … Neurological observations should be recorded as noted below. If at any stage in the recordings of 'Neuro Obs' a deterioration is noted, the resident must be referred to emergency service (Ambulance) for assessment and treatment as medically indicated. The Manager or Clinical Nurse Manager must be notified of such event …
>
> Frequency of recordings should be:
>
> When using the Glasgow Coma Scale (GCS) to assess levels of consciousness —
>
> For patients with GCS <15: ¼–½ hourly recording until GCS 15.
>
> For patient with GCS 15: ½ hourly for 4 hours then hourly for at least a further four hours from time of injury.
>
> If at any point of the monitoring phase, deterioration is noted, medical/emergency services input must be sought without delay …
>
> The Registered Nurse or Medical Practitioner will determine the frequency of observations and recordings. This detail will be recorded by the Registered Nurse in the Long Term Care plan or Short term care plan as appropriate to the event …"

66. The Neurological Observations sheet requires assessment and recording of eye opening response, best verbal response, best motor response, strength of arms, strength of legs, pupil scale, blood pressure, pulse rate, respirations, and temperature. However, the sheet contains no prompt to calculate a numerical score for the GCS assessment.

67. RN E told HDC that she was aware of the Neurological Recordings Policy, and said:

> "[The Policy states] half hourly for 4 hours then hourly for at least a further four hours from time of injury for patients with GCS 15. I started work 8.5 hours after fall on 26 [Month1] and 13.5 hours after fall on 1 [Month2]."

68. RN C told HDC that he was aware of the Neurological Recordings Policy.

69. RN D told HDC:

> "There is some confusion between the wording of the policy and what was usual practice at the time. It was my understanding that neurological observations were required half hourly for the first 2 hours, then 2 hourly for the next eight hours, then every four hours for eight hours … I have noted that [the rest home's] [Neurological Recordings] policy was different but I was not aware of the neurological observations being undertaken half hourly for four hours as per that policy …"

Changes made since incident

70. The rest home told HDC that as a result of this incident, the following has occurred:

a) RN F discussed the areas of in-depth clinical documentation and issues around clinical best practice and communication with all registered nurses during the meeting on 31 Month2 (as discussed above at paragraph 48);

b) A Quality Improvement plan was developed and has been ongoing since December 2018 to continue to improve as a facility and to reduce accidents and incidents, especially falls.

c) A training session on the Fall Preventions Programme was conducted in October 2018, and all registered nurses are now required to complete self-learning on "10 Topics of Reducing Harm from fall".

d) The rest home is in the process of consulting with an external organisation to expedite a review of the orientation and yearly competency requirements for registered nurses, and to conduct a training session on "Completion of Neuro-observations".

e) The rest home's Human Resources Consultant and a Nurse Advisor from the external organisation discussed with RN F her responsibilities as a Facility Manager.

71. RN F told HDC that as a result of this incident, she now meets with the nurses on duty during her daily facility walk, and enquires about any new incidents. She has also completed several training, leadership, and professional development courses to upskill her knowledge and to be an efficient Facility Manager.

72. RN F said that she consulted with the external Nurse Advisor for further support and clinical supervision. She also now conducts regular Quality Meetings, one with the Management Team, and another with the registered nurses.

73. RN D told HDC that this incident has made him more vigilant, especially in his clinical decision-making, and he has been following organisational policies on any accidents and incidents strictly, and has implemented strategies accordingly.

74. RN C told HDC that as a result of this incident:

> "I always make sure that … For any fall, head to toe assessment is done, regular monitoring is carried out and the GP is informed immediately, depending on the severity of the fall. For all the incidents involving head, neurological observations is done as per [the rest home's] policy and, if needed as per assessment, send the resident to the hospital. I also ensure that a proper hand over is given to the incoming nurse."

75. RN E told HDC that as a result of this incident, she immediately changed her practice, and no longer relies on the handover alone, but instead checks and assesses the resident herself. She said that she has "been attending RNs education sessions regularly to update and refresh nursing practice". She also completed an online course on falls prevention twice, and now always follows the "post fall clinical pathway" in her new workplace. She is also undertaking an online course and workshop programme on the "Deteriorating Patient".

Responses to provisional opinion

Ms B

76. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. Ms B stated:

> "I feel disheartened, disappointed and angry. Because we entrusted the care of our loved one to [the rest home] … [T]here are a lot of inconsistencies in statements from the RNs and we feel there was complete negligence in the care they provided."

The rest home and RNs C, D, E, and F

77. The rest home and RNs C, D, E, and F were provided with an opportunity to comment on the provisional opinion. The rest home and RNs C, D, and E had no further comments. RN F stated:

> "I would like to emphasize again that, I am very critical of myself, of the fact that it took until 21 [Month2], to start an investigation and implement any corrective actions."

Relevant standards

78. The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) state:

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers …
>
> Quality and Risk Management Systems Punaha Whakahaere Kounga, Tirotiro Whakararu
>
> Standard 2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles."

Opinion: Introduction

79. This opinion concerns the care provided by the rest home and RNs C, D, E, and F to Ms A in relation to neurological observations and subsequent care following her falls on 26 Month2 and 1 Month2.

Opinion: Rest home — breach

80. As a healthcare provider, the rest home is responsible for providing services in accordance with the Code.

81. Expert advice was obtained from RN Sheryl Lilly, who advised:

> "I consider that appropriate measures were in place to help reduce falls, progress notes indicated the staff were aware of [Ms A's] high falls risk … there is a plan for reducing falls in both short term and long term care plan. I consider these measures meet accepted standards."

82. I accept RN Lilly's advice about the adequacy of the measures for preventing falls. However, I am concerned about the standard of care provided following Ms A's falls, as discussed below.

Neurological Recordings policy

83. The rest home's Fall Prevention Programme Policy states that if a head injury occurs following a fall, then the Neurological Recordings Policy (the Policy) should be instigated.

The Policy referred to the use of the GCS to assess the level of consciousness, and stated that at least eight hours of neurological observations should be conducted, and that ultimately the registered nurses or a medical practitioner should determine the frequency of observations and recordings.

84. The rest home utilised a Neurological Observations Sheet, but no space to input a GCS score was included on the sheet. None of the registered nurses calculated a GCS score when undertaking neurological observations following either the fall on 1 Month2 or the fall on 26 Month1.

85. RN D told HDC that there was some confusion about the wording in the Policy, and that the wording was at odds with his understanding of the Policy. RN E and RN C said that they were aware of the Policy.

86. My expert advisor, RN Lilly, said that on discussion with several of her peers, it was agreed that best practice is for neurological observations to be undertaken for 24 hours following a fall if the fall resulted in a knock to the head or it was unwitnessed. RN Lilly advised that the minimum requirement of eight hours of neurological observations, as stated in the Policy, was not safe practice. Further, RN Lilly said:

> "The policy states that the RN or medical practitioner will determine the frequency of observations, this event highlighted the dangers of not setting a best practice standard and a resident's care was compromised by lack of critical thinking and nursing skill."

87. In relation to the Neurological Observations Sheet, RN Lilly advised:

> "I note further that the Neurological observations [sheet] to be filled out is incorrect, it does not align with the GCS form used nationwide. There are significant omissions that mean it cannot correctly reflect the facility's neurological observation policy. For example there are no GCS scores to add up to the required 15 … this may be intentional, to suit the environment but the policy should reflect this."

88. I accept this advice. Despite the registered nurses being aware of the Policy, no GCS scores were recorded. I am critical that the Neurological Observations Sheet contains no reference to GCS scores, and that this does not align with the wording of the Policy, which requires the length and frequency of the observations to be determined by reference to the GCS scores.

89. RN Lilly referred to the National Institute of Clinical Excellence Clinical Guidelines relating to frequency of neurological observations, which state that observations should be performed half-hourly until the GCS equals 15. For patients with a GCS of 15, the minimum requirement for observations is more complex (with the frequency changing as time passes since the incident, or if any deterioration occurs). The guidelines indicate that observations should not occur less frequently than two hourly.

90. I am concerned that the rest home's Policy states that registered nurses will determine the frequency of observations, but includes no guidance on best practice standards. In this case, the relevant nurses did not undertake neurological observations of the appropriate frequency or for the appropriate length of time following both falls. In my opinion, this failure by the nurses is also attributable to the lack of guidance in the Policy.

The rest home training on neurological observations

91. All registered nurses at the rest home had to complete the orientation programme, which included the subject of "fall prevention — fall risk assessments". The orientation programme does not specifically include training about neurological observations. RN D said that she cannot recall receiving specific training in relation to neurological observations. RN E said that all registered nurses were required to read the policies and sign to acknowledge that they understand the policies. Prior to this incident, training regarding falls was not conducted separately from the orientation programme.

92. RN Lilly advised:

> "There is no reference to competencies around neurological observations and acute assessment … it appears that the management team may have also failed to ensure that the orientation programme was properly followed … and ensuring that the orientation programme did not become a 'tick box' exercise."

93. I accept RN's Lilly's advice. The rest home also accepts that it should ensure that competencies for registered nurses are being met, rather than being signed off as a "tick box" requirement. I am critical that staff members were not trained on the rest home's policy and requirements for undertaking neurological observations following a fall.

Conclusion

94. The NZHDSS require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers. The rest home needed to have in place adequate systems, policies, and procedures, and then ensure compliance with those policies and procedures, so that the care provided to Ms A was appropriate, and that any deviations from good care were identified and responded to.

95. The rest home also has a responsibility for the actions of its staff. I consider that at the time of the incident, the rest home staff had a lack of understanding about when neurological observations needed to be done, and for how long, and that it was not clear that residents must be woken to complete neurological observations. In my opinion, staff were not provided with appropriate guidance and training in relation to neurological observations and falls in general. This is evident by the number of nurses who did not meet the appropriate standard.

96. RN Lilly advised: "[T]here is no reference to competencies around neurological observations and acute assessment although I would consider a Registered Nurse should

be competent in these areas regardless." I agree, and have commented on the care provided by individual nurses below.

97. Nevertheless, in my view, the failure to conduct neurological observations for an appropriate frequency or length of time following the falls on 26 Month1 and 1 Month2 is also attributable to the systemic issues at the rest home. In particular, there was a lack of adequate policy, documentation, and training regarding neurological observations.

98. Accordingly, I find that the rest home breached Right 4(1) of the Code.

Opinion: RN C — breach

Care provided following fall on 26 Month1

99. On 26 Month1, Ms A suffered an unwitnessed fall at 2.20pm. She was discovered by RN G. RN G completed an adverse event form and started neurological observations at 2.30pm. RN G prepared a plan following the fall, including the use of restraint, and contacted the Facility Manager. RN C began his shift at 3pm and was informed about the fall by RN G, and instructed to continue the neurological observations. RN C contacted Ms B regarding the fall and conducted neurological observations at 3.30pm, 4.30pm, and 8.30pm. He recorded his observations in the Neurological Observations Sheet. RN C said that he did not conduct any further neurological observations (after 8.30pm) as Ms A was asleep. RN C's shift finished at 11pm. RN C accepts that he should have continued the neurological observations.

100. RN Lilly advised that "it is considered best practice to carry out [neurological observations] for at least 24 hours after a head injury", and that RN C "did not meet the expected standard of care".

101. I agree with RN Lilly's advice, and am critical that RN C did not continue to take neurological observations after 8.30pm.

Care provided following fall on 1 Month2

102. At 5.30pm on 1 Month2, Ms A fell and hit the back of her head, and this was witnessed by RN C, who was on duty from 2.30pm to 11pm.

103. The Fall Prevention Programme policy states that following a fall, the registered nurse should formulate any corrective action plan that is assessed as being appropriate and feasible. RN C did not commence a short-term care plan, and did not inform the Facility Manager about the fall immediately. RN C accepts that he omitted to do this at the time of the fall.

104. RN Lilly advised: "[RN C] was in breach of the facility's Falls policy as the RN did not commence a short term care plan after the fall nor did the RN inform the Manager until two days later."

105. I accept RN Lilly's advice, and am critical that RN C did not prepare a short-term care plan and did not inform the Facility Manager about the incident in a timely manner.

106. RN C took neurological observations immediately at 5.30pm, and again at 6pm, 6.30pm, 7.30pm, and 8.30pm. The results were recorded in the Neurological Observations Sheet as "stable". RN C said that he stopped taking neurological observations after 8.30pm, because Ms A was asleep and the previous observations had been stable. RN C told HDC that he should have continued to monitor Ms A.

107. RN Lilly advised:

> "The Neurological observation [sheet is] evidence that neurological observations were only carried out half hourly for one and half hours and then one further hour, and not again on [RN C's] shift … [RN C] failed to recognise the possible dangers of a noted head injury and carry out safe and appropriate nursing care. I consider this a severe departure from accepted practice."

108. I am critical that RN C did not continue to take neurological observations during his shift. I am even more critical that neurological observations were not continued for the fall on this date, as this was the second fall Ms A had suffered with a knock to the head in a five-day period. RN C was aware that Ms A had suffered a knock to the head on 26 Month1 and, in my opinion, this should have highlighted the need to conduct neurological observations for a longer period of time.

Conclusion

109. I am critical that after Ms A went to sleep on both 26 Month1 and 1 Month2, RN C did not continue to take neurological observations throughout his shift (in order to complete a 24-hour period of observations). As a consequence, any neurological symptoms displayed by Ms A would have been missed. I am also critical that the Facility Manager was not informed of Ms A's fall, and that no short-term care plan was commenced following the fall on 1 Month2. Accordingly, I find that RN C breached Right 4(1) of the Code.

Opinion: RN D — breach

Care provided following fall on 1 Month2

110. On 1 Month2, RN D began his night shift at 11pm. He said that he cannot recall the handover he received from RN C on that day. RN C said that he told RN D that Ms A had had a fall and had a lump on her head, and was on neurological observations. RN C also noted in the progress notes that Ms A had had a fall and had injured her head. RN D told HDC that he believes that he did complete neurological observations at the commencement of his shift at 11.30pm, but did not transcribe the results onto the Neurological Observations Sheet.

111. At 3.20am, RN D noted in the progress notes that Ms A's pad was changed and there were no new concerns. RN D said that although he wrote the note, it was likely that the HCA had changed Ms A's pad. RN D cannot recall why he did not take neurological observations overnight, but said he was likely to have been busy attending to the needs of other residents. He explained that during his shift there was one less staff member on duty. RN D told HDC that he is aware that his decision not to wake Ms A to complete neurological observations was a mistake.

112. Based on the evidence, I accept that RN D was aware that Ms A had had a fall and required neurological observations. Although RN D cannot remember the handover, this information was apparent in the progress notes. I am unable to determine whether RN D completed neurological observations at the beginning of his shift, as he did not record this in the progress notes.

113. I also acknowledged RN D's comment that his shift was busy and there was one less staff member on duty. RN Lilly considered RN D's comment and advised:

> "[T]he opportunity here was to prioritise the time caring for [Ms A's] acute needs and use direction and delegation to instruct caregivers around other resident needs to ensure they continued to be met."

114. RN D accepts that he did not take any further neurological observations throughout his shift. As stated above, RN Lilly advised that neurological observations should be conducted for at least 24 hours following a fall with an injury to the head. In relation to RN D, RN Lilly stated:

> "Despite not wanting to disturb [Ms A] during the night a competent RN is expected to be able to make sound clinically based decisions relating to resident safety and care. I consider this a severe departure from accepted practice."

115. I accept RN Lilly's advice. Ms A fell at 5.30pm, and RN D's shift fell within the 24-hour period following the fall. RN D has accepted that he should have woken Ms A to conduct neurological observations. Regardless of whether RN D did complete neurological observations at the start of his shift (11.30pm), I am critical that he did not record this on the Neurological Observations Sheet, and did not undertake any further neurological observations. As a consequence, any neurological symptoms that Ms A may have displayed would have been missed. Accordingly, I find that RN D breached Right 4(1) of the Code.

Opinion: RN E — breach

Care provided following fall on 26 Month1

116. RN E began her shift at 11pm on 26 Month1. RN E was aware that Ms A had fallen and sustained an injury to her head. During handover, she was told by RN C that Ms A's condition and neurological observations were stable. However, RN E did not conduct any

neurological observations during her shift. RN E said that as Ms A's condition was stable and her observations were normal, she let Ms A sleep. RN E was aware that RN C had commenced neurological observations, and she accepts that neurological observations should have been continued for 24 hours.

117. As stated above, RN Lilly advised that neurological observations should be conducted for at least 24 hours following a fall where an injury to the head is sustained. RN E's shift was still within the 24-hour period following the fall. RN Lilly advised that RN E "did not meet the expected standard of care".

118. I accept RN Lilly's advice and I am critical that RN E did not undertake any neurological observations during her shift. I note that RN E accepts that she should have continued the neurological observations.

Care provided following fall on 1 Month2

Failure to conduct neurological observations

119. Following Ms A's fall at 5.30pm on 1 Month2, RN E was the registered nurse on duty from 7am to 3pm on 2 Month2. RN E did not undertake any neurological observations, as she said she was told that Ms A's observations were stable and Ms A was sleeping. She also said that her shift started 13.5 hours after the fall. RN E let Ms A sleep until 12.30pm, and then woke her up to examine her. RN E has accepted that she should have assessed Ms A at the beginning of her shift and continued to undertake neurological observations.

120. RN Lilly advised that RN E "made a decision to leave [Ms A] asleep for five and a half hours before waking her … nor was it a clinically sound decision relating to resident safety and care. Best practice is to continue neurological observations for 24 hours after a head injury." RN Lilly considers that a registered nurse should be competent in the area of falls and neurological observations.

121. I accept RN Lilly's advice that RN E should have used her clinical judgement and assessed Ms A at the beginning of her shift, and should have completed neurological observations during the shift. I am critical of RN E for these omissions.

Failure to escalate Ms A's condition appropriately

122. As discussed above, RN E let Ms A sleep until 12.30pm. RN E then examined Ms A and noted that she was less responsive and had vomited, but that otherwise her observations were normal. RN E contacted Ms B and then called an ambulance at 1.10pm. However, RN E told the call handler that the situation was not urgent, and that Ms A could wait for an ambulance. As a result, the ambulance was not dispatched immediately. At 2.20pm (around an hour later), RN E contacted the ambulance again, as Ms A had deteriorated. An ambulance was dispatched immediately.

123. RN Lilly advised:

> "Although [RN E] felt [Ms A's] clinical observations were within normal limits, ie, her Blood pressure, oxygen status and pulse, the standard signs for concern around a

> head injury are vomiting and decreased responsiveness … [RN E] failed to recognise the symptoms of a possible severe head injury and the need for urgent treatment … [RN E] did not meet accepted practice by seeking immediate medical attention for that resident."

124. RN Lilly considered this to be a "moderate to severe departure from accepted practice". I accept RN Lilly's advice. I am critical that RN E failed to recognise the symptoms of a possible head injury and did not inform the ambulance that Ms A needed urgent medical attention.

Conclusion

125. I am critical that RN E did not:

a) Conduct neurological observations during her shift following Ms A's fall on 26 Month1;

b) Conduct neurological observations during the start of her shift on 2 Month2;

c) Recognise the symptoms of a possible severe head injury; and

d) Inform the ambulance service that Ms A required urgent medical attention.

126. As a consequence of RN E's failure to conduct neurological observations, and to recognise the significance of the neurological symptoms exhibited by Ms A at 12.30pm, there was a delay in dispatch of the ambulance. Accordingly, I find that RN E breached Right 4(1) of the Code.

Opinion: RN F — adverse comment

Delay in investigation of fall on 1 Month2

127. RN F was the Facility Manager of the rest home. On 3 Month2, RN F was made aware of the fall that occurred on 1 Month2, but she did not take any further action. Following a complaint from Ms B to the rest home on 21 Month2, RN F commenced an internal investigation regarding the fall, and remedial actions were then taken.

128. RN Lilly advised that the role of the "Facility Manager is often the quality and risk management facilitator to ensure that systems in place are followed and corrective action plans are in place where systems have failed". She further stated:

> "I am critical of the fact that an investigation did not happen until after the complaint despite lack of nursing care and following of procedures. There is no evidence of corrective staff training immediately after the event or implementation of a corrective action plan."

129. I am critical that RN F did not immediately investigate or take any further actions following the fall on 1 Month2, despite being made aware of the incident on 3 Month2.

Recommendations

130. I recommend that RN C, RN E, and RN D:

a) Each provide a written apology to Ms A's family for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

b) Undertake further education and training on falls and neurological observations. Confirmation that the training has been completed should be provided to HDC within six months of the date of this report.

131. I recommend that RN F provide a written apology to Ms A's family for the criticism made in this report. The apology is to be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

132. I recommend that the rest home:

a) Provide a written apology to Ms A's family for its breach of the Code. The apology is to be sent to HDC, for forwarding to Ms B, within three weeks of the date of this report.

b) Review its Neurological Recordings Policy, taking into account RN Lilly's comments (in the Appendix to this opinion), and provide a copy of the updated policy to HDC within three months of the date of this report.

c) Review its Neurological Observations Sheet to ensure consistency with its Neurological Recordings Policy, with a particular focus on the use of GCS scores, and provide a copy of the updated sheet to HDC within three months of the date of this report.

d) Audit its compliance with the Neurological Recordings Policy within the last three months, and report the results of the audit to HDC within three months of the date of this report. If 100% compliance is not achieved, the rest home is to advise HDC of the further actions that will be taken to ensure 100% compliance.

e) Report back to HDC regarding the outcome of the rest home's external consultation about its orientation and yearly competency review, as discussed at paragraph 70(d) above, within three months of the date of this report.

f) Arrange training for its staff on the updated Neurological Recordings Policy referred to in (b) above, and provide evidence of that training to HDC within six months of the date of this report.

g) Ensure that in the intervening period since these events occurred, all the "recommendations for further improvement" identified by my clinical advisor in her report have been addressed fully, and that there are sufficiently robust measures in place for monitoring the ongoing compliance of staff, and report back to HDC within six months of the date of this report.

Follow-up actions

133. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's, RN D's, RN E's, and RN F's names.

134. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to HealthCert (Ministry of Health), and it will be advised of the rest home's name.

135. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Aged Care Association and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Sheryl Lilly:

"**1. Disclaimer**

I, Sheryl Lilly, have been asked to provide an opinion to the Commissioner on case number C17HDC01545 and I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

2. Expert's Background

I have been a New Zealand Registered nurse for Thirty years with a background in clinical care and aged care nursing management. I am an owner/operator of a 20 bed rest home for the past twelve years and also own another 28 bed facility, that I purchased 6 years ago. I am also a Career Force assessor.

3. Instructions from the Commissioner

I have been asked to review the documentation sent to me and advise whether I consider the care provided to [Ms A] at [the rest home] was reasonable in the circumstances, and why.

In particular please comment on:

1. Were measures put in place to reduce her risk of falls appropriately and according to the policy in place at the time of the events?
2. Was the policy in place adequate?
3. Was the nursing care provided on the 26 [Month1], appropriate?
4. Was the nursing care provided on the 1st and 2nd [Month2], following the fall on the 1st [Month2] appropriate?
5. Was the falls training provided prior to [Month1] adequate?
6. Please consider whether reasonable care was provided by the following individuals:
   - Facility Manager — [RN F]
   - RN that witnessed fall — [RN C]
   - Night nurse — [RN D]
   - RN that called the ambulance — [RN E]
7. Any other matter in this case that you consider warrants comment.

4. Factual summary

[Ms A] was known as a high falls risk and had a number of falls. On 1 [Month2] she again fell and sustained a lump on the back of her head. Neurological observations

were commenced but not done overnight. On 2 [Month2] at approximately midday she vomited, was not responsive to verbal stimuli but other observations were within normal limits. An ambulance was called at 1.10pm but advised it was safe to wait for an ambulance, however a second call was made at 2.20pm when [Ms A's] condition deteriorated and she was transferred to hospital. [Ms A], sadly, died [a short time later].

5. Expert Review

1. Were measures put in place to reduce her risk of falls appropriately and according to the policy in place at the time of the events.

There is evidence of both a short term plan on admission and long term plan established on the 24 [Month1]. Both plans refer to [Ms A's] high falls risk. Measures put in place were to keep the area clutter free, support [Ms A] as necessary and to monitor her movements as she is unsteady on her feet due to leaning to one side. Progress notes indicated [Ms A's] prominent lean to the left and her constant unsteady wandering.[1] It was also noted that she did not respond well to being asked to sit down for her safety. PRN restraint was also put in place with the consent of the family and GP for when her safety became an issue.

I consider that appropriate measures were in place to help reduce falls, progress notes indicated the staff were aware of [Ms A's] high falls risk. There is evidence of a mobility guide as per [the rest home's] falls prevention programme, although there is no evidence of a management plan as required by the falls policy, there is a plan for reducing falls in both the short term and long term care plan.

I consider these measures meet accepted standards.

2. Was the policy in place adequate?

[The rest home] has a Falls Prevention Programme policy[2]. This policy covers Assessment, planning, intervention, and evaluation of a person who is considered a falls risk. It also covers the actions after a fall, including the use of the Accident and incident form, post fall investigations, the commencing of neurological observations, further preventative measures and the review of these measures. The policy also refers to the responsibilities of staff in the event of a fall.

I consider this policy meets industry standards.[3]

3. Was the nursing care provided on the 26 [Month1], appropriate?

The progress notes dated 26 [Month1] stated that [Ms A] fell at 1430 hrs. She was checked over, nothing untoward noted, vital signs taken and recorded. Neurological observations were taken at 1430, 1500, 1530, 1630 and 2030 hours and again on the 27 [Month1] at 0700, 1100 and 1400 hrs. In the progress notes on the 26 [Month1] it states at 2230 a lump on the back of her head was noted.

The accepted practice for actions immediately after a fall includes physical assessment for injury and neurological observations for 24 hours if the fall resulted in hitting the head or was unsighted. It is also common practice to inform the GP of the fall if the head has been involved and there is deterioration in the neurological observations.

In this instance [Ms A] was physically assessed and neurological observations commenced; however, they were not carried out for the required 24 hours, despite a lump on [Ms A's] head being noted that evening and after instruction by the GP to continue the observations after visiting [Ms A] on the 27 [Month1].[4] The on call manager was not informed, and no Short term care plan was put in place despite the presence of a wound.

The RNs on duty over this 24 hour period were in breach of their facility's falls and neurological observation policies and did not meet the expected standard of care[5]. I consider this to be a serious departure from accepted practice.

4. Was the nursing care provided on the 1st and 2nd [Month2], following the fall on the 1st [Month2] appropriate

[Ms A] fell and hit her head at 1730 hours on the 1st [Month2]. Following the fall she was assessed and found to have no injuries apart from a lump on the back of her head.[6] [Ms A] was put onto PRN restraint in the lazy boy and neurological observations (neuro obs) were commenced. Cares were carried out later in the evening and neuro obs continued half hourly until 2030 hours. The RN on duty reports that [Ms A] was asleep thereafter and no neuro obs were done. No further neuro obs were carried out during the night shift despite hygiene cares having been done at 0200 and 0530 hrs.[7]

It is considered best practice to carry out Neuro Obs for at least 24 hours after a head injury; this is also stated in [the rest home's] Neurological Policy.

The following morning shift of the 2 [Month2], [Ms A] was left unchecked by an RN until Midday. When she was checked she was found to have vomited, was drowsy but responsive to loud voice, although hardly responding to verbal stimuli[8]. An ambulance was called and was told by the RN that [Ms A] could wait for an ambulance.

The nursing care over the 1st and 2nd of [Month2] in relation to the fall was inadequate, accepted procedures around neurological observations were not followed, there was no continuity of care in relation to assessment and evaluation of [Ms A's] condition overnight and into the next day, and there was a lack of critical thinking considering the presentation of [Ms A] at the time the Ambulance was called.

Considering that there was clinical failure on both the 27th [Month1] fall and the 1st [Month2] fall to follow correct procedures as discussed above, my peers and I consider this a severe departure from accepted practice.

5. Was the falls training provided prior to [Month1] adequate?

The information that I have been provided with shows no evidence of education around falls and prevention prior to [Month1]. There is evidence of first aid training for staff, including those involved in this investigation; I am unable to comment if this training was adequate in relation to falls. There is evidence of falls prevention and risk assessment in the staff orientation and competency reviews last; however I am unable to comment on the adequacy of these reviews.

I would recommend that yearly updates be undertaken with a competency questionnaire around fall prevention, risk assessment and procedures after a fall.

6. Please consider whether reasonable care was provided by the following individuals.

Facility manager [RN F]:

It is accepted practice for the Facility Manager to oversee the facility's operations including being able to delegate to other RNs to ensure the smooth running of the facility thru clinical policies and procedures. A Facility Manager (FM) is often the quality and risk management facilitator and ensures that systems in place are followed and corrective action plans are in place where systems have failed.

[RN F] was not made aware of the event until the 3rd [Month2]. If [RN F] investigated the lack of clinical competency at that time I would consider the Facility Manager has met accepted practice; however, there is only evidence of an investigation that was carried out after the complaint was received from [Ms A's] family on the 21 [Month2] by [RN F], and the need for improvements were identified[9].

I am critical of the fact that an investigation did not happen until after the complaint despite lack of nursing care and following of procedures. There is no evidence of corrective staff training immediately after the event or implementation of a corrective action.

Despite [RN F] stating that corrective issues were raised at the RN meeting on the 31st [Month2][10] I consider that there was a moderate departure from accepted practices.

[RN C]:

[RN C] witnessed the fall of [Ms A], he states that he assessed her for injuries, noted a lump on the back of her head, started neurological observations and completed an incident form, and informed the family[11]. However, The Neurological observation chart evidence that Neurological observations were only carried out half hourly for one and half hours and then one further hour, and not again on [RN C's] shift; this was in breach of [the rest home's] falls policy[12]. [RN C] failed to recognise the possible dangers of a noted head injury[13] and carry out safe and appropriate nursing care.[14] I consider this a severe departure from accepted practice.

Night Nurse [RN D]

In [RN D's] written statement[15] she believed she checked [Ms A's] neurological observations (neuro obs) when she started her shift on the evening of the 1st

[Month2], there is no written evidence of this on the Neurological chart started that evening. [RN I] decided not to wake [Ms A] to carry out further neuro obs as she gets agitated when awake. I note that the progress notes dated nocte 2 [Month2] at 0320 hours that [Ms A's] pad was changed but no neuro obs done while there was an opportunity to do so.

[RN I] was in breach of [the rest home's] policies around falls and neurological observations.

Despite not wanting to disturb [Ms A] during the night a competent RN is expected to be able to make sound clinically based decisions relating to resident safety and care. I consider this a severe departure from accepted practice.

[RN E]

In [RN E's] written statement dated 4/10/18 she states she made a decision to leave [Ms A] asleep for five and a half hours before waking her. Again this was in breach of [the rest home's] policy around falls and neuro observation policy, nor was it a clinically sound decision relating to resident safety and care. Best practice is to continue neurological observations for 24 hours after a head injury. Neuro Obs were not done until [Ms A] was found to have vomited and was drowsy. It was at this time [RN E] called the ambulance and told them that it was safe to wait.

Although [RN E] felt [Ms A's] clinical observations were within normal limits, ie, her Blood pressure, oxygen status and pulse, the standard signs for concern around a head injury are vomiting and decreased responsiveness; with the presentation of [Ms A], the RN on duty failed to recognise the symptoms of a possible severe head injury and the need for urgent treatment, [and] although she updated the ambulance when she recognised further deterioration in [Ms A], [RN E] did not appear confident in her RN role and did not meet accepted practice by seeking immediate medical attention for that resident.

Due to the fact that [RN E] reacted promptly to [Ms A's] further deterioration my peers and I consider there was still a moderate to severe departure from accepted practice.

Recommendations for further improvement.

In light of the fact that all three RNs on duty for the 18 hours after [Ms A's] fall did not carry out clinically sound decisions around correct procedures following a head injury I recommend a review of [the rest home's] RN orientation and yearly competency requirements. There appears to be a systematic and clinical failure to ensure that RN competencies are actually being met, but rather being signed off as a 'tick box' requirement.

Sheryl Lilly RN

[**Endnotes**]

1 Progress notes.

2 Policy [number]

3 HDSS Adverse Event Reporting 2.4

4 Response by [Dr H]

5 Nursing Council Code of Conduct.

6 Submission from [RN C]

7 Statement by [RN D]

8 Statement by [RN E]

9 Statement to [HDC] dated 17 October 2018 plan.

10 [RN F], written statement dated 17/10/18

11 Written statement submitted by [RN C] dated 26 [Month2]

12 [The rest home's] falls preventative programme.

13 Incident form dated 1 [Month2]

14 New Zealand Nursing Council competencies, domain 1 and 2

15 [RN I] written statement dated 15/10/18 nocte 2 [Month2] at 0320 hours that [Ms A's] pad was changed but no neuro obs done while there was an opportunity to do so."

The following further expert advice was obtained from RN Lilly:

"**1. Disclaimer**

I, Sheryl Lilly, have been asked to provide an opinion to the Commissioner on case number C17HDC01545 and I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

2. Expert's Background

I have been a New Zealand Registered nurse for Thirty years with a background in clinical care and aged care nursing management. I am an owner/operator of a 20 bed rest home for the past twelve years and also own another 28 bed facility, that I purchased 6 years ago. I am also a Career Force assessor.

3. Instructions from the Commissioner

I have been asked to further review added documentation and advise whether it causes me to amend the conclusions drawn in my initial advice.

And to also comment on:

1. The appropriateness of the policies/guidelines at [the rest home] regarding falls and neurological observations as at [Month2], noting that your previous advice said that neurological observations should be conducted over a 24 hour period, following falls but [the rest home's] neurological observation policy requires a shorter duration.

2. The adequacy of the training and orientation programme provided at [the rest home] prior to [Month2].

3. Any further comments or amendment to your initial advice about the following individuals following their responses:

- Facility Manager [RN F]
- RN that witnessed fall — [RN C]
- Night nurse [RN I]
- RN that called the ambulance — [RN E]

4. Whether there is any systematic failure at [the rest home]

5. Any other matter in this case that you consider warrants comment.

Having reviewed my initial advice, I do not wish to amend my conclusions, but will comment further as follows:

1. The appropriateness of the policies/guidelines at [the rest home] regarding falls and neurological observations as at [Month2], noting that in your previous advice you said that neurological observations should be conducted over a 24 hour period, following falls but [the rest home's] neurological observation policy requires a shorter duration.

As I commented in my initial review I consider that [the rest home's] falls policy meets industry standards. However there is a question of the duration of neurological observations required after a suspected or actual head injury from a fall. I have referenced the National Institute of Clinical Excellence Clinical Guidelines to show best practice.[1] It does not, however indicate the length of time that neurological observations should be done for. On discussions with several of my peers, it was agreed best practice should be for 24 hours. [The rest home's] neurological observation policy states that 8 hours is sufficient if the resident has proven to be stable; my peers and I do not consider this a safe practice, especially if there is an obvious head injury as in this case. The policy states that the RN or medical practitioner will determine the frequency of observations; this event highlighted the dangers of not setting a best practice standard and a resident's care was compromised by lack of critical thinking and nursing skills. I note further that the Neurological observations form to be filled out is incorrect, it does not align with the GCS form used nationwide.[2] There are significant omissions that mean it cannot correctly reflect the

[1] https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines
[2] Glasgowcomascale.org

facility's neurological observation policy. For example there are no GCS scores to add up to the required 15, and the eye, verbal, and motor responses have missing components; this may be intentional, to suit the environment but the policy should reflect this.

2. The adequacy of the training and orientation programme provided at [the rest home] prior [to Month2]

I was not asked in my initial advice to review the orientation programme, and the documentation that I now have has been updated in April 2019 and I am unsure what, if any, changes there have been.

Having reviewed the staff competencies prior to 2017 that relate directly to their orientation, it appears to cover a large range of subjects including falls risk and prevention, accidents and Incidents. There is no reference to competencies around neurological observations and acute assessment although I would consider a Registered Nurse should be competent in these areas regardless, or take professional responsibility[3] to seek further guidance if unsure. It is difficult to comment on the adequacy of the training and orientation programme as it would depend on how well each section is covered by the person orientating the new staff member, but the subject matter is appropriate and appears adequate.

3. Any further comments or amendment to your initial advice about the following individuals following their responses:

- *Facility Manager [RN F]*
- *RN that witnessed fall — [RN C]*
- *Night nurse [RN I]*
- *RN that called the ambulance — [RN E]*

Facility Manager [RN F] — No further comment

[RN C], [RN I] and [RN E] — All three RNs have acknowledged their mistakes in their reflections and have furthered their education on falls and falls prevention; however I feel there is a need for further education on acute assessment and critical thinking, and it would be appropriate for these RNs to further reflect against the New Zealand Nursing Council competencies. There is also an opportunity to seek education on Direction and Delegation[4]. The RNs' reflections referred to busy work load and understaffing. It is an expectation of a competent RN to use Direction and Delegation;[5] the opportunity here was to prioritise the time caring for [Ms A's] acute needs and use direction and delegation to instruct caregivers around other residents' needs to ensure they continued to be met. A registered nurse has a duty of care to provide safe

[3] New Zealand Nursing Council Competencies, Domain One — Professional Responsibility
[4] http://www.nursingcouncil.org.nz/index.php/content/download/447/1922/file/nurse_delegation_RN.pdf
[5] www.nursingcouncil.org.nz/index.php/content/download/.../nurse_delegation_RN.pdf

and competent care[6] and the event may have been avoided if direction and delegation was utilised.

5. Whether there is any systematic failure at [the rest home]

[The rest home] had systems in place in the form of policies and procedures. These systems that I have been able to review in the form of policies appear to be robust. It appears the systematic failure was the failure of staff to follow the correct procedures.

As I stated in my initial review it appears that the management team may have also failed to ensure that the orientation programme was properly followed; this includes ensuring that staff are aware of their job descriptions and ensuring that the orientation programme did not become a 'tick box' exercise.

Sheryl Lilly RN"

Further expert advice was received from RN Lilly:

"You have asked me to further comment on:

Short term care plan and the on-call manager was not informed:

1. You have advised that in relation to the fall on 26 [Month1] — short term care plan was not prepared and the on-call manager was not informed. I have checked the incident form and the manager was informed and the GP was informed in the following morning and there was a plan to use restraint following the GP's review — can you please advise whether this changes your advice regarding the subsequent management of the fall on this date;

2. Following the fall on 1 [Month2] — there was also no short term care plan prepared and the manager was not informed until 3 [Month2] — can you please also comment on the appropriateness of this and the level of departure if any.

3. You have advised that neurological observations should be conducted for 24 hours if the fall resulted in hitting the head or was unsighted. Can you please also clarify regarding the frequency of the neurological observations in cases like this where the fall was witnessed and/or there was a head injury. Please also provide the frequency of the observations if the fall was witnessed and no head injury etc.

Thank you for giving me the opportunity to comment further on my review dated 6/8/19.

On reading your comments above (1), I believe I had the dates of the two incidents confused and would like to amend my comments to read:

[6] New Zealand Nursing Council Code of Conduct.

Although the on call manager was informed, and a Short term care plan was put in place around restraint to prevent further falls, this does not change my advice in regards to 'The RNs on duty over this 24 hour period were in breach of their facility's neurological observation policies and did not meet the expected standard of care[7]. I consider this to be a serious departure from accepted practice.'

On reading your comment above (2) I would like to add: The RN on duty was in breach of the facility's Falls policy as the RN did not commence a short term care plan after the fall nor did the RN inform the Manager until two days later.

Considering that there was clinical failure on both the 27th [Month1] fall and the 1st [Month2] fall to follow correct procedures as discussed above (in my original report), my peers and I consider this a severe departure from accepted practice.

3. I have further referenced the National Institute of Clinical Excellence Clinical Guidelines to show best practice. It states as follows:

Perform and record observations on a half-hourly basis until GCS equal to 15 has been achieved. The minimum frequency of observations for patients with GCS equal to 15 should be as follows, starting after the initial assessment:

- Half-hourly for 2 hours.
- Then 1-hourly for 4 hours.
- Then 2-hourly thereafter. [2003]

1.8.8 Should the patient with GCS equal to 15 deteriorate at any time after the initial 2-hour period, observations should revert to half-hourly and follow the original frequency schedule. [2003]

1.8.9 Any of the following examples of neurological deterioration should prompt urgent reappraisal by the supervising doctor.

- Development of agitation or abnormal behaviour.
- A sustained (that is, for at least 30 minutes) drop of 1 point in GCS score (greater weight should be given to a drop of 1 point in the motor response score of the GCS).
- Any drop of 3 or more points in the eye-opening or verbal response scores of the GCS, or 2 or more points in the motor response score.
- Development of severe or increasing headache or persisting vomiting.
- New or evolving neurological symptoms or signs such as pupil inequality or asymmetry of limb or facial movement. [2003, amended 2007][8].

[7] Nursing Council Code of Conduct.
[8] https://www.nice.org.uk/guidance/cg176/chapter/1-Recommendations#admission-and-observation

I reiterate that these guidelines do not state the length of time that the neurological observations should be continued. It is accepted practice to follow the above guidelines when there is a fall sustaining a head injury or a suspected head injury whether it is sighted or an unsighted fall. I would not expect Neurological Observations to be done if there was no head injury with a witnessed fall.

Regards
Sheryl Lilly RN"