HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate clinical oversight of elderly woman in secure dementia unit

1. In November 2022, the Health and Disability Commissioner (HDC) received a complaint from Mr A in relation to the care provided to his mother, Mrs B, at Northbridge Lifecare Trust (Northbridge), a retirement complex, in October 2022.

2. Mrs B (aged 80 years at the time of events) resided in the Memory Care Centre (MCC), a secure dementia care facility at Northbridge. She had a history of Alzheimer's dementia with cognitive impairment, low mood, agitation, and other comorbidities.

3. Mr A's complaint concerns the management of an incident on 30 October 2022 where Mrs B is reported to have hit a health care assistant (HCA), and Northbridge called the police in response. Mr A is concerned that police were called to a situation with a distressed dementia patient and that Northbridge did not contact health services until the family intervened.

Information gathered

4. Northbridge had notified the Ministry of Health of a nursing shortage, indicating that they had five vacancies for registered nurses the week commencing 24 October 2022. It informed HDC that the staff shortages and disruption from the COVID-19 pandemic had resulted in staff training being placed on hold over the 12 months before the incident. Mr A reported that the family were not made aware of the staffing difficulties.

5. Northbridge told HDC that Mrs B presented with 'episodes of aggression both verbally and physically' throughout her admission to the MCC. Northbridge report that the behaviours escalated from July 2022 and persisted until the incident on 30 October 2022. Progress notes reference several incidents over this period where she is reported to have slapped or hit residents and staff and screamed at, grabbed, and threatened other people.

6. Northbridge's Clinical Manager, Registered Nurse (RN) C, initiated a behaviour chart on 25 August 2022 that is referenced several times within the progress notes. Although HDC requested a copy of this chart, Northbridge was unable to locate it. No evidence has been provided to indicate post-incident analysis, nursing assessment, or changes to Mrs B's care plans in response to behavioural events.

7. Progress notes indicate that Mrs B was regularly reviewed by general practitioners (GPs) between July and October 2022. They increased her quetiapine (an antipsychotic medication used 'off label' to treat behavioural and psychological symptoms of dementia (BPSD)) on 24 and 30 August 2022 after discussion with care home staff about her behaviour. Mr A stated that the family were not consulted or informed about Mrs B's medication changes. The records indicate that a GP requested a blood test for delirium and referral to Mental Health Services for Older Adults (MHSOA) on 7 September 2022; however, Mrs B did not allow staff to take her bloods, so the referral was not progressed until 10 October 2022.

8. RN C documented that the family were informed that a behaviour chart had been commenced for Mrs B and that she was to be referred to MHSOA following a family meeting on 16 September 2022.

9. RN C made several attempts to escalate to MHSOA between 10 and 19 October 2022 because of Mrs B's presentation. MHSOA gave advice over the phone to cease quetiapine and commence risperidone (a second-line antipsychotic medication used to treat BPSD) on 14 October 2022. MHSOA physically assessed Mrs B on 19 October 2022, the outcome of which was to refer her to the Needs Assessment and Service Coordination (NASC) service to assess for a move to psychogeriatric-level care.[1] Mr A told HDC that the family were not aware of the referrals to MHSOA or the plan for Mrs B to be assessed by NASC.

10. An interRAI assessment[2] was completed on 16 October 2022, and Mrs B's care plan was updated accordingly. Although this assessment identified a significant increase in Mrs B's 'Aggressive Behaviour Scale' score from the previous assessment in November 2021 (11 months prior), there is no indication of any increase in safety measures implemented by the leadership team while they sought external support.

Events of 30 October 2022

11. At approximately 9.30am, Mrs B was reported to be agitated and attempting to hit two care staff. A third staff member who came to intervene was hit in the stomach and fell to the floor. An incident report was completed, but this focused on the staff member and provided limited information about Mrs B or follow-up actions taken. The incident was discussed at a health and safety meeting in December 2022; however, no further internal investigation took place because Mrs B had moved to a specialist psychogeriatric service on 1 November 2022.

12. The Lead Care Facility Manager at the time, Ms D, stated that because of Mrs B's presentation, she was unapproachable for PRN (as needed)[3] risperidone. In contrast, Mrs B's medication chart indicates that this was administered at 9.26am. In the afternoon, MHSOA were told that Northbridge staff had administered the PRN medication at around 10.45am.

13. Care staff escalated the incident to their team leader, who informed the on-call team and senior management (including Ms D and RN C). This is in line with Northbridge's Management of Challenging Behaviour and Emergency Restraint policies at the time. The on-call nurse, RN E, was asked to assist by RN C. She stated that, by the time she arrived at the MCC, Mrs B was already settled (the records do not indicate what time RN E arrived). At 11.31am, RN C advised RN E to call the police to 'fetch [Mrs B] as she is mentally unstable and violent'.

[1] Psychogeriatric-level care is designed for people with a mental health or dementia disorder who require a high level of nursing care and management of challenging behaviour.
[2] A Long-Term Care Facilities Assessment, which is a comprehensive assessment of the needs, strengths, and preferences of those in aged residential care.
[3] Additional dose of medication to be taken should Mrs B display signs of agitation.

14. At 12.21, RN E documented that she had contacted police and Mrs B's other son, Mr F. Mr A told HDC that his brother, Mr F, was not contacted by Northbridge, and he called Mr F to inform him of the situation. Progress notes do not state the intended outcome of calling the police. In later statements, RN E noted that she 'reported the matter to police'; Ms D and the team leader both stated that the intention was for the police to transport Mrs B to a mental health ward at North Shore Hospital, which has a unit that provides inpatient assessment and treatment for older adults requiring MHSOA support.

15. The police were subsequently stood down and did not attend the situation. Northbridge's Management of Challenging Behaviour and Emergency Restraint policies allowed that, in some circumstances, it may be necessary for the police to be called; however, this would only be considered if family members, other professionals, or the out-of-hours crisis service provided by MHSOA are not available to support.

16. The only contact with the crisis team was at 2.25pm, by which time Mrs B was reported to be calm. Mr A reports that this was only following his intervention and not a decision made by Northbridge staff. The crisis team advised Northbridge to monitor Mrs B and handed over to MHSOA the following day, who supported the NASC service with securing a bed in a psychogeriatric care home. There is no evidence of any contact with other health agencies about Mrs B on 30 October 2022.

17. At 11.36am, Ms D informed Mr A of the incident and the decision to call the police. Ms D told HDC that the decision to call the police was made after consultation with Mr A and stated that he agreed with their involvement.

18. Mr A strongly disputes this and stated that there was no consultation and that he asked for the police to be stood down. Ms D did not document their conversation on Mrs B's progress notes. The team leader recorded that Mr A asked to drive his mother to the hospital because he was concerned that she would be distressed by the presence of police. Mr A stated that he arrived on site at approximately 12.20pm, by which time his mother was no longer displaying any signs of agitation.

Clinical advice

19. Clinical advice was sought from RN Jane Ferreira, in-house aged care advisor for HDC (Appendix A). She identified the following departures from the expected standard of care:

- Clinical management of behavioural events between July 2022 and October 2022: **moderate to significant** departure.
- Police escalation on 30 October 2022: **mild to moderate** departure.
- Care planning for Mrs B: **moderate to significant** departure.
- Policies for challenging behaviour management, restraint management, and adverse event reporting: **mild to moderate** departure.

Responses to provisional decision

20. Mr A was given the opportunity to respond to the 'Information gathered' section of the provisional decision. His comments have been incorporated into this report where appropriate. Mr A has shared the significant impact this incident has had on his family:

> 'We were shocked at the sudden move of Mum out of Northbridge which separated her from her husband of 50+ years. This caused us great distress and distress to Dad which then also necessitated moving Dad to [the same rest home as Mrs B] so that my parents could still be together'.

21. Northbridge were also given the opportunity to respond to the provisional decision. They did not dispute the finding, accepted the recommendations and reiterated their focus on ensuring meaningful improvement and strengthening practice moving forward.

Decision: Northbridge Lifecare Trust — breach

22. Having considered all the information relevant to this investigation, I accept the above departures identified by RN Ferreira. Mrs B was entitled to have services provided with reasonable care and skill and, in my opinion, this did not happen. For this reason, I find Northbridge Lifecare Trust in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

23. While I acknowledge there are extenuating circumstances that may warrant police intervention, and Northbridge's Management of Challenging Behaviour and Emergency Restraint policies set out the circumstances when this may be necessary, I do not consider the event involving Mrs B on 30 October 2022 falls into this category. In my opinion, more should have been done by MCC staff to anticipate and respond to her behaviours. The agitated state Mrs B displayed from time to time is not unusual, noting that typically people in specialist dementia care have high dependency needs and might display difficult or antisocial behaviours. It is therefore particularly concerning that MCC, as a dedicated secure dementia unit, was ill equipped to respond to Mrs B's behaviour.

24. I accept that the incident occurred towards the end of the COVID-19 pandemic and that Northbridge was experiencing a long-term shortage of RNs. However, I am critical that senior clinical staff were aware of the changes in Mrs B's presentation yet there is no evidence of nursing assessment, behavioural analysis, or short-term care planning. Such oversight would have provided necessary information to ensure caregivers could support Mrs B appropriately, particularly given the disrupted training over the COVID-19 pandemic. In his response to the provisional opinion, Mr A shared that, after moving to an alternative dementia-level care environment, Mrs B did not require PRN antipsychotic medication, and the service was able to reduce her regular dose shortly after she moved.

25. I am concerned that there appears to have been a focus on pharmacological intervention rather than attempts to understand the underlying causes of behaviour, which should be the primary approach when caring for individuals with BPSD.[4]

26. It would have been accepted practice for Mrs B's interRAI assessment and care plan to be reviewed when a change in behaviour was identified. This did not occur, and the delayed review after 11 months was significantly outside of the Age-Related Residential Care (ARRC) provider agreement of at least six-monthly reviews. Although the updated interRAI identified the significant increase in Mrs B's aggressive behaviour, the amended care plan failed to offer personalised guidance surrounding de-escalation or incident management. Further to this, although there is reference to behaviour monitoring in the progress notes, I am critical that this documentation could not be found and does not appear to have been used to inform Mrs B's care.

27. There is a lack of investigation, analysis, or rationale contained within the care record to explain why the 30 October 2022 incident was perceived as more severe than other episodes of similar behaviour from Mrs B (in that it warranted police involvement). Events of the day remain unclear, as highlighted by the conflicting recall of events and documentation, including that relating to the administration of PRN risperidone.

28. While I accept that, in some extreme circumstances, police involvement may be necessary to ensure the safety of all parties, the Health Quality & Safety Commission Te Tāhū Hauora Frailty Care Guides and Northbridge's organisational policies recognise that reasons for acute behaviour change may be health related. As such, I am critical of the decision to call the police and find that seeking assessment from a paramedic or mental health services would have been more appropriate in the first instance when responding to Mrs B's behaviour on 30 October 2022.

Changes made since events

29. Most of the staff involved in this incident no longer work at Northbridge. The new management team have acknowledged the deficiencies in the care provided to Mrs B, engaged with the investigation, and emphasised their ongoing commitment to service improvement. Several changes have been implemented since the incident:

- All policies have been updated to align with current Ministry of Health | Manatū Hauora standards.
- Increased RN staffing levels, including coverage Monday–Sunday in the MCC (19 RNs are now employed, compared with eight in 2022).
- All staff working in the MCC have completed dementia training modules.
- Staff have received training in documentation standards and the reporting process, and guidelines have been established to ensure consistency.

[4] bpacNZ. Managing the behavioural and psychological symptoms of dementia. 2020. https://bpac.org.nz/2020/bpsd.aspx.

- The clinical documentation system has been upgraded to VCare,[5] which centralises resident information.
- The ISBAR[6] tool is now used when escalating issues to the GP to ensure clear communication and consistency between staff.
- Communication with families is prioritised and documented, and updates are emailed for transparency.

Recommendations and follow-up actions

30. In light of the changes made, I recommend that Northbridge Lifecare Trust:

- Provide a written apology to Mrs B and her family for the deficiencies in care identified in this report. The apology is to be sent to HDC within three weeks of the date of the final report for forwarding to Mr A.
- Provide a copy of the updated guidelines for Challenging Behaviour, Restraint Management, and Adverse Event Reporting to HDC within three weeks of the date of the final report.
- Provide evidence of the staff training surrounding dementia care and documentation to HDC within three weeks of the date of the final report.
- Conduct an audit of compliance against expected documentation standards to evaluate the effectiveness of the new clinical documentation system and provide HDC with the outcome report with any corrective actions to be implemented within three months of the date of the final report.

31. A partly anonymised copy of this report, naming Northbridge Care Trust and the clinical advisor on this case, will be sent to HealthCERT and the NZ Aged Care Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

[5] An electronic care management programme that stores care plans, assessments, and progress notes in one system.
[6] The ISBAR communication framework is used to create a structured and standardised communication format between health care workers. It is particularly useful for reporting changes in a patient's status and/or deterioration between health care services or shifts.

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 : Northbridge Lifecare Trust

FILE NUMBER : C22HDC02817

DATE : 29 August 2023

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Northbridge Lifecare Trust. 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 dated 11 November 2022
   - Provider response dated 28 November 2022
   - Clinical records, including nursing assessments, care plans, progress notes, GP notes, medication prescription and administration records, behaviour charts, and incident reports
   - Organisational policies, including Restraint Elimination, Management of Challenging Behaviour and Emergency Restraint, Incidents and Accidents/Adverse Event Reporting, In-service Education
   - Additional information received 28 April 2023, including nursing and medical information, communication, and education records.

3. **Complaint**
   Mrs [B]'s son has raised concern regarding the leadership and management of Mrs [B]'s care while [she was] exhibiting signs of distress on 30 October 2022 and related communication and decision-making at the time.

4. **Review of clinical records**
   For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your

peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

- Clinical care, incident event management, care planning
- Application of organisational policies and staff training.

Background

[Mrs B] was admitted to the care home on 18 May 2020 at dementia-level care. Prior to admission she resided with her husband in an independent living apartment at the village. Her medical history included Alzheimer's dementia with cognitive impairment, hypertension, osteoarthritis, osteoporosis, transient ischaemic attacks (TIAs), hyperlipidaemia, constipation, low mood, and agitation. File information shows that [Mrs B] was independently mobile, tolerated a normal diet, and required supervision and prompting with activities of daily living.

[Mrs B] presented with a reported decline in mood, behaviour, and functioning across 2022. Entries refer to a reluctance to accept carer assistance to meet personal care requirements, with accounts of increasing physical and verbal distress and related altercations with other people. [Mrs B] had been seen by her General Practitioner (GP) and referred to mental health services. On 30 October 2022, [Mrs B] became distressed, resulting in an altercation event. The duty team contacted [Mrs B]'s son and police services for support. [Mrs B] was reassessed as requiring a higher level of care and transferred to a specialist dementia setting (psychogeriatric-level care) on 1 November 2022.

a) Do you consider the clinical management of the behavioural events on 9 and 30 October 2022 by nursing and care staff to be in line with expected standards for a dementia care setting?

Submitted nursing progress notes 3 October 2022 to 1 November 2022 describe increasing concern with [Mrs B]'s wellbeing. Entries discuss episodes of agitation with physical and verbal aggression, noting miscommunication as an identified trigger to distress. The Management of Challenging Behaviour policy (May 2022) provides discussion about physical distress with examples of contributing factors, such as constipation, illness, infection, delirium, medication, hunger, fatigue, pain, fear, and sensory overload, among other influences; however, there is no evidence of any wider nursing assessment or event analysis completed, which would be considered accepted practice in the circumstances. Given the increasing safety risks and wellbeing concerns, accepted practice would be to commence a short-term care plan to support [Mrs B]'s care and safety needs and guide staff actions until she could be assessed by a specialised health professional. This would include observation of vital signs, nutrition, hydration, and elimination patterns, behaviour and pain monitoring records, intentional rounding to support resident safety, and a care escalation plan.

Records show that [Mrs B] was seen by her GP on 4 October 2022, and clinical notes discuss a referral to Mental Health Services for Older People (MHSOP). She was seen by an Occupational Therapist on 6 October 2022, and clinical notes refer to a functional assessment, commenting that [Mrs B] was independent with mobility, eating and drinking, requiring supervision and guidance with dressing, grooming, toileting, and hygiene needs. This is reflected in an interRAI assessment dated 16 October 2022 and care plan, which discuss an increased need for supervision and support due to changes in mood and behaviour.

A progress note entry on 7 October 2022 states '*medications need to be crushed and put in her food otherwise she will refuse'.* While the medication prescription lists medications suitable for crushing, the nursing care plan does not specifically discuss medication administration, the use of covert interventions, or EPOA involvement and informed consent; however, the organisation's medication management policy was not provided in the evidence bundle to inform further comment. From a review of related nursing information, there appears to be limited evidence of clinical nurse leadership and oversight of medication management, or non-pharmacological strategies, during the timeframe in question.

Progress notes on 9 October 2022 refer to an Accident/Incident form; however, this was not sighted in the evidence bundle. An entry at 1602hrs states '*threatened staff, physically hit staff, unpredictable behaviour, she is dangerous to both residents and staff'.* There is no evidence of nursing assessment attempted or completed at the time of the event, or during the next shift by a registered nurse (RN), which would be considered accepted practice. An entry by the Clinical Manager (CM) on 10 October refers to GP follow-up regarding the MHSOP referral; however, it is unclear what senior nurse assessment occurred or if additional safety measures were put in place. The CM entry indicates staff were reassured and advised to complete 'proper documentation'; however, it is unclear if an event debrief occurred in line with the Adverse Event policy guidelines or what documentation was required by the CM. The manager's entry in the care record 10 October 2022 states that [Mrs B]'s son was informed of the event and that family were supportive of a referral to MHSOP for reassessment. InterRAI information indicates that [Mrs B]'s husband held EPOA, but it appears that family members were supporting decision-making responsibilities at the time.

The care record reflects contact with MHSOP and escalation of concern about [Mrs B]'s wellbeing by the care home on 11, 14, 18, and 19 October 2022. Medications appear to have been rationalised by the GP in line with MHSOP recommendations; however, there is no evidence of RN assessment, short-term care planning, or monitoring to inform this process. There does not appear to be evidence of post-event incident analysis completed by the leadership team, nursing assessment, GP referral, or introduction of increased care and safety measures, which would be considered accepted practice.

The care record on 30 October 2022 refers to CM and RN involvement in supporting the team to manage a stress and distress event, with discussion of event escalation in line with care management pathways. The Management of Challenging Behaviour policy and

Emergency Restraint policy describe organisational guidelines and expectations for managing acute events of concern. Both documents state to contact the local hospital crisis team and, if not responding or available, to call the police. The event report appears to have been reviewed by the care home manager; however, there is no discussion of event debrief, corrective actions, or identified quality improvements in line with significant event management.

From the evidence reviewed to respond to this question, it appears that [Mrs B] was presenting with signs of health and wellbeing changes for several months, which contributed to care and safety concerns raised by the care team and indicated a need for reassessment to an appropriate care environment.

While the care record reflects evidence of escalation to the GP and mental health teams, there are identified opportunities for improvement in the recognition of change for people living with dementia, including nursing assessment, personalised care planning with appropriate interventions, and incident management processes, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to significant.

b) Do you consider the circumstances surrounding the incident of 30 October warranted escalation to the police?

As discussed in question (a), organisational policies refer to police involvement for risk events. The care record reflects event escalation by the team lead to an RN with statements of collaboration between the care home manager, CM, and RN. The care record refers to engagement with the Crisis Team, that a decision was made for police support, and that family had been informed of transfer for further care, which appears in line with organisational processes in place at the time.

The Managing Challenging Behaviour policy lists a range of contributing factors to physical events; however, there is no evidence the clinical flags were considered by the care home team. There is no evidence of nursing assessment attempted or completed to inform hospital transfer documentation or that guidance and support was sought from [Mrs B]'s GP. Medication administration records 30–31 October 2022 show that [Mrs B] received her regular breakfast medication at 0743hrs followed by an additional (PRN) dose of medication (risperidone) at 0936hrs with a comment of 'very agitated' in the administration record. There does not appear to be a corresponding entry in the care record, which would be considered accepted practice. There does not appear to be evidence of consultation between the HCA and duty RN prior to administration of the PRN medication, which is considered accepted practice, nor evidence of a discussion held regarding triggers to escalating behaviour or use of non-pharmacological strategies in the first instance, with medications used as a last resort. Given this medication was introduced as recommended by MHSOA on 14 October, accepted practice would be to ensure qualified nurse oversight and GP involvement in care.

The Health Quality & Safety Commission Te Tāhū Hauora Frailty Care Guides provide a range of resources to support and inform nursing assessment and guide clinical decision-making (HQSC, 2019). As outlined in the resources, in the event of acute health or behavioural change, paramedic consultation and support would be considered an appropriate intervention, with ambulance transfer to an acute care service provider as indicated. [Mrs B]'s son has expressed concern that a police presence may have further exacerbated [Mrs B]'s distress and his preference for family involvement to support safe de-escalation. This view is reflected in the Age-Related Residential Care (ARRC) Services Agreement and Ngā Paerewa Health and Disability Service Standards (HDSS), which require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person in a timely way of any change in the resident's health condition, any identified risk or concern regarding their care and safety needs, or any adverse event. Having open communication and a shared understanding of care responsibilities and decision-making is particularly important for families who are acting on behalf of a resident living with a diagnosis of dementia and experiencing distress.

From the evidence reviewed to respond to this question, it appears the duty team followed their organisational policy, which informed their actions at the time. However, there are identified opportunities for improvement in nursing assessment, person-centred care planning, clinical decision-making, and policy criteria for resident transfers, which would be viewed similarly by my peers.

- Departure from accepted practice: Mild to moderate

c) Do you consider the care planning for [Mrs B] provided adequate guidance for staff to manage any escalation in behaviour for [Mrs B]?

The ARRC agreement (E4.5) outlines care planning requirements for residents who reside at dementia-level care. This includes a description of current abilities and agreed support, an outline of care, activity, and safety requirements across a 24-hour period, with personalised strategies for minimising episodes of stress and distress. [Mrs B]'s care plan provides discussion of her care requirements. The care plan was reviewed prior to discharge, in line with an interRAI assessment completed on 16 October 2022. The care plan provides a goal under Mood and Behaviour to reduce episodes of anger, aggression, and promote safety. The care plan refers to displays of territorial behaviour, stating that [Mrs B] disliked people going to the smoking area, with comments of 'shouts at staff, hits out during cares, and verbally aggressive'. The care plan refers to increased interRAI assessment data 16 October 2022, commenting that the aggressive behaviour scale triggered a score of 11/12, compared with 1/12 in the last interRAI assessment dated 25 November 2021, which would be considered a significant change in resident presentation. It is unclear why the nursing assessment and resident review process was delayed, as this is outside of contractual timeframes and service provider responsibilities; however, I note from the provider response that there were workforce shortages at the time, which may have contributed to the delays in timely nursing assessment and resident review processes.

Activities records indicate that [Mrs B] enjoyed music and singing, helping at times with daily care home routines, and visits from her husband and family.

Care plan interventions state to allow more personal space and check MediMap (for prescribed medications), noting that when behaviour is not managed by other means, to offer a cigarette. I note there is no evidence that a smoking risk assessment was completed or that a safe smoking plan was in place to support [Mrs B] while living in a dementia-level care environment. It is unclear if [Mrs B] required supervision while smoking to ensure cigarettes were safely extinguished, what plan was in place regarding storage and access to her cigarettes and lighter, her smoking frequency and a related risk management plan, such as access to a fire blanket, or escalation steps. A supporting Health and Safety policy was not provided in the evidence bundle to inform further comment.

The provider has stated that [Mrs B] displayed frequent signs of unrest and distress between July and October 2022. It is unclear if [Mrs B] was able to access outdoor spaces, such as the smoking area, when feeling overwhelmed during the day and at night. Progress notes comment that [Mrs B] requested carers to open a door but was advised 'we cannot open the door at this time', yet the restraint policy refers to resident access to external areas, stating (the care home will) provide a private area to wander without feeling detained, with a goal to keep other residents, staff, and visitors safe. As discussed in question (d), there appears to be some blurring between restraint management and dementia-level care responsibilities.

[Mrs B]'s care plan does not provide specific guidance regarding de-escalation strategies, requirements for safety checks, nursing assessment, incident management, or care escalation. There is no reference to the use of monitoring forms such as bowel records or evidence of RN review to rule out constipation as a contributing factor to observed changes in mood or wellbeing. The care plan states that [Mrs B] was able to tell staff when she needed the toilet; however, it is unclear if she was able to provide a reliable elimination history given her medical conditions and level of care. The provider has discussed episodes of interrupted skin integrity; however, there is no evidence that skin or pain assessments were completed by an RN or oral intake was reviewed when considering contributing factors to reported events. Behaviour monitoring forms provide evidence of review in 2020–21, but there is no evidence provided of behaviour monitoring or RN oversight during the timeframe in question.

From the evidence reviewed to respond to this question, it appears that [Mrs B]'s care plan provided minimal guidance to the care team regarding her care and safety needs, which would be viewed similarly by my peers. Short- and long-term nursing care plans provide care guidance to ensure service consistency and continuity of care across shifts and are required to be supported by timely assessment and evaluation processes.

- Departure from accepted practice: Moderate to significant.

d) Do you consider the policies for challenging behaviour management, restraint management, and adverse reporting to be in line with current Ministry of Health sector standards, and were these followed for the incident 30 October 2022?

The organisational policies listed above provide evidence of review dates in May 2021 and November 2022 but do not appear to reference the revised Ngā Paerewa Health and Disability Service Standards (HDSS) 2022, and, in particular, changes made to restraint management processes. There appears to be some blurring noted between recommended actions and provider responsibilities to restraint management when caring for people who are assessed as requiring dementia-level care.

The provider has described [Mrs B]'s behaviour as erratic between July and October 2022 and referred to a frequency of physical and verbal altercations between [Mrs B], residents, and the care team. An event that resulted in physical contact between parties would be considered significant, and the Adverse Event policy states that family will be notified of incidents as soon as possible following the incident. It is unclear if incident reports were completed for all individuals involved. The Accident/Incident monthly analysis form provides a prompt to ensure that if the incident concerns two residents, to copy the incident form and file in both resident files; however, further guidance is unclear regarding event investigation, corrective actions, and clinical governance processes.

The Management of Challenging Behaviour policy states that, if the challenging behaviour is an ongoing problem rather than an isolated incident, medical staff may need to refer the resident to a specialist. The provider has advised this approach was informally discussed with [Mrs B]'s family in September but not documented; however, referral only occurred in October 2022. It is unclear why the CM did not facilitate nursing assessments and a review of interRAI assessment data when changes in resident presentation were first identified and re-establish connections with the MHSOP team at this time, given [Mrs B] was known to the service.

The Adverse Event policy states that, in the event of a serious accident or hospital transfer, the Facility Manager or Clinical Manager will be informed as soon as possible. It appears that, on 30 October 2022, staff escalated their concerns to the on-call team lead, who sought support from the care home managers, in line with policy guidance. The Management of Challenging Behaviour and Emergency Restraint policies refer to seeking support from the hospital crisis team and, if not responding or available, to call the police. As outlined in the Challenging Behaviour policy, reasons for distress may be health related and require a health assessment, therefore it is unclear why paramedic services were not considered to support this process at the time.

From the evidence reviewed, the policies appear to provide guidance about resident behaviour, supportive strategies, incident management, and event follow-up, including seeking GP or allied health input; however, there is limited discussion about nursing assessment, identification of risk or safety concerns, and relevant care planning. The documents provide limited discussion of communication with the EPOA, family/whānau, or wider responsibilities to care partnerships, communication, and informed consent.

There is also limited discussion of incident evaluation or trend analysis and how this is communicated with consumers, nominated representatives, or other stakeholders to provide reassurance about ensuring resident safety and appropriate care.

For this question, I believe the policy documents meet the minimum standard of accepted practice in the circumstances. There are identified opportunities to review policies and processes relating to resident admissions to dementia-level care, the management of resident stress and distress, and associated responsibilities to open communication and informed consent, which would be viewed similarly by my peers.

- Departure from accepted standards: Mild to moderate.

e) Do you consider the orientation programme and educational schedule is sufficient to ensure all staff are receiving adequate training in relation to challenging behaviour management, restraint, and dementia for Northbridge Lifecare Trust?

The ARRC agreement (E4.5f) states that the provider must ensure that each carer directly involved in caring for residents at dementia-level care achieves the required educational unit standards (23920, 23921, 23922, 23923) in line with the national qualification framework, within 18 months of employment. This criterion is assessed as part of the Ministry of Health surveillance and certification audit processes. The provider has submitted evidence of education and training delivered to the care home team in response to learnings from this complaint. While evidence of training material was not included, the education calendar and attendance records suggest that education has been delivered via in-house sessions and through online learning modules. There is evidence of updated orientation checklists (2023) for Registered Nurse, Enrolled Nurse, and Healthcare Assistant roles; however, there is no supporting policy or clinical competency information provided to inform further comment.

5. **Clinical advice**

I note that the events occurred during the COVID-19 pandemic period 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 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 HDC online modules for further learning - https://www.hdc.org.nz/education/online-learning/

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Health and Disability Commission.

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