HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Aged Care Commissioner

(Case 20HDC01516)

Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The following issue was identified for investigation:

- *Whether Summerset Care Group Holdings Limited (trading as Summerset Falls) provided an appropriate standard of care to Mrs A from December 2018 to November 2019.*

3. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's great nephew
Summerset Care Group Holdings Limited (Summerset)	Aged residential care service

4. Further information was received from:

Health New Zealand | Te Whatu Ora (Health NZ)[1]	National health agency
Ms C	Clinical nurse leader/acting care centre manager[2] at Summerset

5. In-house clinical advice was received from aged-care advisor and registered nurse (RN) Jane Ferreira (Appendix A). In response to the provisional report, Summerset obtained its own clinical advice from aged-care expert Ms D (Appendix B).

Information gathered

Introduction

6. Mrs A, aged 99 years at the time of events, was a resident at Summerset Care Group Holdings Limited (trading as Summerset Falls), an aged residential care facility, from 28 December 2018 to November 2019.

[1] On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora | Health New Zealand (now called Health New Zealand | Te Whatu Ora).

[2] Initially, Ms C was a clinical nurse leader, and in August 2019 she became the acting care centre manager.

7. Mrs A's great nephew, Mr B, raised several concerns relating to the overall standard of care provided to Mrs A by Summerset Care Group Holdings Limited (Summerset).

8. This report focuses on the key issues raised by Mr B.

Background

9. Mrs A was admitted to Summerset on 28 December 2018 at a rest-home level of care, following a significant head injury (a left frontal subdural haematoma[3]) during a fall at her home in November 2018. Mrs A had a short stature at 154cm. Mrs A's medical history included cognitive impairment on a background of dementia with short-term memory loss, congestive heart failure,[4] expressive aphasia,[5] osteoporosis,[6] frailty,[7] and atrial fibrillation.[8]

10. At the time of her admission to Summerset, Mrs A mobilised with the support of a lower walking frame and carer supervision. She required assistance with activities of daily living.

11. Mrs A's great niece was her Enduring Power of Attorney (EPOA) for personal care and welfare (not activated). However, the complaint to the Health and Disability Commissioner (HDC) and Summerset emerged from Mr B.

12. Mrs A passed away in late 2019. I take this opportunity to express my sincere condolences to Mr B and his family.

Falls management

Complaint

13. Between January and August 2019, clinical records show that Mrs A experienced 18[9] fall events with injuries, resulting in multiple hospital admissions. In response to the provisional report, Mr B said that Mrs A had a further fall on 21 October 2019, but clinical notes do not confirm this. Mr B told HDC that these falls were avoidable and should not have happened. He said that the cumulative harm resulting from these falls left Mrs A physically and cognitively disabled, and this occurred because of Summerset's ineffective falls prevention mechanisms and the failure by Summerset staff to evaluate Mrs A's health status after she suffered multiple fall events.

Falls Prevention and Management Policy

14. Summerset's Falls Prevention and Management Policy at the time of the events (dated March 2018)[10] states the following:

[3] A collection of blood between the skull and the surface of the brain.
[4] A progressive heart condition that causes fatigue and shortness of breath.
[5] A communication disorder that affects a person's ability to process language.
[6] A disease in which bone strength weakens and is susceptible to fracture.
[7] A group of symptoms including fatigue, weight loss, and changes in mental wellbeing. Frailty is associated with an increased risk for falls.
[8] An irregular and fast heartbeat.
[9] The statements provided by Mr B indicate that there may have been three further falls, but clinical records show evidence of only 18 falls.
[10] A subsequent review of the policy was completed in August 2019.

- All residents are to have their falls risk assessed within 12 hours of admission. The falls risk is to be noted within the initial care plan along with actions staff are to take to minimise the falls risk;
- All falls are to be documented on an incident form;
- When residents have been identified as having increased falls risk, the care plan will clearly outline interventions to address individual risk factors;
- Neurological observations will be completed on all residents suffering from an unwitnessed fall (for at least six hours) despite the resident feeling sure that they did not hit their head;
- Post-fall actions should include a review, which should be documented in the progress notes by a registered nurse, and the note should identify all factors that contributed to the fall and any changes required in the care plan as a result;
- Residents who have more than one fall within a seven-day period should have a full medical review to identify further strategies to prevent falls;
- Frequent fallers (defined as three or more falls within a 30-day period) should have a multidisciplinary team (MDT) review of their medical condition and functional and cognitive ability to ensure that adequate strategies are in place to mitigate further falls. This should include a general practitioner (GP) review of medications and pain management, pharmacist review of medications, physiotherapy review of balance, strength and gait, environmental review of room set-up, equipment review of mobility aids and daily living support, review of footwear and foot problems, review of toileting regimens and continence assessment, review of nutritional status, and review of vision and hearing abilities; and
- Frequent fallers should be notified to regional quality managers (RQMs).

15. The Falls Prevention and Management Policy does not outline the process for reviewing 'CAT A' events or when a fall event is to be classified as a 'CAT A' event and does not include a definition of a 'CAT A' event. However, Summerset told HDC that a 'CAT A fall event' is a fall that results in the resident sustaining a fracture or if a resident is admitted to hospital due to injury following a fall.

Care plan and risk assessments

16. On admission, several assessments were completed for Mrs A. These showed inconsistencies regarding Mrs A's falls risk.

17. A short-term care plan (STCP) dated 29 November 2018 noted that Mrs A was a *high* falls risk. A Falls Risk Assessment Tool (FRAT) screening (also dated 29 November) noted that Mrs A was a *low* falls risk. A long-term care plan (LTCP) dated 28 December 2018 noted that she was a *high* falls risk, whilst an interRAI assessment dated 21 January 2019 reflects a *medium* risk. interRAI assessments were also completed on admission and in September 2019, which indicated that Mrs A had multiple fall events and referenced Mrs A's care plans.

18. The STCP recorded that Mrs A had the following problems/needs:

- She tended to neglect her lower walking frame (LWF) during mobilisation;
- She had been admitted to hospital prior to her admission to Summerset due to a fall;
- She tended to be unsteady during the night; and
- She experienced confusion, especially on waking.

19. The STCP did not record other risks that would increase Mrs A's susceptibility to falls, such as her short stature, recent head injury, frailty, and osteoporosis. In addition, there was no reference to Mrs A's dementia-specific behaviours such as wandering, lack of insight, or impulsivity.

20. Mrs A's progress notes on admission contain minimal guidance regarding her pre-admission history, the outcome of nursing assessments on admission, her care and safety requirements, or direction on her initial care plan.

21. A FRAT screening was repeated on 28 February 2019 following a fall, increasing Mrs A's falls risk from low to medium. However, neither the LTCP nor the STCP were updated to reflect this increased risk.

22. In response to the provisional report, Mr B told HDC that the care plans were 'totally unfit' for purpose and that Summerset did not make appropriate changes to the care plans to address the substantial changes in Mrs A's needs that occurred.

Falls interventions

23. The following interventions were implemented by Summerset to minimise fall events:

- One- to two-hourly visual checks;
- Physiotherapy review for Mrs A's mobility;
- Trial of a later bedtime routine;
- Ensuring that the call bell was within reach;
- Regular toileting and offering of food/fluids;
- One-on-one activities to keep Mrs A stimulated during the day and diversional therapy input;
- Regular repositioning in bed;
- GP review of falls;
- Keeping Mrs A's room clutter free;
- Movement of her bed against the wall; and

- Provision of the following equipment — Lo-Lo bed,[11] crash mats[12] on either side of Mrs A's bed, sensor mat,[13] passive infrared sensors (PIR),[14] and hip protectors.

24. This Office requested evidence of the one- to two-hourly visual checks completed, but Summerset was unable to locate a record of this. The progress notes refer to visual checks undertaken, with comments such as '[r]egular checks done', but do not always state the frequency of the checks or whether these occurred one- to two-hourly. In response to the provisional report, Mr B said that the above measures were not taken in a timely or appropriate manner and that the interventions were not in line with Mrs A's needs.

25. The progress notes refer to staff advising Mrs A to push the call bell for support. Mr B told HDC that this intervention was unrealistic given Mrs A's dementia and short-term memory loss. In response to the provisional report, Mr B emphasised that the fall measures set out in Mrs A's latest LTCP were 'redundant' as they did not address the high risks associated with Mrs A's care and were not measurable interventions.

26. HDC requested a copy of Summerset's Quality, Staff and Clinical Meeting minutes to assess the oversight and strategies put in place to address Mrs A's frequent falls. Summerset did not provide these minutes as 'the minutes are very high level'.

27. Summerset told HDC that there was no occupational therapist involvement as nursing staff had not identified that a referral was required. Summerset said that it does not have a contract with an occupational therapist, and any referral would have to be made through Health NZ on an 'as required' basis.

28. Summerset told HDC that there was no specific policy regarding the referral of a resident to geriatric rehabilitation or to a geriatrician or gerontology nurse specialist. Summerset said that any referrals to these specialists are made by the GP, and this occurs after a registered nurse identifies that a review is clinically indicated and raises it with the GP. Summerset stated that its staff did not believe a referral for Mrs A was indicated.

Overview of falls incidents

29. Clinical records show that, over seven months, Mrs A experienced 18 falls, most of which were unwitnessed and occurred in the bedroom, either in the afternoon or evening. The table below provides an overview of the falls Mrs A experienced.

Fall number	Date	Time	Location	Injury/symptoms	Witnessed	Category A event
1	6-Jan-19	2.45pm	Toilet	Small laceration to head	No	No
2	28-Feb-19	2.20pm	Outside facility when	Left ankle swelling	No	No

[11] A Lo-Lo bed is a mobility-focused adjustable bed that sits very low to the ground in its lowest position.
[12] Crash mats act as a protective barrier absorbing the impact of a fall and reducing the risk of injury.
[13] A sensor mat is designed to detect movement and notify care staff (by way of an alarm) when a resident steps on it.
[14] An electronic sensor that behaves as a motion detector.

			with family			
3	1-Mar-19	3.30pm	Bedroom	Left ankle swelling	No	No
4	1-Mar-19	11.30pm	Bedroom	Left bimalleor (ankle) fracture[15] and right clavicle[16] fracture	No	Yes
5	19-Mar-19	12.15pm	Bedroom	No	No	No
6	4-Apr-19	7.30am	Bedroom	No	No	No
7	13-Apr-19	4.40pm	Lounge/ dining	No	No	No
8	18-Apr-19	9.20pm	Toilet	Skin tear on right shin	No	No
9	2-May-19	4pm	Bedroom	Right knee pain	No	No
10	16-May-19	6.30pm	Hallway	Pubic rami[17] fracture	No	Yes
11	13-Jun-19	10.40pm	Bedroom	No	No	No
12	20-Jun-19	12.50am	Bedroom	Back pain	No	Unknown
13	14-Jul-19	12.40pm	Dining area	No	No	No
14	24-Jul-19	5.40pm	Hallway	No	Unknown	Unknown
15	25-Jul-19	5.55am	Bedroom	Lumbar sprain	No	No
16	28-Jul-19	2pm	Bedroom	No	Yes	No
17	29-Jul-19	6.10am	Bedroom	No	No	No
18	18-Aug-19	4.45pm	Hallway	Lumbar three (L3) compression fracture[18] and cut on lip	Yes	Yes

30. In 9 of the 18 fall events, Mrs A experienced an injury or symptoms of pain and/or swelling. Four of the nine events also resulted in hospitalisation.

31. Mr B questioned whether there may have been three further falls in addition to the 18 discussed above. First, Mr B noted that an STCP completed on 31 March refers to a possible head injury, but the clinical notes do not indicate how this occurred. Secondly, Mr B referred to bruising noted on Mrs A's lower limbs on 8 April 2019, with no record of the cause of the bruising. Thirdly, Mr B told HDC that on 21 October 2019 Mrs A had been found on the floor in a 'pool of faeces' by her cousin, and this fall incident was not recorded. While clinical records and correspondence from Summerset do record Mrs A having experienced an episode of incontinence on 21 October 2019, they do not confirm whether this resulted in a fall.

[15] A break of one or more of the bones that make up the ankle joint.
[16] Collar bone.
[17] A crack in the pelvis.
[18] A break in the vertebra that causes it to collapse.

32. Clinical records show that incident forms and neurological observations were completed for all 18 fall incidents. Post-fall nursing assessment forms and incident forms indicated that vital signs had been monitored. Monitoring records provided to HDC in response to the provisional report confirm that Mrs A's vital signs were monitored regularly after falls occurred.

33. Summerset told HDC that each fall was investigated by the clinical manager or nursing staff, and additional measures were implemented to further reduce Mrs A's risk of falling. However, the clinical records provided contain minimal details of the assessments completed or the findings. The clinical records show the following:

- Head-to-toe assessments were completed for fall incidents 1, 3, 5, 9, 13, and 16. However, there is no detail on the findings.
- Fall incidents 2, 4, 6, 7, 8, 10, 11, 12, 14, 15, 17, and 18 were documented with no indication of whether a head-to-toe assessment was completed.
- The progress notes for fall incidents 9, 10, 11, 14, 15, 16, and 17 contain no entry by a registered nurse, as required by the Falls Prevention and Management Policy.
- The incident forms and/or progress notes do not record contributing factors for fall incidents 1, 4, 6, 8, 10–15, and 17.
- No post-falls nursing assessment forms were completed for incidents 7 and 11.
- Incident forms for incidents 12 and 14 do not record whether these were considered to be Category A events.
- There is limited discussion of what falls interventions were implemented in response to each fall.

34. As noted by Summerset's Falls Prevention and Management policy, frequent fallers are required to undergo a full MDT review. However, Mrs A's clinical documentation shows no evidence of a review of her vision or hearing ability. In response to the provisional report, Summerset told HDC that if staff interacting with Mrs A on a day-to-day basis did not have any reason to suspect that her vision was failing further, or that she was having difficulty hearing, there would be no reason for staff to specifically comment on a known fact.

Communication of falls events

35. Mr B raised three concerns regarding the falls that occurred between 28 February 2019 and 1 March 2019. First, he said that Summerset staff told him that it was unclear which fall over this period had caused Mrs A's ankle to break. Secondly, he told HDC that staff did not inform the family that there had been *two* falls on 1 March 2019. Thirdly, Mr B said that Summerset did not inform the family that Mrs A had a clavicle fracture in addition to the ankle fracture.

36. Clinical records show that following fall 2 on 28 February 2019, Mrs A's great niece checked her for bumps and bruises, then took Mrs A back to Summerset to be assessed by the physiotherapist and nursing staff. The physiotherapist noted left ankle swelling from a possible left ankle sprain and completed an X-ray referral. The clinical records show that a registered nurse suggested sending Mrs A to hospital for evaluation. In addition, Mr B told

HDC that the family had also considered taking Mrs A to the accident and emergency centre. However, the physiotherapist suggested that the hospital would not accept Mrs A given that it was a sprain. It appears that the GP was not informed of fall 2.

37. Following falls 3 and 4, the left ankle swelling is recorded as having increased, and Mrs A was taken to hospital for further management. Clinical notes do not indicate which fall event caused the fracture. Mr B told HDC that staff provided conflicting statements as to which fall event caused the ankle fracture. This was acknowledged by Summerset in December 2019.

38. Clinical records show that following fall 3, Summerset notified Mrs A's niece of the fall by phone, and following fall 4, a registered nurse left a voice mail for the niece advising of the fall and that an ambulance had been called. This was followed up by a morning nurse, who informed Mrs A's niece that Mrs A had been hospitalised.

39. Clinical records show that on 2 March 2019, Summerset staff were informed by Health NZ that Mrs A had sustained a left ankle fracture. However, it appears that Summerset staff were not informed of Mrs A's clavicle fracture. Following Health NZ's update to Summerset, Summerset staff informed Mrs A's niece of the ankle fracture, and it was recorded that the niece 'was also informed by [Health NZ] about the fracture'.

40. Health NZ's discharge notes record that Mrs A had a clavicle fracture and required a sling for management. However, Summerset's progress notes do not refer to the clavicle fracture or the use of a sling, and it appears that no STCP was commenced for the clavicle fracture.

Clinical oversight over falls incidents

41. Mr B told HDC that there was a lack of effective, timely clinical oversight for Mrs A's falls incidents. Summerset told HDC that the RQM had been notified of Mrs A's frequent falls and falls 4, 10, and 18. Summerset said that the RQM is notified automatically through email notification when any event is deemed a CAT A event, and this occurs when the event is uploaded on VCare (Summerset's patient management system). However, Summerset did not provide evidence of the emails sent to the RQM, including the actions taken by the RQM or the guidance provided by the RQM to Summerset staff. In response to the provisional report, Summerset said that it would be a substantial task to go through and find the evidence of these notifications.

42. Further, Summerset told HDC that any trend analysis (on repeated incidents) was done manually on VCare.

43. Initially, Summerset said that it completes a Root Cause Analysis (RCA) for falls that result in hospital admission or injury, but in a further statement Summerset told HDC that RCAs 'were not necessarily required for CAT A events' at the time of events. As seen in the above table, there were four major injuries resulting from Mrs A's falls. However, evidence of RCAs or other investigation for these injuries has not been provided.

44. Although incident forms were completed for all 18 falls, the incident forms and clinical notes do not always record the contributing factors for the falls, as required by Summerset's Falls Prevention and Management policy.

45. Regarding the fracture on 1 March 2019, Summerset told HDC that an investigation was not completed as there were no witnesses to what occurred, and Mrs A was referred to hospital for assessment, making it difficult for any reliable investigation to occur.

46. Mr B told HDC that there were 'serious delays' in reviewing the incident forms and closing them off. As Summerset did not provide a copy of its incident management policy, it is unclear what timeframes were associated with the completion of incident reviews. This information is also not available in the Falls Management Policy.

Consideration of urine infection as a contributor to falls

47. Mrs A was continent on admission to Summerset. However, clinical notes show that sometime in January 2019 Mrs A developed delirium and urinary incontinence (symptoms that could indicate a urinary tract infection (UTI). Neither Mrs A's care plans nor her progress notes indicate whether a UTI could have contributed to the fall on 28 February 2019. Mr B told HDC that the EPOA was also not updated on these concerns prior to her visit on 28 February 2019.

48. Mrs A sustained her first fall while attempting to go to the toilet. Increased confusion continued through January and February; however, it appears that a behavioural monitoring form was not commenced.

49. On 25 February 2019, a registered nurse recorded in the clinical notes that Mrs A had flank[19] pain and required a midstream urine test to check for a UTI. A urine sample was sent to the laboratory for analysis. Summerset told HDC that the result was negative, but the GP chose to treat empirically with antibiotics.

50. Ms C recorded that the GP saw Mrs A on 26 February 2019 for concerns regarding confusion and urinary incontinence. The GP noted that Mrs A did not have a fever but was commenced on a short course of antibiotics.

51. Summerset told HDC that as the laboratory result showed no UTI, it would not have been appropriate to log it as a UTI on the infection prevention and control log.

52. On transfer to hospital on 2 March 2019, Mrs A was diagnosed with a UTI.

Environmental safety and suitability of equipment

Complaint

53. Mr B told HDC that there was an absence of critical equipment throughout Mrs A's care that caused serious safety issues. These are outlined below.

Lo-Lo bed provision

54. Mr B told HDC that Summerset did not provide Mrs A with a Lo-Lo bed in a timely manner. He said that a Lo-Lo bed was necessary because when Mrs A sat on a 'normal bed' her feet would be at least 30 to 40cm off the ground, and 99-year-olds 'should not have to jump or

[19] Side of the body, between the ribs and hips.

slid[e] off their beds'. Mr B said that frontline staff told him that a Lo-Lo bed could not be provided without an adequate explanation.

55. Clinical notes record that a Lo-Lo bed was provided on 31 July 2019. Summerset confirmed that the Lo-Lo bed was provided in July 2019. Mr B said that this was first requested around February 2019, and the family made multiple requests for a Lo-Lo bed and it was not provided earlier, nor were they provided with an option to rent one or bring Mrs A's bed from home.

56. Summerset provided variable statements regarding the lack of earlier provision of a Lo-Lo bed:

a) Initially Summerset told HDC that prior to the implementation of a Lo-Lo bed, Mrs A was on a standard electric hospital bed, which was appropriate for her needs and met Summerset's obligations under the aged residential care (ARC) agreement.

b) Summerset's second statement to HDC noted that Lo-Lo beds are a risk for some residents as they can act as a restraint or barrier to safe mobilisation — hence, they are provided only following review with the RQM. Summerset said that Lo-Lo beds were available to be rented short term to meet the needs of the resident until a purchase could be made and that Lo-Lo beds are available for residents based on the needs of the resident. Summerset did not say whether the RQM completed an assessment of Mrs A's need for a Lo-Lo bed or whether Mrs A was referred to the RQM at the outset.

c) Ms C told HDC that she recalled the Lo-Lo bed being raised in March 2019. She said that Mrs A had no difficulties getting out of a standard bed, and she would not have been able to do this if the bed had been too high. Ms C said that eventually the Lo-Lo bed was provided to accommodate the family's request, but actually the bed was too low for Mrs A.

57. Summerset told HDC that it has a national budget for medical equipment purchases, and each year it audits the beds in all care centres, including numbers, age, condition, and functions of the beds, and plans for replacement are developed based on the needs of residents.

Bed rails

58. Mr B told HDC that Summerset did not give enough consideration to the use of bed rails as a falls prevention mechanism. Further, Mr B told HDC that the request for bed rails was due only to the repeated declined requests for a Lo-Lo bed.

59. Summerset's Restraint and Enabler Policy (dated April 2018) defines restraint as the use of any intervention or action that limits a resident's normal freedom of movement. The policy stipulates that a restraint should be used only as a last resort to maintain the safety of the resident, staff, and others, and should be used only if clinically indicated. The policy classifies bed rails as a form of restraint. The policy states that there is an increased risk for confusion and agitation, including injuries caused by trying to mobilise over or around the bed rails. This is reinforced further in the Falls Prevention and Management Policy, which states that 'bed rails in particular can contribute to increased harm for the resident' and that restraints do not prevent falls.

60. Summerset told HDC that nursing staff considered the use of bed rails for Mrs A, but due to her cognitive decline and poor insight, coupled with reduced mobility, staff determined that restraint would increase her risk of harm. Summerset said that this was discussed with Mr B on 13 March 2019.

61. Clinical records show that Mr B requested bed rails on 13 March 2019 and that health education was provided on the use of bed rails, including that it had the potential to increase the risk of falls/injury. A nurse then provided an overview of other falls interventions that were in place and recorded that they would refer the issue to the clinical manager, as bed rails was 'not an option'. It is not known whether the clinical manager reviewed the bed rails or what communication was provided to the family after this review.

Sensor mat

62. Mr B told HDC that the sensor mat was an ineffective strategy as it did not activate when Mrs A mobilised.

63. Summerset told HDC that staff have no recollection of Mrs A's sensor mat not working or not activating and that, if it had been faulty, they would have made sure it was replaced immediately. Ms C also denied that the sensor mats did not work, noting that any equipment that did not work would be brought to the attention of the property manager.

64. Summerset told HDC that the sensor mats are checked upon commencement of their use when they are plugged in and before a resident is left alone. Summerset said that clinical notes refer to the sensor mat triggering. Clinical notes on 25 April, 2 May, 13 June, 15 July, 25 July, and 29 July 2019 specify that the sensor mat had triggered.

65. Clinical notes make inconsistent remarks about the sensor mat. Many progress note entries by caregivers and nurses record that the sensor mat was plugged in but do not necessarily record whether it was working. Progress notes on other occasions such as on 2 March, 13 March, 19 March, 22 March, 4 April, and 14 April 2019 do not specify whether the sensor mat had alarmed. Rather, staff documented that Mrs A had been 'found' sitting/lying on the floor after hearing Mrs A fall to the ground.

66. Further, on 18 April 2019, a nurse specifically recorded in an incident form that the sensor mat did not alarm despite it being plugged in. The incident form did not record what actions were taken to address the issue.

67. Ms C told HDC that Mrs A would wriggle down the bed so as to exit the bed away from the sensor mat and deliberately evade its activation. However, this has not been documented in the incident forms or clinical notes. Mr B also told HDC that he considers that Mrs A's moon boot or cast would have made such 'wriggling' difficult.

Room arrangement

68. Mr B told HDC that Mrs A's room arrangement was dangerous. In particular, he said that Summerset placed the right side of her bed against the wall, meaning that Mrs A's subdural haematoma (on the left side) would have been the first point of impact if she fell from the bed. In addition, Mr B said that the bed was pushed against the wall because there was only one motion sensor available.

69. Ms C told HDC that this was the only wall against which Summerset could place Mrs A's bed. She said that using the other wall would have obstructed the entrance to the bathroom of the unit. It would also have meant that the call bell cable would trail across the bed to be within reach of Mrs A, creating a risk of tripping over the cable.

Oversized chair

70. Mr B told HDC that Mrs A was placed in an oversized chair and that this contributed to her falls as it put Mrs A 'below the visual field' of the nursing station, and she did not use a call bell and would try to mobilise herself.

71. Incident reports and clinical records do not always record the contributing factors to a fall or how it happened. However, there is evidence of two falls that appear to have occurred because Mrs A slipped from the chair. The incident reports do not record how the slip happened.

72. Ms C told HDC that Mrs A had a standard chair and that this was reclined at times to allow her to sleep while she was in the nurses' station, where staff had direct observation of her. Neither Summerset nor Ms C explained how Mrs A slipped from the chair. Clinical records show indication of an assessment of the suitability of the chair with respect to Mrs A's short stature.

Moon boot

73. Mr B told HDC that Mrs A's moon boot fitted loosely for over a week.

74. A moon boot was fitted on Mrs A's leg following her ankle fracture on 29 April 2019. On 7 August 2019, a nurse recorded in the incident form that the physiotherapist had alerted nurses to the fact that the moon boot was fitted loosely on the left leg.

75. Clinical notes from Health NZ advised staff to ensure that the footwear was not fitted too tightly, to ensure adequate circulation, which is likely to have contributed to the loose fitting of the moon boot.

76. Following the alert from the physiotherapist, caregivers were shown how to secure the moon boot appropriately. The clinical notes contain no further reference to the moon boot being fitted incorrectly. Likewise, Ms C told HDC that there were no further concerns relating to Mrs A's moon boot being loose.

Pain management

Complaint

77. Mr B raised concerns about Mrs A's pain management, particularly following her ankle fracture and L3 compression fracture. In particular, Mr B had concerns about how Summerset staff assessed Mrs A's pain. Mr B told HDC that 'asking a patient who suffers from dementia if she has pain is a blunt and inaccurate assessment tool'.

Policy

78. Summerset's Pain — Assessment and Management Policy (dated May 2018) states the following:

- Pain has major implications for the older adult and if unrelieved can result in functional loss and increased dependence, reduced mobility, and worsening of cognitive impairment.
- An STCP should be developed when the suspected cause of the pain is likely to resolve (eg, post fracture).
- A registered nurse must reassess the resident for pain two hours following a pain-related event.
- Pain assessments must be completed when an existing resident presents with acute pain or worsening pain, where the pain has not been an issue previously or has been well managed, or when a resident has an injury or incident or returns from surgery and where pain may be new or worsened.
- Pain assessment may be completed using the IOWA (numerical scale) or Abbey (visual) scale.
- The effectiveness of PRN (as required) pain relief is to be documented in progress notes, and residents who have received PRN pain relief over a three-day period or have had five or more doses in a week should be reviewed so that regular pain relief can be prescribed.
- Staff must observe for side effects of pain medications and ensure that strategies are in place to manage these appropriately.

Evidence of pain management

79. As discussed above, Mrs A had multiple injuries following fall events. While the progress notes refer to pain levels being checked, the use of a formal pain assessment tool was inconsistent. Clinical records show evidence of the IOWA pain assessment tool being used, but there is no evidence of the Abbey pain tool being used.

80. Mr B told HDC that verbal assessment of pain for dementia residents is not always effective, and that Mrs A tended not to make complaints about pain. Clinical records refer to non-verbal indicators of pain such as 'moaning', but staff did not always note how this was managed.

81. Mrs A was discharged from hospital on 27 August 2019 following treatment of an L3 compression fracture. Mr B told Summerset and HDC that Mrs A had been prescribed oxycodone[20] throughout her hospital stay and he was concerned that it was not charted once she was discharged back to the Summerset facility.

82. Discharge documentation from Health NZ included a prescription only for paracetamol rather than oxycodone. Mr B said he asked staff to arrange for an oxycodone prescription immediately, only to be told that the GP would review Mrs A nearly a week later and consider prescribing the medication then. Mr B stated that there was no post-discharge GP review until 10 September 2019.

[20] An opioid medication that relieves pain.

83. Summerset told HDC that Mrs A was referred to the GP on 29 August 2019 following reports of pain, and additional analgesia was prescribed on this day. Summerset said that an immediate review of Mrs A was not arranged with the GP as there was no indication for this.

84. Although the presence of pain was documented within the progress notes on 29 August by a registered nurse and a physiotherapist, there is no evidence of a pain assessment tool being used or a pain score being assessed.

85. Summerset told Mr B that, as per Summerset's policy, pain assessment was undertaken by nursing staff following Mrs A's discharge, and paracetamol was administered, but Summerset acknowledged that effectiveness of the pain relief by way of a pain score assessment was not documented.

86. Summerset told Mr B that it also used alternative methods to control Mrs A's pain, including wheat packs, a lumbar cushion, and regular repositioning. However, Summerset acknowledged that this was not documented in the care plan. Summerset told Mr B that a pain assessment was completed following discharge, and Panadol was administered. An STCP started for the fall instructed staff to monitor Mrs A's pain and refer her to the GP if her pain was ongoing.

87. Summerset told HDC that Mrs A underwent a review by the GP on repeated occasions for pain, and the GP prescribed analgesia that they considered appropriate.

Complaints management

88. As indicated above, Mr B raised several concerns about Summerset's standard of care. Mr B was clear that these issues were raised with Summerset staff directly, but his statements to HDC indicate that his concerns were not resolved to a standard acceptable to him.

Policy

89. Summerset's Complaints Policy (dated March 2017) states the following:

- Formal complaints should be acknowledged within five working days.
- If an outcome to the complaint is not provided in 20 days, a letter should be sent every one month to report on the progress of the complaint.
- Once a formal complaint is resolved, the resolution should be recorded in writing, including what actions are to be taken and who is responsible for what, and a copy of this resolution should be provided to both parties for signing.
- Monthly complaint reports are to be generated from the complaints record, and this will be discussed at the monthly quality meeting.
- If the feedback is more like a complaint, the complainant should be referred to the Complaints policy and advised that they may wish to raise an informal or formal complaint.

Complaints record

90. This Office asked for a copy of all complaints made with respect to Mrs A's care. Summerset told HDC that except for a complaint raised in September 2019, no other complaints were registered within its system.

91. As discussed above, clinical records on 13 March 2019 record that Mr B raised concerns about Mrs A's repeated falls. The records show that the concerns were 'expressed in a disappointed tone', suggesting that this was a complaint. However, there is no evidence to suggest that staff encouraged Mr B to make a complaint.

92. Email correspondence shows that on 30 September 2019 Mr B sent a complaint to Summerset that raised concerns about a lack of attendance by staff during staff meetings, Mrs A's pain management, the circumstances surrounding Mrs A's falls, and Mrs A's poor sleep pattern.

93. The clinical records indicate that nursing staff acknowledged the letter on 30 September 2019. A further meeting was held on 22 October 2019 to discuss the concerns. Minutes were taken within the clinical notes by Ms C, who recorded that the family appreciated the meeting and accepted Summerset's apologies.

94. A letter was sent to Mr B by Summerset on 5 December 2019. The letter outlines Summerset's investigation findings into the issues outlined by Mr B on 30 September. However, the investigation findings did not reflect Mrs A's care accurately. It stated that Mrs A had had 13 falls with two fractures (Mrs A had had 18 falls with four fractures). In addition, it appears that Summerset did not inform Mr B that Mrs A had a tendency to evade the sensor mat alarm (as Ms C later told HDC).

95. Summerset's letter acknowledged the contradictory messages given to Mr B about the nature of Mrs A's ankle fracture (in March 2019), where some staff told him that the fracture had occurred with fall 2, while other staff advised that the fracture had occurred with fall 3. Summerset apologised for the conflicting information provided to Mr B and told HDC that it has reminded staff that they need to provide factually correct information to families rather than speculating. Further, Summerset told Mr B that the staff statements regarding sensor mats preventing falls was incorrect. Summerset apologised to Mr B regarding these issues.

96. Summerset's letter also noted that on 22 August the clinical manager reviewed the falls interventions to ensure that all preventive measures were in place. Summerset apologised if the review undertaken was not communicated clearly enough.

Family involvement in care planning

97. While clinical records show evidence of meetings held with Mr B and his family, and evidence of regular communication regarding GP reviews and incidents, there is no evidence of the family's involvement in Mrs A's routine care plan reviews by way of a resident review meeting.

98. Summerset told HDC that although there is no documented evidence that Mrs A's family were involved in her care plan review, staff discussed Mrs A's care with her EPOA regularly. Summerset stated that its usual practice is to involve EPOA/family in care plan reviews and

for EPOA/family to sign a form stating that they were involved. Mr B told HDC that any updates the EPOA received were simple updates, and not informed discussions.

99. In a further statement, Summerset told HDC that when dealing with Mrs A's EPOA, she was satisfied with the steps that were being taken. Summerset said that Mr B was less involved at the time, and his criticism post-event should not overtake what was actually happening at the time, when there was regular communication between Summerset and Mrs A's EPOA.

100. Mr B told HDC that there was no family involvement with care plans or reassessment of need levels, shown by the fact that interRAI assessment results were not shared or discussed, and the family were not informed of a 'massive' decline in Mrs A's cognitive capacity. Mr B also told HDC that Mrs A's family did not receive any clinical records or LTCPs for Mrs A during her care until the last one to two weeks before her passing, despite repeated requests from the family. Mr B said that this meant Mrs A's family were not able to take any meaningful action at the time of events.

Medication error

Complaint

101. Mr B told HDC that Mrs A was provided with an incorrect medication that went unnoticed for two weeks.

Policy

102. Summerset's Medication Management Policy (dated May 2018) outlines the following procedures for Summerset staff to minimise the risk of a medication error:

- All medication deliveries from the pharmacy will be physically checked by a registered nurse and documented on the Medication Delivery signing sheet.
- Accuracy of medication charting is vital and where staff have any concerns, they must follow this up with the prescriber.
- All residents will have their medications reviewed three monthly by the GP. The review date will be documented in MediMap.
- If the pharmacy is the subject of a dispensing error, the pharmacy must be contacted to inform them of the error.
- When a medication incident occurs, the usual incident reporting process follows and the resident/EPOA is to be informed.
- Medication reconciliation (the process of comparing the resident's medication order to medications the resident has been taking) should occur on return from a stay in hospital.

Medication incident

103. Mrs A arrived at Summerset on 27 August 2019 post hospital discharge. A medication prescription from Health NZ noted a dose increase for her medication metoprolol,[21] from 23.75mg to 47.50mg for poorly controlled atrial fibrillation. However, this change was not

[21] A medication used to treat heart conditions.

implemented by pharmacy and Summerset staff. This meant that Mrs A received 23.75mg of metoprolol from 27 August 2019 to 10 September 2019.

Incident management

104. The error was picked up by the pharmacist on 10 September 2019 and Summerset completed an RCA on the error, which noted the following issues:

- The medication prescription sent by the hospital was confusing — the script indicated 23.75mg, but under the 'signature' area, a dose of 47.50mg was noted.
- The medication was delivered (as part of a blister pack) at dinner time, which meant that staff did not have time to check the new blister pack against the medication script.
- Registered nurses did not follow the five rights of medication administration[22] and did not check the content of the pack against the medication script or Medi-map.[23]
- Registered nurses were complacent.

105. In addition, there is no evidence of a medication reconciliation being completed, as required by the Medication Management policy. It is not known whether hospital staff were also informed of the error.

106. The following corrective actions were taken in response to the error:

- The GP, family, and staff were notified of the error.
- The pharmacy reviewed its dispensing procedure.
- Pharmacy staff were requested to deliver medications 30 minutes before dinner time.
- All registered nurses involved in administering the medication completed medication competencies.
- Summerset '[i]ntensified proper receiving of medication pack; that is checking it against the script or medi-map'.

Relevant standards

Aged Residential Care Contractual Obligations

107. The ARC contract with Health NZ lists the following obligations for ARC providers:

- Services must be resident-centred and promote residents' independence and their quality of life.
- Providers must involve residents in decisions and encourage involvement of families in the provision of care.

[22] The 'Five Rights of Medication Administration' are a set of principles that ensure patient safety and reduce medication errors. The five rights are: right patient, right drug, right dose, right route, and right time.
[23] Summerset's medication management system.

- Providers must provide a caring, comfortable, and safe environment that respects residents' privacy and dignity.

Health and Disability Sector Standards 2008

108. The Health and Disability Sector Standards 2008 (NZHDSS) state the following:

> '1.1.13 The right of the consumer to make a complaint is understood, respected, and upheld …
>
> 1.1.8 Consumers receive services of an appropriate standard …
>
> 1.1.9 Service providers communicate effectively with consumers and provide an environment conducive to effective communication …
>
> 1.2.8. Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers …
>
> 1.3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner …
>
> 1.3.5. Consumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery …
>
> 1.3.6.1. The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes …
>
> 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process …
>
> 2.6 Family of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals …
>
> 3.5 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery …
>
> 4.2 Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose …'

Opinion: Summerset Care Holdings Group Ltd — breach

Introduction

109. Mrs A was a 99-year-old woman who resided in Summerset's care home from December 2018 until her passing in November 2019. Over the course of Mrs A's 11-month admission at Summerset, she experienced 18 fall events, some of which resulted in significant injuries and subsequent hospitalisation. Mr B complained to HDC about the standard of care provided to Mrs A by Summerset, particularly in relation to Summerset's falls management practices.

110. At the outset, I express my sincere condolences to Mr B and his family for Mrs A's passing. The circumstances surrounding Mrs A's falls were understandably upsetting for her family, and I appreciate their wish for an investigation. At the same time, it is important to acknowledge that Mrs A was an elderly woman with multiple comorbidities, including dementia, frailty, and osteoporosis, which increased her susceptibility to falls. In addition, it is not my role to determine why or how a fall occurred but rather to determine whether the standard of care provided to Mrs A was appropriate, which is the focus of my investigation.

111. While Mr B raised several concerns with HDC, this report focuses on the key standard-of-care issues, namely whether Mrs A's falls risk was recognised and mitigated appropriately, the adequacy of Mrs A's post-falls management, and communication with Mrs A's family. I am guided by my aged-care advisor, RN Jane Ferreira, in determining the key issues.

112. I have carefully reviewed all information on file, including the responses from Summerset and the clinical advice it received from Ms D, Mr B, and Health NZ, and I consider that aspects of Mrs A's care were not of an appropriate standard. I outline the reasons for my opinion in the following sections.

Falls management

113. Mrs A's multiple fall incidents were a primary concern for Mr B. While there is a dispute as to how many falls occurred, it is not relevant to my decision to make a finding on the exact number of falls that occurred, as my key concerns relate to the inconsistencies in the falls risk assessments, post-falls care management, and falls prevention planning.

114. I consider that many aspects of the care provided were appropriate, including clear guidance for staff in the event of a fall, the completion of baseline risk assessments and follow-up risk assessments following falls, regular FRATs, and adherence to the recommended framework for reporting incidents. However, I consider that other aspects of care did not meet accepted standards. I discuss each issue in turn below.

Adequacy of falls policy

115. RN Ferreira advised that Summerset's Falls Prevention and Management Policy was largely appropriate and provided clear guidance to staff, including the requirements for completion of falls risk assessments, mobility needs, care and safety responsibilities, falls review criteria, falls prevention and risk reduction interventions, management strategies to inform care planning, and incident management responsibilities. She said that the policy also recognises the importance of collaboration with a range of health professionals.

Adequacy of risk assessments

116. RN Ferreira was concerned about Mrs A's falls risk assessments.

117. First, RN Ferreira advised that although a falls risk assessment, LTCP, and interRAI assessment followed policy and were completed within the required timeframes (except for in September 2019), the progress notes contained minimal guidance by registered nurses regarding Mrs A's pre-admission history, the outcome of admission nursing assessments, care and safety requirements, or direction to an initial care plan when Mrs A was first admitted to the care home on 28 December 2018.

118. Secondly, the risk assessments were inconsistent. Preadmission screening classified Mrs A as a *medium* falls risk using the FRAT tool, whereas on admission the FRAT tool classified her as a *low* falls risk, while the initial care plan stated that she was a *high* falls risk. Further, her interRAI assessment of 21 January 2019 reflects a *medium* risk. The inconsistent risk assessments were also noted by Ms D, but Ms D advised that the variability did not alter the mitigations or Mrs A's falls management plan, which in her view were reasonably consistent.

119. Thirdly, RN Ferreira advised that subsequent falls risk assessment scores were not reflected in the care planning. A FRAT risk assessment was completed on 28 February 2019 as part of a post-fall event follow-up, which increased Mrs A's risk from low to medium. However, RN Ferreira advised that it was not clear whether Mrs A's nursing care plan was updated to reflect this increased risk. Likewise, on 14 March 2019 the interRAI assessment shows that Mrs A's falls risk was high, but the LTCP appears not to have been updated to reflect this increased risk.

120. Fourthly, RN Ferreira advised that following the fall on 28 February, the incident report was based on verbal information gathered from Mrs A's family, as the fall occurred offsite. RN Ferreira said that accepted practice would involve completing a full nursing assessment with objective and subjective information involving resident feedback about the fall, pain and vital signs, confusion and level of consciousness, skin integrity, range of motion, and mobility changes, ensuring that these findings were reported on the incident report and progress notes.

121. Fifthly, RN Ferreira advised that when Mrs A slipped off her chair on 1 March, there was no consideration of triggers leading to the fall event or consideration of Mrs A's unmet needs, such as boredom, loneliness, pain, and/or toileting. This meant that it was unclear whether additional measures were implemented to support Mrs A's safety needs, such as increased visual checks. RN Ferreira also advised that no repeat pain or vital sign assessment occurred, as required by Summerset's Falls Prevention and Management Policy. Further, while monitoring of neurological observations continued following a fall event the previous day (28 February 2019), they were completed at two-hourly intervals. RN Ferreira advised that accepted practice would involve increasing the frequency of the neurological observations as per Summerset's policy.

122. Sixthly, RN Ferreira said that on 28 February/1 March, Mrs A's blood pressure was elevated between midnight and 2am, but it appears that blood pressure readings were not repeated. RN Ferreira advised that this should have occurred, given Mrs A's history of head injury and pain.

123. Lastly, Summerset's Falls Prevention and Management policy stipulates that frequent fallers should have an MDT review to ensure that relevant interventions to reduce falls risk are in place. RN Ferreira advised that although there is evidence of input from the GP, pharmacy, and a physiotherapist, there was a lack of involvement from a specialist gerontology health professional or an occupational therapist in assessing the appropriateness of Mrs A's safety and equipment needs. This meant that there was a lack of holistic assessment of Mrs A's needs. On the other hand, Ms D advised that there *was* an MDT approach to Mrs A's assessments and planning, which involved GP review for medications, and physiotherapy,

nursing, podiatry and diversional therapy review. In addition, Ms D advised that all factors such as environment, physical status, and cognition were considered.

124. I acknowledge the differences in the clinical advice. However, I prefer RN Ferreira's advice. This is because whilst physiotherapy, diversional therapy, podiatry, and nursing care occurred, the MDT review and actions required did not reflect the heightened needs of an older person who had repeated falls in a short space of time or demonstrate the increased vigilance or proactiveness required to look after such a person. Aspects such as hearing and vision assessments were also not recorded. Although day-to-day observations may not have required such assessments (as provided by Summerset), I consider that it is clear that Summerset's post-falls policy requires such assessments.

125. In my opinion, comprehensive risk assessments are fundamental to developing well-informed nursing care plans and reducing the likelihood of adverse events. Risk assessments are ongoing processes and need to ensure that they are responsive to the consumer's changing needs. I concur with RN Ferreira that falls can be an indicator of health deterioration, and therefore there is a professional responsibility to complete nursing assessments and recognise risk or health changes. In this case, I consider that the risk assessments were completed inadequately, without meaningful analysis or adequate consideration of Mrs A's circumstances, which is in conflict with NZHDSS 3.5.

Adequacy of care planning

126. Mrs A's care plans show that there were comprehensive falls interventions at baseline, and clinical notes show that staff were responsive to fall events and changes to Mrs A's condition, and they completed regular assessments. Nutritional supplements were also provided to Mrs A as per policy. This was reflected in Ms D's advice. However, RN Ferreira had several concerns about Mrs A's care planning and care delivery.

127. First, typically care plans should reflect the risk assessments completed by nurses. However, there were several instances where this did not occur. As mentioned above, there were inconsistencies in the measurement of Mrs A's falls risk. RN Ferreira advised that this meant that Mrs A's LTCP was not updated accurately to reflect Mrs A's risk and ensure that falls interventions remained relevant to support Mrs A's progressive decline in cognitive and physical function. For instance, I note that Mrs A's dementia-specific behaviours such as impulsivity and wandering were not included within her care plans.

128. Secondly, there were limitations in the STCP completed. RN Ferreira advised that while an STCP was commenced to manage Mrs A's left ankle pain and swelling on 28 February 2019, the care plan provided limited guidance about comfort, medication use, and management of Mrs A's safety and essential care needs while on bed rest. Further, RN Ferreira advised that Mrs A's right clavicle fracture was overlooked because an STCP was not completed to reflect sling use, positioning, pain management, and care and safety risks. In addition, the progress notes make no reference to the right clavicle fracture.

129. Thirdly, between 28 February and 1 March 2019, Mrs A suffered three falls. The incident evaluation states that it is unclear which of the three falls caused the fracture, as an X-ray was completed after the last of the three falls. RN Ferreira advised that while a physiotherapy and registered nurse risk assessment was completed on 28 February, the

nurses waited for the X-ray referral, rather than proactively seeking GP guidance based on observations of increased ankle swelling. RN Ferreira said that there was a lack of timely escalation to the GP, with the nurses choosing to wait until the next GP round, rather than escalating immediately. This is particularly concerning given that, at the time, the family wished to take Mrs A to the emergency room. RN Ferreira advised that if a resident has severe pain on standing or refuses to stand, then immediate GP/NP (nurse practitioner) or urgent care review should be sought, particularly when there are concerns about weight-bearing. RN Ferreira said that nursing staff could have considered seeking a paramedic review for a post-falls assessment.

130. RN Ferreira advised that overall, given the frequency of Mrs A's falls and her high falls risk, it would have been appropriate to have implemented more frequent visual checks at high-risk times and considered safety measures such as a review of equipment and/or options for a one-to-one carer.

131. RN Ferreira advised that the deficiencies related to care planning represent moderate departures from the accepted standards of care. On the other hand, Ms D advised that all appropriate falls prevention interventions were utilised responsively by Summerset and that every effort was made to ensure that the available risk management strategies were used. I acknowledge Ms D's advice; however, I prefer RN Ferreira's advice as it corroborates closely with the evidence on hand. In my opinion, while there was a reliance on generic solutions, the care plans did not effectively address individual risk factors such as changes in Mrs A's cognitive status and were not responsive to her changing needs.

Incident management process

132. This Office requested a copy of Summerset's Incident Management procedure. Summerset did not provide this information, but its Falls Management and Prevention policy outlines some of its responsibilities in managing falls incidents.

133. The Falls Management and Prevention policy stipulates that frequent fall events are to be notified to the RQM. Summerset told HDC that the RQM was notified of Mrs A's frequent falls, as all CAT A events trigger an automatic email to the RQM. However, Summerset did not provide evidence of such notification, including any actions taken by the RQM, stating that this would take considerable time to retrieve, and the clinical records contain no reference to notification of incidents to the RQM. Without this evidence, it is unclear whether these incidents were notified to the RQM, as required by Summerset's policy.

134. I note that there were at least three CAT A fall events, which Ms D also confirmed. Summerset's Falls Management and Prevention policy does not define a CAT A event or outline the incident management processes to be followed in such cases. However, Summerset's revised policy states that a CAT A incident is a 'reportable event'. Typically, these involve events of a serious nature. Both RN Ferreira and Ms D advised that there is no evidence of an investigation into the CAT A events. RN Ferreira advised that this is not in line with routine incident management and quality improvement processes. Ms D agreed with this advice. While routine incident forms were completed, there is no evidence of an RCA, trend analysis, or any other review involving input from senior leaders or MDT to identify the root causes and subsequent actions to address these.

135. Further, as noted, Mrs A experienced multiple falls over a short time. Mr B complained to HDC that the interventions to mitigate Mrs A's risk were 'generic' rather than personalised. A similar sentiment was expressed by RN Ferreira, who advised that the care planning did not reflect Mrs A's changing risk levels and was not personalised. I also note that although incident forms were completed, they did not critically analyse the contributing factors to the incident or provide an evaluation of the interventions in place. As the contributing factors were not critically evaluated or reflected in the forms, they could not be disclosed to the family. I discuss this later in the report.

136. Finally, while clinical reviews were completed by Ms C and a formal investigation was initiated by Summerset in October 2019 in response to Mr B's complaint, I note that the investigation findings were based on inaccurate facts. This included the number of falls and the number of fractures sustained by Mrs A. This meant that subsequently incorrect information was communicated to Mr B.

137. As noted by the Health Quality & Safety Commission (2017),[24] incident reporting is of value only if it is accompanied by meaningful analysis that leads to system changes designed to prevent recurrence of adverse events and near misses. Lessons learnt must be shared locally by individual health and disability service providers.

Communication and collaboration amongst internal staff

138. RN Ferreira advised that registered nurses have a professional responsibility to complete nursing assessments, recognise risk or health changes, escalate concerns to a senior nurse, and seek guidance from a GP or acute care services.

139. RN Ferreira is concerned that although Mrs A was assessed by a physiotherapist following a fall on 28 February 2019, and the physiotherapist recommended an X-ray referral as the next step, the nurses chose to wait for the X-ray referral rather than to proactively seek GP guidance based on observations of increased ankle swelling. RN Ferreira advised that the delay in seeking GP guidance on this occasion represents a moderate departure from the accepted standard of care.

140. Further, I note that there appears to have been a lack of communication between nurses and with the reviewing GP. Nursing notes do not indicate discussion with the GP regarding the changes in Mrs A's cognitive function, falls history, increased confusion, and impulsive behaviours. Likewise, it is not known what communication occurred between internal staff, including during shift changes, about mitigating Mrs A's falls, due to a lack of shift handover documentation and staff meeting minutes.

141. The above factors reflect a lack of collaboration amongst internal staff at Summerset.

Consideration of UTI as contributor to falls

142. RN Ferreira advised that in the days prior to Mrs A's fall on 28 February 2019, there was confusion, changes in her demeanour, and flank pain. Mrs A was assessed by the GP, and a urine sample was tested. Although the urine sample was not conclusive for a UTI, Summerset told HDC that Mrs A was commenced on antibiotics for suspicion of a UTI.

[24] National_Adverse_Events_Policy_2017_WEB_FINAL.pdf

Further, I note that Mrs A developed new urinary incontinence following her admission, which was not present at baseline.

143. RN Ferreira advised that older people with a UTI are at greater risk for fall events and at greater risk for developing delirium. She advised that there was a lack of consideration for Mrs A's delirium, recent UTI, and precautionary care interventions such as hydration monitoring. RN Ferreira said that the clinical notes provide limited discussion about nursing assessment and related actions regarding a UTI, and it appears that no STCP was commenced to guide Mrs A's clinical requirements. In addition, it appears that the UTI was not logged within the infection prevention and control log. Although Summerset said that a UTI test was not conclusive, it is clear that staff did not consider a UTI as a contributor to Mrs A's falls on 28 February and 1 March.

Conclusion

144. RN Ferreira advised that cumulatively the above deficiencies represent *mild to moderate departures* from the accepted standards of care. On the other hand, Ms D considers that these deficiencies in falls management represented only a *mild departure* from the accepted standards of care because all appropriate falls prevention interventions were utilised by Summerset. I note that apart from the level of departure, Ms D agreed with RN Ferreira's advice regarding the falls management.

145. I acknowledge that the two clinical advisors differ in the degree of departure identified; however, both concur that there were deficiencies in Mrs A's falls management. Therefore, on the basis of the clinical advice and evidence before me, I am critical of the standard of care provided to Mrs A. While essential nursing care was occurring, there is evidence to suggest that the care was not responsive to Mrs A's individual care needs, and the interventions provided were not proportionate to the risk and frequency of her falls. I consider that this resulted from a lack of critical thinking and poor oversight from the clinical leadership team.

Pain management

146. Mr B raised several concerns about Summerset's management of Mrs A's pain. In addition, I note that Ms D advised that the pain assessment, management, and evaluation were not at the expected standard.

147. RN Ferreira reviewed Summerset's Pain Assessment and Management policy and advised that it was appropriate. She said that the policy provided appropriate guidance regarding the assessment, care, documentation, and reporting responsibilities of nursing staff. However, she noted concerns regarding the application of the policy in some areas.

148. First, RN Ferreira advised that although analgesia was prescribed, there was a lack of regular pain assessments for Mrs A when she was discharged from hospital on 27 August 2019 following treatment of her L3 compression fracture. The clinical records refer to back pain, and nursing notes record that staff were 'monitoring for signs of pain'. However, the clinical records show no evidence that a pain assessment tool was being used. Similarly, RN Ferreira advised that after Mrs A sustained a left ankle injury on 28 February, pain scores were not recorded throughout March, despite Mrs A experiencing pain. On the other hand, Ms D advised that pain was assessed frequently, but inconsistently. Ms D advised that references

had been made to pain across the LTCP and STCP and in the progress notes, although she accepted that there was no pain monitoring chart.

149. Secondly, RN Ferreira advised that while Mrs A received regular pain relief between 29 August and 17 September 2019 to treat her pain, pain assessments do not appear to have been repeated following analgesia administration to measure its effectiveness. After Mrs A sustained a left ankle injury on 28 February, a pain score of three was recorded and analgesia was administered, but a pain score was not repeated to determine the effectiveness, which is in conflict with Summerset's Pain Management policy.

150. Thirdly, RN Ferreira advised that after Mrs A was prescribed opioid analgesia, clinical records do not show evidence of monitoring for side effects such as dizziness, nausea, fatigue, constipation, and, more importantly, how this affected her falls. RN Ferreira stated that this was not within accepted standards for a new medication. She advised that there were changes in Mrs A's wellbeing between 29 August and 17 September 2019, such as decreased appetite, weight loss, and drowsiness, but nursing staff did not consider the side effects of opioid medications as being a contributing factor and or escalate it to the GP.

151. Lastly, clinical records demonstrate that Mrs A experienced significant pain on some occasions, such as on 28 August, as demonstrated by nursing and physiotherapy notes. RN Ferreira advised that staff did not escalate these concerns to a senior staff member or the GP for review and/or commencement of new medication.

152. Further, I note Mr B's concern that staff were using verbal assessments to monitor Mrs A's pain. This is partially shown by the use of IOWA pain assessment tools. However, I also note references to non-verbal indicators within the progress notes, which suggests that staff did consider this, although a lack of documentation makes it difficult to assess how this was managed. Ms D also advised that in a resident who is unable to communicate, the Abbey Pain Scale should be used, and this was not utilised by Summerset staff.

153. RN Ferreira advised that the above deficiencies regarding Mrs A's pain management represent a moderate departure from the accepted standards of care. I accept RN Ferreira's advice and disagree with Ms D's advice based on the evidence available. Regular pain assessment, including consideration of the effectiveness of any interventions, is crucial for maintaining comfort, preventing complications, and promoting recovery. I am critical that this did not occur for Mrs A.

Communication with family

154. Mr B's complaint indicated concerns about the communication provided to him by Summerset staff. Similarly, RN Ferreira raised concerns about the standard of communication provided to Mrs A's family. Ms D also noted that there were a couple of instances in which Mrs A's family were not notified in a timely manner. First, Mr B told HDC that Summerset staff did not inform the family that Mrs A had suffered a clavicle fracture from the fall that occurred on 1 March 2019. As discussed above, clinical records do not reference Mrs A's clavicle fracture, and there was no STCP in relation to the management of this fracture, suggesting that this injury had been overlooked. I consider it more likely than not that the clavicle fracture was not communicated to Mrs A's family.

155. Secondly, RN Ferreira advised that while there is evidence of regular discussions with family within the clinical notes around care decisions, as has been advised by Ms D, there is no evidence of their formal participation and involvement in Mrs A's care review process, initially in January 2019, or during the second review in September 2019, which is not in accordance with the ARC agreement and NZHDSS 2.6, which stipulates the need to allow family to participate in evaluation of clinical services and planning of cares. This is concerning given the clear and repeated interest by Mrs A's family to be involved in her care.

156. RN Ferreira advised that the resident review process is an opportunity to revalidate the currency of resident care information in partnership with the resident and their nominated representative(s) and the care team, to ensure that an accurate resident profile is maintained.

157. Thirdly, clinical records show evidence of Mrs A's family raising concerns about her falls on several occasions. Clinical records show that Summerset staff appeared to be responsive to their concerns, with a telephone conversation being held on 13 March, a formal meeting on 23 July 2019, and staff engaging with Mrs A's family on several occasions during their visits to the care home. Ms D advised that the family were contacted within one day of most falls occurring and generally these communications became more proactive following hospitalisation and major injury events. However, RN Ferreira advised that although there are no documented meeting minutes, it does not appear that the family were updated on findings from any serious event investigations, offered an apology, or invited to meet with the senior leadership team prior to October 2019.

158. A lack of explanation as to how and why Mrs A's multiple fall events occurred likely heightened the family's stress and eroded their confidence in Summerset's commitment to Mrs A's care. Moreover, there were missed opportunities for the family to provide practical solutions that were resident-centred, such as the provision of a Lo-Lo bed, and to implement meaningful changes.

159. Fourthly, a discussion was held over the phone on 13 March 2019 regarding bedrail use to prevent falls, in which staff acknowledged the suggestion, and health education was provided to Mr B regarding the risks associated with bed-rail use. Further, as stated above, several other concerns were raised by the family. RN Ferreira advised that Summerset could have communicated in a more constructive manner with a summary of the discussion points and agreed outcomes and reference to the discussion in Mrs A's LTCP.

160. Lastly, I note that there were inconsistencies in the information provided to Mr B. Staff provided conflicting statements as to how and when Mrs A's left ankle injury occurred and advised Mr B that a sensor mat would prevent a fall, rather than alert staff to movement. These conflicting statements were acknowledged by Summerset, and it apologised to Mr B for these communications. Further, as discussed above, Mr B was led to believe that a Lo-Lo bed was available within Summerset's facilities.

161. RN Ferreira advised that the above deficiencies in communication represent mild to moderate departures from the accepted standards of care. I accept this advice. Good communication between families and care providers is vital for delivering high-quality, resident-centred care. By fostering open and clear communication, care providers can

better meet the needs of residents and their families. Unfortunately, this did not occur for Mrs A's family.

Documentation

162. There were several instances within the clinical records where documentation was lacking. This includes the lack of initial guidance within progress notes by nursing staff following Mrs A's admission to Summerset, the absence of head-to-toe assessment findings, inconsistencies within risk assessments, incomplete falls assessments such as lack of documentation as to whether an incident was a CAT A event, a lack of progress note entries by registered nurses following falls, a lack of contributing factors to fall events and individualised risk factors, and a lack of documentation regarding the actions taken by the senior leadership team. Regarding pain management, there was inconsistent use of pain assessment tools, a lack of pain assessments following injuries, and a lack of documentation of pain scores following interventions and use of alternative pain relief methods. Finally, there was a complete absence of critical areas of care such as visual checks completed and evidence of RQM intervention following serious events.

163. Documentation is a record of patient/client care. It is essential for good clinical communication and a core requirement by the NZHDSS.[25] The standards state that care providers are responsible for maintaining clear, concise, timely, and accurate records, but in this case this did not occur.

164. The multiple examples of poor documentation reflect poorly on the system at Summerset. Clinical records should reflect a clinician's reasoning and are an important source of information regarding the patient's care. Documentation is also a key component of ensuring continuity of care, so that the next clinician can understand the rationale behind previous clinical decisions. In my opinion, clinical documentation is a cornerstone of good care, and a required standard of professional practice. In addition, poor clinical notes hamper later inquiry into what happened — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry. Therefore, I am critical about the multiple areas where documentation standards were not adhered to.

Conclusion

165. In summary, there were several departures from accepted standards by Summerset in the provision of Mrs A's care, of which I am critical. Cumulatively, I find that Summerset breached Right 4(1)[26] of the Code of Health and Disability Services Consumers' Rights (the Code) for the following reasons:

- The lack of personalised care to mitigate Mrs A's falls risk, including a failure to complete comprehensive falls risk assessments and care plans and consider UTI as a contributor to her falls;
- The lack of timely escalation to the GP following a fall injury and lack of communication with the GP following hospital discharge;

[25] https://www.standards.govt.nz/shop/nzs-8134-12008
[26] The right to have services provided with reasonable skill and care.

- The inadequate evaluation of Mrs A's multiple fall events;
- The lack of effective assessment and monitoring of Mrs A's pain;
- The lack of effective communication with Mrs A's family; and
- The deficiencies in documentation.

Environmental safety and equipment use — adverse comment

166. Mr B expressed multiple concerns regarding the equipment and the environment in which Mrs A was situated, highlighting their potential impact on her risk of falls.

167. Clinical notes show that a variety of equipment was used such as hip protectors, crash mats, a Lo-Lo bed, and sensor mats to mitigate Mrs A's high falls risk. In addition, Mrs A's bed was placed against the wall, and she was moved close to the nurses' station. During a night shift, often Mrs A was placed within the nursing station to increase oversight. Clinical notes also show that the nursing team ensured that the environment was decluttered and that Mrs A's call bell was within reach.

Lo-Lo bed provision

168. Mr B told HDC that a Lo-Lo bed was not provided to Mrs A in a timely manner, which he considered was a critical issue given Mrs A's short stature at 154cm, which meant that her feet were hanging off the bed. Mr B told HDC that staff informed him that a Lo-Lo bed was not available. This contrasts with Summerset's response in which Ms C told HDC that the standard bed Mrs A had initially was appropriate for her and there were no issues with her mobility.

169. Mr B told HDC that initially his family requested the Lo-Lo bed in February 2019; however, it was not provided to Mrs A until July 2019, as confirmed by Summerset. Clinical records confirm that the issue of the Lo-Lo bed was raised by Mr B as early as 13 March 2019.

170. Summerset provided varying statements regarding the earlier provision of a Lo-Lo bed. Initially it told HDC that its obligations to the ARC contract were met by providing a standard bed for Mrs A. In its second statement, Summerset told HDC that a Lo-Lo bed could act as a restraint and is provided only after a review by the RQM. Ms C's statement corroborates this. However, Summerset did not explain whether the RQM did in fact review the matter or what communication was provided to Mr B.

171. RN Ferreira advised that while Summerset may have met ARC obligations, the timely implementation of a Lo-Lo bed demonstrates a lack of commitment to person-centred care, as required by NZHDSS.

Sensor mats

172. Mr B told HDC that the sensor mats were ineffective as they did not always trigger upon movement.

173. Summerset told HDC that staff have no recollection of Mrs A's sensor mat not working, and the clinical notes record the sensor mat having been triggered. In addition, Ms C told HDC that Mrs A would wriggle down the bed so as to exit the bed away from the sensor mat and

deliberately evade its activation. Ms C told HDC that if the equipment had been faulty, it would have been brought to the attention of the property manager and acted upon.

174. The clinical records indicate that while there were instances where the sensor mat was triggered, there were also instances where it did not trigger. The records do not demonstrate why the mat did not trigger, and I found no evidence that Mrs A was deliberately evading the sensor mat. It is also not known what actions were taken to address the sensor mat not triggering, as there is an absence of documentation on the matter.

Equipment suitability

175. RN Ferreira advised that while a physiotherapist was involved in Mrs A's care, it is unclear whether the physiotherapist reviewed the suitability of Mrs A's bed or chair. The physiotherapist considered Mrs A's gait, balance, and strength, but there is no evidence that Mrs A's height or bed height were considered during the physiotherapy assessments for sit-to-stand transfers. RN Ferreira advised that bed/chair/toilet height is appropriate when a person's hip or knee angle is greater than or equal to 90 degrees with the feet flat on the floor.

176. RN Ferreira said that bed or chair suitability could also have been assessed by occupational therapists. Summerset told HDC that occupational therapists are contracted privately, indicating that this was the reason for not involving them in the assessments. However, Summerset did not indicate whether a discussion was held with Mrs A's family to arrange for a private OT assessment, which may have been indicated in Mrs A's circumstances.

Oversized chair

177. Mr B told HDC that Mrs A was provided with an oversized chair and that this contributed to her falls.

178. Incident reports and clinical records do not always record the contributing factors to a fall or how it happened. However, there is evidence of two falls that appeared to occur as a result of Mrs A slipping from her chair. The incident reports do not record how the slip happened.

179. Ms C told HDC that Mrs A had a standard chair and that this was reclined at times to allow her to sleep while she was in the nurses' station, where staff had direct observation of her. Neither Summerset nor Ms C explained how Mrs A slipped from the chair, and, as discussed previously, it appears that the suitability of the chair with respect to Mrs A's short stature was not assessed at the time.

Environment suitability

180. Mr B told HDC that Mrs A's bed was placed on the left side of the wall, which was unsuitable because it meant that Mrs A would fall onto her right side, where her previous head injury was located.

181. Ms C told HDC that this was the only wall on which Mrs A's bed could be placed, because use of the other wall would obstruct the entrance to the bathroom of the unit. Ms C said that placing the bed on the other wall would also have meant that the call bell would trail

across the bed to be within reach of Mrs A, which would create a further risk of tripping over the wire of the call bell.

182. I accept Ms C's explanation, but I note that this was not documented. Likewise, RN Ferreira advised that there was little discussion of environmental suitability within the evaluation of the falls events and Mrs A's care plans. Further, I note that while the environment was checked to ensure that it was decluttered, and the bed was placed close to the nurses' station, it appears that other aspects of the environment were not reviewed. RN Ferreira advised that a lack of information was collected about how Mrs A accessed the bed, her settling routines, and her access to lights, handrails, or other touch points. In addition, RN Ferreira advised that it appears that bed safety products such as a perimeter guard mattress do not appear to have been considered.

Conclusion

183. In summary, while I acknowledge the concerns Mr B raised about the environment in which Mrs A resided, I consider that many of these concerns were relatively minor and were addressed appropriately through Summerset's response.

Complaint management — adverse comment

184. Summerset told HDC that only one complaint was raised by Mr B. This relates to the letter sent by Mr B on 30 September 2019. However, clinical records show that complaints were likely raised earlier. Clinical records on 13 March 2019 note that Mr B sounded disappointed, meetings were held with the clinical team in July, and Mr B said that he had to keep repeating his concerns to staff.

185. The clinical records do not record whether Mr B was referred to Summerset's complaints policy.

186. Summerset's complaints policy stipulates that if feedback received sounds like a complaint, then the complainant should be referred to the complaints policy and advised on how to raise a formal complaint. However, there is no evidence to suggest that this policy was followed by staff.

187. I am concerned by Summerset's failure to record Mr B's initial concerns within its complaints log and refer Mr B to its complaints policy. Complaints serve as a mechanism to identify and address issues that impact patient safety and improve the quality of care residents receive. Logging complaints ensures they are tracked so that issues that occur repeatedly can be analysed to identify systems issues. I consider that in this case Mr B would have benefitted from earlier engagement through a formal complaints management process.

Transfer process between hospital and care home — adverse comment

188. RN Ferreira noted several concerns regarding the transfer of care from the care home to the hospital, and vice versa.

189. First, RN Ferreira advised that when Mrs A was transferred to Health NZ on 2 March 2019 due to a suspected fracture, the nursing notes did not discuss the transfer of care process, such as what time the ambulance was called or what supporting documents were completed as per patient transfer requirements.

190. Mrs A was discharged from another hospital admission on 27 August 2019. RN Ferreira advised that usual practice upon discharge from acute care would be for the hospital team to review medication use during the admission period to inform the discharge prescription and the ongoing plan of care. However, the clinical records do not show evidence of a handover occurring. Summerset stated that the handover would have occurred verbally and then been documented within the clinical notes. However, review of the clinical notes shows no evidence of this handover. RN Ferreira advised that this is a key opportunity for the care home nurses to gather essential information about the hospital stay and ask additional questions to clarify care requirements prior to accepting the resident back to the care home.

191. RN Ferreira said that, as part of the transfer, usually the care home is required to inform the GP/NP of a resident's return and, where indicated, clarify instructions from the discharge summary in line with service provider responsibilities. The clinical records show no evidence of a GP being informed. Summerset confirmed to HDC that no initial communication occurred with the GP as there was no indication for such a requirement.

192. RN Ferreira advised that the above deficiencies represent mild to moderate departures from the accepted standards of care regarding transfers of care. As RN Ferreira noted, older people are at risk of deconditioning and health decline following hospitalisation, and therefore it is crucial to identify changes from pre-admission presentation and make changes to the care plan. This should be done in partnership with the family and resident.

Medication management — educational comment

193. Mr B told HDC that Mrs A was provided with an incorrect medication, which went unnoticed for two weeks.

194. Summerset told HDC that this related to a metoprolol dosing error. When Mrs A arrived following discharge from hospital on 27 August 2019, pharmacy staff did not note the increased medication dose of metoprolol from 23.75mg to 47.50mg. As a result, a blister pack containing a metoprolol dose of 23.75mg dose was sent to Summerset. The incorrect medication dose was then administered by nurses until 10 September 2019, which is when the error was noted by the pharmacy.

195. An RCA completed by Summerset staff noted the key contributors to the issue as being that the pharmacy dispensed the wrong dose, the medication script sent by the hospital was written poorly, and staff did not follow the '5 Rs' for medication administration or checking of the blister pack against the medication script. The pharmacy, Mrs A's family, the GP, and the registered nurses were advised of the error, and incident forms were completed.

196. RN Ferreira reviewed Summerset's Medication Management policy and advised that this met accepted standards. In addition, she reviewed the incident response and advised that staff took appropriate steps to manage the incident.

197. I accept this advice and agree that the incident management was largely appropriate in that the error was responded to appropriately and relevant systems issues were identified. However, I note that the RCA did not acknowledge the lack of compliance against Summerset's internal policy regarding the completion of a medication reconciliation when Mrs A first returned to Summerset. In addition, there appears to be no evidence of staff

contacting the prescriber/hospital to clarify the medication script, as required by Summerset's policy in instances where the script is unclear. Further, the RCA is not dated or signed, which makes it difficult to determine the timeliness of the response.

Falls Prevention and Management Policy — educational comment

198. As stated above, RN Ferreira advised that Summerset's Falls Prevention and Management Policy was largely appropriate. I also note that since the time of the events, significant changes have been made to the policy. However, RN Ferreira noted that other aspects of the Falls Prevention and Management Policy could be improved. This includes clarification of reporting fall events that occur offsite, and associated care pathways and health and safety responsibilities. I agree and consider that a further review of the policy would be beneficial in light of this report.

Restraint use — no breach

199. Mr B told HDC that his request for bed rails to support falls prevention were ignored by Summerset staff.

200. Summerset's Restraint and Enabler Policy was reviewed by RN Ferreira, who advised that the policy was appropriate. Bed rails are classed as a restraint, and the Restraint and Enabler policy stipulates that restraint is to be used only as a last measure to maintain safety of the resident, and restraint should be used only if clinically indicated. Both the Restraint and Enabler Policy and the Falls Prevention and Management Policy stipulate that bed rails can contribute to increased harm for the resident and increase the risk for confusion and agitation, including injuries caused by trying to mobilise over or around the bed rails.

201. Clinical notes show that Mrs A's family requested bed rails as a safety intervention on 13 March 2019. Summerset told HDC that nursing staff had considered the use of restraint but ultimately determined that bed rails would increase the risk of harm, due to Mrs A's cognitive decline and poor insight, coupled with her reduced mobility. This was further reiterated in Ms C's statement to HDC. Clinical records show that this decision was communicated to Mr B on 13 March and that health education was provided.

202. RN Ferreira advised that the actions taken by Summerset with respect to bed rails was appropriate. I accept this advice and agree that the use of bed rails was neither clinically indicated nor safe in Mrs A's circumstances at the time.

Moon boot — no breach

203. Mr B told HDC that Mrs A's moon boot was fitted loosely for over a week and that this had contributed to her falls risk.

204. A moon boot was fitted on Mrs A's leg following her ankle fracture on 29 April 2019. On 7 August 2019, a registered nurse recorded in the incident form that the physiotherapist had alerted nurses to the fact that the moon boot was fitted loosely on the left leg. Ms C told HDC that moon boots are fitted with Velcro straps, which is what was loose on this occasion. In addition, clinical notes from Health NZ advised staff that the footwear was not to be fitted too tightly, to ensure that there was adequate circulation, which is also likely to have contributed to the loose fitting of the moon boot.

205. Following the alert from the physiotherapist, caregivers were shown how to secure the moon boot appropriately. The clinical notes contain no further references to the moon boot being fitted incorrectly.

206. Based on the above information, I am satisfied that staff managed the risk associated with loose footwear appropriately once alerted.

Room arrangement — no breach

207. Mr B told HDC that Summerset placed Mrs A's bed on the right side of her room against the wall. This meant that Mrs A would fall on her left side, that is, the side where she had a head injury. Mr B also asserted that Mrs A's lower leg cast following her left ankle fracture would have made exiting the bed more challenging with this room arrangement.

208. Ms C told HDC that this was the only wall against which Summerset could place Mrs A's bed. Ms C said that use of the other wall would have obstructed the entrance to the bathroom of the unit. It also would have meant that the call bell cable would trail across the bed to be within reach of Mrs A, creating a risk of tripping over the cable.

209. Further, I note that Mrs A had a right clavicle fracture as well as a left ankle fracture. Although it is not clear how the clavicle fracture was managed (if at all), placement of the bed against the wall on the left or right would not have been ideal. Under these circumstances, I consider that Summerset staff considered Mrs A's room arrangement appropriately.

Changes made since events[27]

210. Summerset told HDC that it has implemented the following changes:

- Reminded its staff about the requirement to undertake follow-up pain assessments after pain relief has been administered;
- Completed a two-hour moving and handling education session on 18 March 2019 and 25 March 2019;
- Implemented a new pain assessment tool called 'PainChek', which uses AI facial recognition to automate pain assessments for residents who cannot verbalise their pain level;
- Completed falls management training for staff on 1 May 2019, 15 July 2020, and 2 October 2020;
- Completed further training with the nursing team to ensure that they have the required focus relating to transitions from hospital to the care centre, ensuring that there is extra vigilance and assessment of pain;
- Reminded staff of the requirement to ensure that family involvement is documented for care plan reviews;

[27] Summerset told HDC that the changes made were 'general improvements that have been made in areas that would be relevant to [Mrs A]'.

- Recruited a national dementia specialist to support staff training and build knowledge in caring for people with dementia;
- Reviewed the Falls Prevention and Management Policy and Procedure and implemented a revised version in August 2019, which provides details on the quality improvement framework for falls prevention. This discusses benchmarking of falls data (fractures in relation to falls, falls with injury, and falls without injury) nationally against other care home providers. As part of this programme, results of RCAs from fall events are also discussed and training needs are identified; and
- Formed a national falls prevention group and falls prevention champion roles.

211. Further, in response to the provisional report, Summerset said that it undertook the following:

- Ceased use of the FRAT (as this tool does not assess for all risks that older people face, which in turn impacts the clinical judgement and resulting care plans, differing from the scores obtained using the tool);
- Changed to a comprehensive falls action checklist that aims to identify falls/risks that currently apply for each individual resident and cues nurses with appropriate risk reduction strategies to include in the Resident Care Plan and also triggers referrals to other healthcare team members and additional assessments as indicated. The checklist is issued on admission, at resident scheduled reviews, and post CAT A falls/events. The form is being integrated into the electronic system to facilitate direct care plan entry;
- Changed clinical handovers so that the correct workflows are encouraged for nurses to enter their progress notes in the electronic resident management system. This improvement has ensured that progress notes are completed in a timely manner and ensures that clinical handover information remains in the resident's electronic record;
- Refined falls management training to align with system changes at Summerset Falls and best practice, including the use of SBAR to support inter-professional communication;
- Employed a national clinical pharmacist three days a week and commenced multidisciplinary review teams to review unhelpful polypharmacy, and training on medicines optimisation and the contribution residents' medicines add to falls risk;
- Improved nutrition for residents, with up to 80–85% of residents now being prescribed vitamin D, and a boosting of an intake of calcium and protein to maintain muscle; and
- Introduced a care charter to guide staff in person-centred care policy, with monitoring of implementation via internal auditing.

Recommendations

212. I acknowledge the significant number of changes made by Summerset since the time of the events. In addition, I am mindful that providing recommendations at this stage for errors that happened some time ago is likely to have limited practical benefit. However, I consider that moving forward, it would be valuable to implement the following recommendations:

a) I recommend that Summerset provide a formal written apology to Mr B and his family for the breaches of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr B and his family, within three weeks of the date of this report.

b) I recommend that Summerset review its Falls Prevention and Management Policy in light of this report. Evidence of this review, along with corrective actions to be implemented, is to be provided to HDC within three months of the date of this report.

c) I recommend that Summerset review its incident management processes in line with the deficiencies identified within this report. Evidence of this review and corrective actions to be implemented is to be provided to HDC within three months of the date of this report.

d) I recommend that Summerset consider completing training for its staff on the following topics:

- Complaints management procedure; and
- Investigating incidents, including CAT A and repeat events.

Evidence of the training being completed by way of provision of attendance records of staff is to be provided to HDC within three months of the date of this report.

e) I recommend that Summerset review its medication reconciliation process in line with the deficiencies identified in this report. Evidence of this review and corrective actions to be implemented is to be provided to HDC within three months of the date of this report.

Follow-up actions

213. A copy of this report with details identifying the parties removed, except Health NZ, Summerset Group Holdings Limited, Summerset Falls, and the clinical advisor on this case, will be sent to HealthCERT at the Ministry of Health, and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

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

'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Summerset Falls Care Home. 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.

Documents reviewed.

- Letter of complaint received 19 August 2020 and additional communications.
- Provider communications 13 October 2020 to 12 December 2023.
- Clinical records including nursing assessments, care plans, progress notes, monitoring forms, incident reports, communication records, medication records, hospital health records, GP notes and allied health records.
- Organisational policies and related information including complaints management, falls prevention and management, medication management, pain management, restraint and enabler use, education and training records.
- Additional information including response communications and expert advice.

Complaint

Mrs A's family have expressed concern regarding the care Mrs A received while resident at the care home in 2019. Their concerns relate to falls prevention and management, pain management, clinical oversight, communication and care.

Background

Mrs A, aged 99 years, was admitted to Summerset Falls Care Home on 28 December 2018 at rest home level care. Prior to admission to aged residential care she had lived at home, supported by community care teams, family and friends. Mrs A sustained a significant head injury in a fall event at home in November 2018, requiring hospital admission. Following treatment, she was discharged to a care home then later transferred to Summerset Falls Care Home. Mrs A's medical history included cognitive impairment on a background of dementia, atrial fibrillation, congestive heart failure, previous subdural haematoma with expressive aphasia sustained after a fall event, osteoporosis and frailty. Admission information reported that Mrs A was at risk of falls with nursing documentation indicating that she mobilised independently with the assistance of a walking frame and carer supervision and required some assistance to meet activities of daily living. Clinical assessment information refers to cognitive changes with short-term memory loss. Mrs A's niece held the Enduring Power of Attorney (EPOA) for personal care and welfare, although it was not activated at the time of admission indicating that Mrs A was still able to make decisions for herself. Between January and August 2019 Mrs A experienced multiple fall events with injury resulting in hospital admissions with ankle, clavicle, lumbar and pelvic fractures and related health concerns. During this timeframe she began to present with signs of cognitive and physical decline, and by October 2019 required full assistance to meet all activities of daily living. Mrs A's

health continued to decline, and she sadly passed away before her 100th birthday in late 2019. I extend my sincere condolences to Mrs A's whānau/family at this time.

Review of clinical records

For each of these questions please comment on whether the additional documentation provided has any bearing on any or all aspects of the original advice.

Please advise:

1. What is the standard of care/accepted practice?
2. Has there been a departure from the standard of care or accepted practice? If so, please identify how the care departs from standards or accepted practice, and the extent of that departure (mild departure, moderate departure, or severe departure) having regard to the scale in the table below:

No departure	The care provided was consistent with standards and accepted practice in all respects.
Mild departure	While generally acceptable, the care provided did not meet some standards or accepted practice to a minor extent.
Moderate departure	The care provided did not meet a particular standard or accepted practice but there were relevant mitigating factors present and considered.
Severe departure	The care provided fell well below an acceptable standard in respect of an essential aspect of the consumer's care, and there was an absence of relevant mitigating factors.

3. How would the care be viewed by your peers?

Question 1. Clinical Oversight

a) Please comment on the timeliness of nursing assessment, and post-fall monitoring of Mrs A following her return to the care home on 28 February 2019, and in the days preceding her hospital admission. Was this evidenced as consistent with accepted nursing practice. As part of this, please include comment whether any screening or consideration for urinary tract infection or delirium is evidenced.

What is the standard of care/accepted practice?

The organisation's Falls Prevention and Management policy and related post-falls process appears to provide clear guidance for qualified nurses and care teams to follow,

with reference to required sector standards, and refers to respected clinical and care resources provided by the Health Quality & Safety Commission of New Zealand. The policy outlines requirements for completion of falls risk assessments, mobility needs, care and safety responsibilities and falls review criteria. Appendix 1 of the policy discusses falls prevention, risk reduction interventions and management strategies to inform care planning. The policy refers to incident management responsibilities, post-fall management, fall investigation, identification of contributing factors to the fall, and corrective actions which appears in line with contractual requirements outlined in the Age-Related Residential Care (ARRC) Agreement and Ngā Paerewa Health and Disability Service Standards.

It would be expected that following a fall event, a resident would be assessed by an RN according to Falls policy guidelines, risk assessments completed with appropriate interventions in place. This would include providing the resident with a safe environment, continued RN oversight with focused carer support in place to ensure the resident was able to safely meet activities of daily living in line with care plan interventions. Any identified deviation from the resident's baseline, or known presentation, would require escalation to a senior nurse, communication with whānau/family, and involvement of specialist health professionals.

The reviewed nursing and medical progress notes state that Mrs A presented with confusion, changes in demeanour, and back/flank pain in days prior to the fall event on 28 February 2019. She was seen by her general practitioner (GP) on 26 February 2019 due to health and wellbeing concerns and commenced on a short course of antibiotic therapy for a suspected urinary tract infection (UTI).

As outlined in the Health Quality & Safety Commission's (HQSC) Frailty Care Guides, older people who are experiencing a UTI are at greater risk of fall events and developing delirium (HQSC, 2019; HQSC, 2023). Factors for nursing consideration would include monitoring a resident's vital signs, fluid intake, continence needs and elimination patterns, pain, mobility, decision-making, personal care requirements and safety needs. Partnered with this are responsibilities to communication and documentation standards to ensure well-informed care partnerships occur between the resident, their whānau/family and care team, to support delivery of appropriate care.

Registered nurses (RN) are responsible for the assessment, planning and delivery of resident care, and it would be considered accepted practice for the RN team to have close oversight of an unwell resident. Nursing progress notes appear to provide limited discussion of ongoing nursing assessment and related actions at this time. It is unclear if a short-term care plan (STCP) with supportive interventions was commenced to guide Mrs A's clinical requirements and whether the UTI was logged in the event management system as part of quality and infection prevention and control reporting responsibilities. It is unclear from the submitted documentation whether Mrs A was assessed by an RN prior to her outing on the 28 February 2019, if family were updated of her health status, or if health education was provided by the duty RN regarding care and safety needs.

The electronic care record reports that on 28 February 2019 Mrs A sustained a left ankle injury in a fall event while offsite with family. Nursing progress notes state that Mrs A

and her family returned to the care home and described the event to the duty registered nurse (RN). The nursing entry states that Mrs A presented with left ankle swelling and difficulty weight-bearing. She was assessed by the care home's physiotherapist whose primary assessment reported a possible left ankle sprain. Physiotherapy (PT) notes, nursing entries and the fall event report indicate that first aid measures were applied, neurological observations commenced, with a PT recommendation for an x-ray once the swelling had reduced. The event report states that the GP was not informed at this time. The Falls policy states that all falls are required to be reported into the electronic event management system, however, does not provide clarification regarding the criteria for reporting resident events that occur offsite, care pathways and related health and safety responsibilities which may present an improvement opportunity.

The duty RN appears to have completed an event report based on the verbal information provided by Mrs A's family. The report states that Mrs A was '*checked for bumps and bruises by her niece right after the fall … seen by the physiotherapist upon coming back to the Care Centre … head checked for bumps … checked for cognition, orientation, pain …*' As outlined in the Falls policy and post-fall management guidance, accepted practice would be to complete a comprehensive nursing assessment including subjective and objective information such as resident feedback about the fall, pain and vital signs, confusion and level of consciousness, skin integrity, range of motion, mobility changes and ensure findings were reported on the incident report and progress notes, in line with evidence-based practice and documentation standards. Event information reflects that a post-fall assessment and fall-event checklist were completed following the fall event, in line with policy guidance, noting the event occurred offsite. Mrs A's falls risk was reviewed in line with the Falls policy and reassessed to medium risk (14) on 28 February 2019.

A STCP to manage pain and swelling was commenced, however the interventions provide limited guidance about comfort, medication use, or management of Mrs A's safety and essential care needs while on bedrest with the ankle injury. Records show that a pain assessment was first undertaken at 1930hrs on 28 February 2019. Progress notes on the afternoon shift, 28 February 2019 discuss a swollen ankle, complaints of ankle pain with a pain score of (3), moderate pain, and administration of prescribed as-required (PRN) paracetamol. Nursing records do not reflect a pain score following administration of analgesia to determine medication effectiveness as outlined in the organisation's Pain Management policy. The care record shows that the next pain assessment was recorded in April 2019 which would be considered below accepted standards. The Falls Management policy discusses indications for neurological observations, assessment responsibilities and the monitoring process: *half hourly for two hours, hourly for four hours, then two hourly until discontinued ...*

The electronic neurological observations monitoring form reflects that Mrs A was assessed on the afternoon shift 28 February 2019, in line with policy guidelines. Documented recordings appear to be within her usual range, as shown in monthly observations records. However, it appears that Mrs A's readings became elevated at 0000hrs (BP 144/80, P.107) and were still above baseline at 0200hrs (BP131/98, P.88). There is no evidence that recordings were repeated at the time for clarification given

Mrs A's history of head injury, pain assessment completed, or that the frequency of monitoring was increased to ensure greater oversight, in line with falls policy guidance. It appears that neurological observations were completed at 0400hrs and 0612hrs on 1 March 2019 prior to the end of the shift. Progress notes state … (Mrs A) *has been settled this shift … asleep most of the time … has tried to get out of bed but has pain, assisted back to bed. Comfortable when not moving …* The RN entry provides no discussion about vital sign fluctuations or proposed rationale such as pain, repositioning or delivery of care. There is no evidence of pain assessment scores, further nursing actions, or discussion of care handover to the incoming shift.

It is unclear from RN progress notes if any nursing assessments occurred on the morning shift, 1 March 2019. Records show that neurological observations were not checked until 1602hrs on the afternoon shift which appears to be outside of falls policy guidelines and recommended practice standards (HQSC, 2019; HQSC, 2023).

It would be considered accepted nursing practice that communication and care of a resident following a fall event, including completion of post-fall observations, is a prioritised shift responsibility. Shift handover is an opportunity for nurses to peer-review post-fall findings to inform nursing actions, shift planning and resident care requirements. Given Mrs A's health history, raised vital signs, and compromised mobility due to the ankle injury it would be considered good practice to ensure that ongoing nursing assessment and post-fall interventions occurred in line with policy guidance and professional practice responsibilities.

A nursing entry at 2136hrs on 1 March 2019 and event report 2200hrs states that the duty RN had been informed by the RN on the previous shift that Mrs A had been found sitting on the floor of her bedroom at 1530hrs following an unwitnessed fall event. It is unclear why the fall event documentation was not completed by the assessing RN at the time, or a statement with rationale provided that care management was handed over to the incoming RN. The post-fall assessment states "slipped off chair" with no injuries reported. There does not appear to be any consideration of triggers to the fall event such as unmet needs (access to call bell or personal items, boredom, loneliness, pain, hunger, thirst, toileting requirements), compromised function due to the fall event the previous day with ankle injury, or recent unwellness with a UTI. It is unclear if additional measures were implemented to support Mrs A's safety needs at this time, such as an increased frequency of visual checks.

The post-fall documentation states "*ankle swollen+++ unable to weight bear, for x-ray and GP review".* The HQSC Frailty Care Guide's post-fall assessment resource states that if a resident has severe pain on standing or refuses to stand, to seek immediate GP/NP (nurse practitioner) review. It is also considered acceptable for RNs working in an aged residential care setting to also seek paramedic assessment to support clinical decision-making regarding further post-fall care.

At 2235hrs on 1 March 2019 Mrs A experienced a further unwitnessed fall event. Nursing documentation reports that Mrs A had rolled out of bed. The event description states that Mrs A was found lying on her back on her bedroom floor, a head-to-toe assessment was completed by the RN with no apparent injuries identified, noting that

Mrs A was assisted back to bed. There is no evidence of pain or vital sign assessment completed at the time. File information shows that neurological observations remained at two hourly intervals from 1602hrs 1 March until 0530hrs 2 March 2019. Accepted practice would be to return to steps shown on the post-fall flowchart for an unwitnessed fall event and nursing education resources and increase the frequency of neurological observations to reduce the risk of an unidentified head injury. File information shows that Mrs A's nominated representative was not informed of the fall events in line with event reporting requirements until 2 March 2019.

Records show the clinical manager responded to event notifications and raised concern regarding weight-bearing difficulties and a suspected fracture. It appears that following senior nurse guidance the duty RN arranged ambulance transfer to hospital for further assessment. The nursing entry provides no discussion of the transfer of care process in line with the organisation's Resident Transfer Policy. It is unclear what time an ambulance was called or what supporting documentation was completed as part of Waitematā DHB (now Health New Zealand | Te Whatu Ora) patient transfer requirements. It appears the electronic incident management system was updated to a "Cat A" fall with fracture event; however, I note there is no evidence of incident investigation in line with incident management and quality improvement processes.

Summary.
The evidence shows that there appear to be concerns relating to the timely completion of nursing assessments, consideration of safety needs, oversight and management of pain, completion of neurological observations, recognition of injury, communication and documentation standards. While the care home had systems and processes in place to guide nursing actions, there appears to be a lack of critical thinking to inform appropriate post-fall actions, care responsibilities and timely escalation. Care records show that the nursing team did not complete a 24-hour period of observation following the first fall event, with incomplete monitoring and review of safety needs following the second and third fall events. I am also concerned about a lack of consideration for Mrs A's recent UTI, delirium risk and responsibilities to precautionary care interventions such as hydration monitoring.

b). Following on from the above question, was the *escalation* of clinical concerns to the GP and allied health services actioned within accepted timeframes, based on Mrs A's clinical presentation from 28 February 2019.

What is the standard of care/accepted practice?
The Falls Management policy provides clear guidance about post-fall care, related clinical decisions and ongoing safety measures. The policy recognises the importance of collaboration with a range of health professionals, in line with accepted practice standards. Falls can be an indicator of health deterioration therefore RNs have a professional responsibility to complete nursing assessments, recognise risk or health changes, escalate concerns to a senior nurse and seek guidance from the GP/NP or acute care services (HQSC, 2019; HQSC, 2023).

Mrs A was assessed by a physiotherapist (PT) on the day of the fall event as evidenced in the care record. The related event report and post-fall assessment reports show that

the GP was not notified of the fall event. Post-fall documentation for the unwitnessed fall event 1530hrs on 1 March 2019 states that the GP was not informed and that Mrs A was to be seen by the GP the next day. Post-fall documentation for the unwitnessed fall event 2330hrs 1 March 2019 states that Mrs A was to be seen at the next GP round. The incident evaluation states … *unclear which of 3 falls caused fracture as x-rays only done after last fall …*

File information shows that the fall events were reviewed by the clinical manager who identified that the RNs waited for the x-ray referral, rather than proactively seeking GP guidance based on observations of increased ankle swelling. It is unclear what post-fall incident review process was in place by the care home leadership team, what post-fall review process occurred by the clinical manager and what expectations were in place regarding communication of care concerns. While event documentation reflects involvement of care home leaders, it is unclear what review process occurred following the three fall events, in line with incident investigation and quality improvement responsibilities.

Summary.
From the information reviewed to respond to this question I consider there to be gaps in nursing responsibilities to timely escalation of resident concern. While progress notes indicate that care was occurring, there is limited evidence of RN assessment and risk analysis to inform nursing actions. As outlined in question (a), health resource guidance states that if a resident has severe pain on standing or refuses to stand, to seek immediate GP/NP, or urgent care review.

c). Has there been a departure from the standard of care or accepted practice?

If so, please identify how the care departs from standards or accepted practice, and the extent of that departure.

From the information reviewed and summary comments, I consider there to be moderate departures from accepted practice in the circumstances.

Departure from accepted practice: *Moderate*

d). How would the care be viewed by your peers? It would be viewed similarly by my peers in the circumstances.

Question 2. Falls Management and Service Provision

a). Please comment on the specificity of Mrs A's interRAI assessments, long-term care plan, and mobility transfer guides; and if these accurately reflect cognitive and falls risk factors to safely guide staff in their care provision.

What is the standard of care/accepted practice?
The Age-Related Residential Care (ARRC) contract (D16.1) states that each potential resident will be assessed using the most clinically appropriate interRAI assessment tool prior to admission. On admission, the resident's health and personal care needs will be assessed to inform an interim care plan, with an interRAI assessment and holistic nursing care plan completed within 21 days of admission to the care home. Further

assessment and care plan review is required to be repeated every six months, or more frequently as clinically indicated.

Mrs A was admitted to the care home on 28 December 2018. Day of admission nursing progress notes provide little discussion regarding Mrs A's preadmission history, the outcome of admission nursing assessments, care and safety requirements, or direction to an initial care plan. Health information shows that Mrs A had recently sustained a head injury in a fall event, mobilised with a walker and had an unsteady gait, was prone to peripheral oedema, had experienced recent delirium, and was considered at high risk of undernutrition. Height is recorded as 154cm and weight 44kg. Mrs A had been assessed on 29 November 2018 (preadmission) as a medium falls risk using a Falls Risk Assessment Tool (FRAT) with a score of (13). She was reassessed on admission to the care home as a low falls risk with a score of (8). A mobility assessment was completed 30 December 2018 which indicated that Mrs A was independently mobile with a frame and mostly independent with assessed activities, requiring supervision and verbal prompts (4/18). Falls risk was identified with the tool reporting "erratic, unsteady" turns.

The initial care plan, however, states that Mrs A was a high falls risk, noting the use of a sensor mat. The plan provides guidance about mobility needs, including the use of a wheelchair if fatigued, activities of daily living, personal care and toileting requirements, level of ability and recommended support. Records show that a Falls-related care plan had been commenced by the previous care home on 29 November 2018 and updated on 16 January 2019. The care plan stated that Mrs A was at high risk of falling, with a recent head injury. She required reminding to use her walker, was prone to being unsettled during the night and confused on waking. It appears that supportive interventions were in place.

An interRAI clinical assessment was completed on 21 January 2019 which identified that Mrs A had situational memory concerns with reported difficulty finding her way around a new environment and recognising team members. Assessment comments refer to night restlessness and orientation concerns. Falls risk does not appear to be triggered. A long-term care plan (LTCP) was implemented on 23 January 2019 based on the interRAI assessment which appears to have been completed within contractual timeframes. The LTCP is comprehensive, reflects interRAI scores, and goals for care with interventions in place for identified needs at the time. The LTCP provides discussion of cognition and mood, noting forgetfulness, with supportive strategies in place. The LTCP identified a goal under Mobility and Falls Risk to *prevent falls, keep safe at all times*. It reflects an interRAI assessment score of Medium falls risk with discussion of falls prevention strategies, care and safety requirements which appeared appropriate at the time. Further sections of the care plan identify that Mrs A was at risk of undernutrition with monitoring interventions in place. Guidance is provided regarding medical needs, personal care and daily activities.

Mrs A's falls risk was reassessed using the FRAT on 28 February 2019 as part of post-fall event follow up, which stated "*now medium risk*" (13). It is unclear whether the nursing

care plan was updated to acknowledge the event and FRAT outcome score which would be considered accepted practice.

Following hospitalisation for the fall with fracture events, and increased care requirements, a "significant change" interRAI assessment was completed on 14 March 2019 and Mrs A was transferred to hospital-level care. The interRAI assessment shows that Falls were triggered (2) as "High Risk" with a comment that stated falls were addressed in the care plan, as evidenced in the Falls Management plan. File information refers to assessed changes in short-term, long-term, procedural and situational memory, noting difficulty comprehending the extent of the leg injury, with a rapid decline in cognitive and physical functioning following the fall events. However, it does not appear that the LTCP was updated from medium to high risk in response to the revised falls risk assessment, or that strategies were reviewed to support the identified decline in cognitive and physical function.

The hospital discharge plan required six weeks of non-weight bearing, under the care of outpatients orthopaedic clinic. An STCP was in place for the lower leg cast in place for a left ankle fracture, but it appears that the right clavicle fracture was overlooked. Hospital guidance is provided for care of the clavicle fracture including sling use for comfort however it would be expected that relevant information including positioning, pain management, care and safety risks be reflected in a STCP. File information shows that following the fall events on 1 March Mrs A experienced 11 further fall events to end July 2019. Fall event information reflects that post-fall care and documentation processes occurred in line with the falls policy but it is unclear from the reviewed documentation whether the care team holistically reviewed all nursing information in the care record, recognised the increasing signs of frailty and decline, or considered different approaches to care such as involvement of specialist gerontology health professionals. Mrs A's mobility assessment was reviewed on 26 July 2019 which indicated a significant increase in the level of required assistance (12/18) from the last assessment.

The specific Falls Care Plan reflects that RNs reviewed Mrs A's plan of care and provided revised guidance in March, May, July and September 2019. Care instructions include requirements for pain assessment, mobility and transfer plans, noting increased support required to meet toileting and personal care needs. Safety measures refer to call bell access and carer checks.

Records show that Mrs A's interRAI assessment and LTCP was next reviewed as part of a routine reassessment process in September 2019, which appears outside agreed contractual timeframes in line with service provider requirements. Comments report that Mrs A's physical and mental state had declined, and that she required the assistance of two carers to meet activities of daily living. Nursing documentation reflects interRAI scores were reflected in the care plan, noting that Mrs A had impaired memory, was unable to make safe decisions, with a cognitive performance score (6/6) and depression score (2/14). Communication was described as delayed, and unable to make a full sentence but able to respond with yes/no or short phrases. Relevant and supportive strategies are discussed in the LTCP.

Falls risk was triggered in the interRAI assessment as high risk, noting that risk and interventions were addressed in the LTCP. The "mobility and falls risk" section identified that Mrs A was unable to walk, requiring full sling hoist transfers with assistance from two care team members to reposition and transfer from bed to chair. Care plan comments refer to multiple fall events over the past six months, with discussion of injury, including left ankle and L3 compression fractures. The interRAI falls CAP reported medium/high risk and FRAT score (17) high risk. The LTCP reflects strategies and supportive interventions as outlined in the Falls policy with generic and personalised approaches to falls prevention. These are listed as well-fitting footwear, hip protectors, a clutter free environment, items in reach, call bell plugged in/working, use of a toileting plan, PT input, daily passive exercises, regular activities. Safety measures include call bell access, use of a sensor mat, low-low bed and provision of intentional rounding completed at two-hourly intervals. Given Mrs A's high falls risk status, frequency of fall events and care concerns raised from whānau, it may have been more appropriate to have implemented more frequent visual checks at high-risk times based on incident analysis, with consideration of additional safety measures such a review of equipment, options for one-to-one carer and/or whānau support, or access to funding for additional care hours.

Summary.
From the information reviewed to respond to this question it is apparent that recognised systems and processes were in place at the care home. Records show that the care team were responsive to fall events and followed the recommended framework of reporting, however there are apparent opportunities for improvement in documentation standards regarding the quality and consistency of care information. As outlined in health resources, the cause of falls can be multifactorial and related to a range of extrinsic or intrinsic factors (HQSC, 2019). This requires nurses to think critically when considering contributing factors to fall events, plan relevant corrective actions, and ensure that nursing documentation is clear, and provides consistent guidance to enable safe delivery of resident care across all shifts.

b). Further to a). Is there evidence of collaboration with the family?

What is the standard of care/accepted practice?
The ARRC Services Agreement and Health and Disability Service Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. It is unclear from the reviewed documentation whether Mrs A's nominated representative participated in the day of admission processes, nursing assessments or contributed to the initial care plan. InterRAI documents state that consent was given by Mrs A's EPOA (not activated, see Pg 13) to gather data and lists participants in the assessment process. The LTCP mentions family involvement in care, but it is unclear from the key documents whether they attended any resident review meetings which would be considered accepted practice, in line with contractual responsibilities. While specific whānau/family records and meeting minutes were not provided in the evidence bundle, entries in the care record show that regular communication occurred between the care home team and Mrs A's nominated representative regarding GP visits, care updates or resident events. It appears that Mrs

A's family provided feedback with progress notes reflecting discussion points from family meetings in response to raised concerns.

Summary.
From the information reviewed it appears that Mrs A's family were regularly involved in care discussions, however there is limited supporting evidence to demonstrate formal participation and involvement in the care review process. The resident review process is an opportunity to revalidate the currency of resident care information in partnership with the resident, their nominated representative and care team to ensure that an accurate resident profile is maintained as part of the evaluation process. While the organisation had policies in place regarding whānau/family participation in care, there appears to be an opportunity for improvement in care review processes and documentation standards.

c). Do you consider the falls risk analysis, investigation and interventions reflected in post-fall risk assessments accurately reflect consideration of an underlying diagnosis of dementia, and associated risks.

What is the standard of care/accepted practice?
The Falls Policy provides guidance regarding requirements for completion of falls risk assessments and post-event analysis. Incident management and patient safety principles recommend that comprehensive reviews of fall events are undertaken to consider why the event occurred, identify any patient factors or system issues and develop corrective actions in line with quality improvement methodology. Mrs A's medical history included cognitive impairment on a background of dementia, with a history of recurrent delirium. Hospital records refer to identified cognitive decline following the fall event in November 2018, prior to admission to the care home. Reviewed nursing assessments refer to short and long-term memory loss, with the LTCP listing supportive interventions to assist Mrs A's orientation to time, place and person. Nursing documentation and event reporting state that fall events were related to impulsivity, forgetfulness, and poor decision making. It is unclear whether the nursing team also considered clinical factors as a possible reason for the increasing frequency of fall events, such as pain, dehydration, constipation, medication involvement, increasing frailty, infection or possible delirium influencing safe decision making. The care record provides evidence of GP involvement in post-fall assessments, but it is unclear whether changes in cognitive function scores from interRAI assessments were shared with the GP to prompt further medical involvement.

Summary.
It is unclear whether fall events were reviewed in partnership with interRAI assessment scores by senior nurses to inform event follow up. While supportive strategies were in place to assist Mrs A with activities of daily living, it does not appear that the RN team considered the relationship between cognitive loss, increasing frailty, signs of loneliness or depression scores, including a change in living circumstances and underlying comorbidities which presents an improvement opportunity.

d). In relation to the above question: "If relevant" were these changes implemented in a timely manner, and do interventions evidence consideration of Mrs A's cognitive capacity.

What is the standard of care/accepted practice?
Following identification of assessed changes in a resident's cognitive function it would be considered accepted practice for the RN team to inform the GP and the resident's nominated representative regarding concerns with consent and safe decision-making and request a medical assessment, which is required to invoke EPOA responsibilities for personal care and welfare. The reviewed interRAI assessment and LTCP (January 2019) indicate that strategies were in place to support Mrs A's cognitive abilities at the time. Following hospitalisation in March 2019, an interRAI assessment was completed due to a significant change in Mrs A's care requirements. A STCP was in place to guide care interventions during the non-weightbearing six-week period, however it does not appear that the LTCP was evaluated and updated to reflect the recent delirium or proposed short-term changes in care level at that time. InterRAI comments refer to frequent falls, unsafe decisions, a need for constant supervision, and changes in short-term, long-term, procedural and situational memory, noting Mrs A was unable to comprehend the extent of the leg injury. The document comments on a rapid decline in cognitive and physical functioning. Progress notes 13 May 2019 reflect that Mrs A's nominated representative requested activation of EPOA responsibilities which records show was discussed with the GP on 14 May 2019, with GP notes reflecting activation on 13 June, following hospitalisation for a pubic rami fracture.

Summary.
As discussed above, activation of EPOA responsibilities is a medical decision. From the information reviewed it appears that Mrs A's nominated representative and GP were regularly involved in her care, and the file record reflects discussion of cognitive decline.

e). Please comment on the overall standard of nursing documentation relating to all falls sustained between 28 February and 27 August 2019 and whether this aligns with accepted standards of nursing practice.

What is the standard of care/accepted practice?
The Falls policy provides clear guidance regarding organisational expectations for post-fall care, documentation and reporting standards. It would be considered accepted practice to ensure that falls risk assessments were regularly completed with relevant and personalised prevention interventions reflected in a nursing care plan. It would be expected that following a fall event both documents were reviewed together with a post-fall assessment and event analysis completed to identify cause, contributing factors and corrective actions (HQSC, 2019; HQSC, 2023). Partnered with this is a responsibility to review clinical leadership, team understanding of falls minimisation strategies, risk mitigation and the importance of personalised plans of care.

On review of the submitted evidence it appears that first response systems and event processes were followed in line with falls policy guidance. The provider has advised that each of Mrs A's falls was investigated by the CCM or other RNs with event evaluation discussing strategies to reduce the risk of falling and related injury (such as sensor mat

use, footwear review and intentional rounding), but it is unclear whether the clinical team considered risk factors such as boredom, loneliness and appropriate use of equipment (e.g. chair style, comfort, positioning or seating in the dining room).

It does not appear that Mrs A's care plan (Jan 2019) was updated with revised interventions as discussed in fall event evaluations. Progress notes provide limited discussion of changes to nursing risk assessments, care and safety needs, and care plan documentation. It is unclear how changes in Mrs A's care were communicated by clinical leaders to the care team at this time. Given Mrs A's frequent fall history it would be expected that a vulnerable resident was actively sighted across each shift.

The Falls Policy (5.1) outlines site-specific responsibilities to falls prevention and management, including data collection, analysis, and improvement interventions. Section (5.2) states that a root cause analysis (RCA) will be completed for falls where a resident is admitted to hospital in response to a Category A reportable event, noting regional quality manager role responsibilities.

The post-fall processes provide limited evidence of event investigation including analysis of themes, contributing factors, or consideration of underlying health and wellbeing changes. It appears that the regional quality manager was notified of the fall-with-harm events resulting in hospitalisation, however it does not appear that significant event investigations occurred, in line with organisational policy standards. There is minimal evidence of event investigation with no evidence of RCA completion in response to the fall with fracture events, or evidence of a completed corrective action plan outlining improvements made in response to this complaint.

Summary.
From the information reviewed to respond to this question, it appears that while event follow up aligned to systems and processes, there are identified gaps in incident management responsibilities and quality improvement steps in the circumstances. Incident management is not just about reporting events. It is a continuous process that involves multiple steps toward resolution and improvement. The review has shown limited evidence of robust falls event investigation, including dedicated analysis of care of a high-risk, vulnerable resident. There is limited evidence of proactive clinical leadership with no evidence sighted of communication with the care team, including minutes from RN clinical review meetings, resident review meetings, quality, health and safety, education and training, or falls committee meetings, in line with policy actions.

f). Please provide comments on the provision of post fracture care in relation to the ankle fracture in February 2019; and further pelvic fracture in May 2019.

What is the standard of care/accepted practice?
As discussed in the Frailty Care Guides, collaboration between service providers is essential to ensure older people are safely and effectively supported while receiving fracture care. Following identification of a fracture and related treatment, it would be considered accepted practice for a verbal nursing handover to occur prior to resident transfer back to the care home. On return, the receiving RN would ensure that relevant nursing assessments were completed, GP informed, and an agreed plan of care

implemented based on specialist team guidance and goals for care. Hospital discharge information and the nursing care record show that Mrs A returned to the care home on 12 March 2019 following three fall events with injury. The RN entry provides a brief summary and states that Mrs A had a cast on her left leg. There is no discussion of sling use for the clavicle fracture or related comfort and care guidance. There is no evidence provided of nursing assessments completed on Mrs A's return to the care home, or review of falls risk, which would be considered accepted practice. It appears that a STCP was commenced for the fracture with generic interventions, however there is limited discussion of how carers were to support Mrs A's care and safety needs. Progress notes provide limited discussion of cast checks including neurovascular, pain and pressure injury risk assessments across each shift.

Orthopaedic clinic guidance refers to a six-week plan of non-weight bearing, followed by transition to a moon boot and gentle mobilisation with PT input. Hospital notes show that Mrs A was reviewed at fracture clinic on 12 and 18 March 2019. File notes discuss the ankle and clavicle fractures, with a recent hypoactive delirium, presence of spinal changes, compression fractures (age unclear) and healed rib fractures. Mrs A was seen again on 29 April 2019 for cast removal. A moon boot was introduced with guidance to start weightbearing under PT supervision. PT notes reflect assessment and relevant exercise plan with evidence of PT assistant support. Flags are identified regarding boot positioning, gait imbalance, deconditioning, memory and potential risk-taking behaviours.

I note there are limited nursing care instructions in the progress notes, or changes made to the STCP and mobility plan, which would be considered accepted practice. It is unclear how the changes in Mrs A's plan of care were communicated to the care team at the time. It is unclear if the RN team reviewed safety strategies and potential falls risk factors to ensure Mrs A's safety needs were maintained given the remobilisation plan.

Mrs A sustained a pelvic rami fracture in fall events on 16 May 2019 and was hospitalised for assessment until 5 June 2019. File information refers to the introduction of hip protectors, but there is limited evidence that pain, skin and risk assessments were completed on return to the care home. Mrs A experienced further fall events on 13 June, 20 June, 14 July, 24 July, 25 July, 28 July and 29 July. Records show she was assessed post-fall by the GP. Fall event evaluation states that relevant care processes were in place, however it is unclear specifically what these were. Given the frequency of fall events and injury history, it would be considered accepted practice for the care home managers to seek guidance, support and involvement from the regional quality manager, clinical and operational leaders at this time.

Summary

It appears that essential nursing care was occurring in the circumstances however there are identified opportunities for improvement in RN documentation standards particularly relating to nursing assessment, care planning and evaluation, and progress note entries, including demonstration of clinical reasoning in line with professional practice standards.

g). Please comment on the involvement of allied health services in relation to Mrs A's recurrent falls and whether relevant referrals are evidenced that are consistent with *Pre 2019* falls policy requirements; and Mrs A's individual circumstances.

What is the standard of care/accepted practice?
The Falls Prevention and Management policy (F16: 2018) in place at the time of Mrs A's admission references recommended practice standards and resources. Appendix 1 lists indications for specialist referral which would still be considered relevant guidance. The care record reflects involvement by the care home's PT for post-fall assessments of Mrs A's balance, strength, and gait, and input from a PT assistant in the delivery of passive exercises under the direction of the PT. Allied health records show that Mrs A received regular podiatry services with PT notes demonstrating care collaboration by recommending referral for a podiatrist-led footwear assessment.

Mrs A was under the regular care of a GP, with evidence of pharmacy involvement in medication reviews. Mrs A was also supported by specialist service teams with evidence of involvement by a Clinical Nurse Specialist from the Fracture Liaison Services and a Gerontology Nurse Specialist regarding a review and reassessment of care level. The provider has outlined processes for allied health referrals noting that the GP, in partnership with the RN team, was responsible for arranging referrals to relevant service providers where indicated. The provider has clarified that occupational therapist (OT) involvement in care home assessments was via a separate service contract. It appears that OT support was not sought regarding Mrs A's care, and as a comment may have been indicated in the circumstances.

Given Mrs A's fall frequency, increasing frailty and vulnerability, it is unclear whether the care home team considered arranging a multi-disciplinary resident review meeting between all stakeholders to review Mrs A's goals for care.

Summary: From the information reviewed it appears that the care home team worked effectively and in partnership with allied health colleagues in the circumstances.

h). Has there been a departure from the standard of care or accepted practice? *If so, please identify how the care departs from standards or accepted practice, and the extent of that departure.*

From the information reviewed and summary comments I consider there to be mild to moderate departures from accepted practice in the circumstances.

Departure from accepted practice: *Mild to Moderate*

i). How would the care be viewed by your peers?

It would be viewed similarly by my peers in the circumstances.

Question 3. Bed Provision

a). Please comment on the style of bed in place for Mrs A on admission, and whether you consider the provision of a lower bed was appropriate and whether changes to bed provision were implemented in a timely manner.

What is the standard of care/accepted practice?

Under the Age-Related Residential Care (ARRC) service agreement, service providers are required to meet a range of contractual obligations and demonstrate compliance through quality assurance processes, in line with the Health and Disability Services Standards. This includes ensuring that safe practices are maintained through the current policy guidance (D15.3) education and training, and provision of relevant equipment (D12g).

Mrs A's family have expressed concern regarding Mrs A's height, falls history and related equipment suitability. The provider has advised that a standard electric bed with an adjustable (high-low) capacity was in place at the time of Mrs A's admission and complied with sector standards. Following multiple fall events this was reportedly revised and a low-low bed introduced in July 2019.

File information reports that Mrs A was small in stature, with a height of 154cm. A falls risk assessment completed on admission in December 2018 stated that Mrs A was at low risk of falls. This was revised to medium risk in February 2019, and high risk in May 2019, with a range of interventions discussed in the care plan, however there is limited discussion of bed access, bed mobility, positioning or equipment use.

Records reflect evidence of PT assessment and involvement in Mrs A's care but it's unclear if bed (or chair) suitability was reviewed during the physical assessments. The FRAT and mobility assessments considered Mrs A's balance, gait and strength but it is unclear whether bed height was considered during assessment of sit-to-stand transfers. Research shows that appropriate bed height (and chair or toilet) is when a person's hip or knee angle is greater than or equal to (≥) 90 degrees with feet flat on the floor, with recommendations that care is personalised and visual markers added to the environment to ensure continuity of safe care (HQSC, 2020; Quigley, 2021).

Occupational therapists are known to provide cognitive, functional and equipment assessment for people in the workplace or living at home in the community. The provider has advised that access to OT services in the aged residential care sector required referral to an independent contractor rather than a hospital-based service. It is unclear whether a discussion was held with Mrs A's family about arranging a private OT assessment to review daily activities, falls risk and equipment suitability, which may have been indicated in the circumstances.

Mrs A was 99 years old when she moved into a care home. Prior to that she had lived at home in a familiar environment with a support network in place. The admission process does not appear to acknowledge this with a lack of essential information collected about bed access, location in the bedroom, or settling routines, such as which side of the bed Mrs A usually exited, access to lights, handrails or other touch points, any preferred items, clothing or footwear, bathroom location and use of mobility aids. The file information shows that whānau/family raised concern about Mrs A's falls risk following her return from hospital and the use of bedrails and a low bed as safety interventions while non-weightbearing with the clinical leader on 13 March 2019.

Falls minimisation strategies reflect the use of landing strips on either side of the bed, a sensor mat, call bell access, regular checks and assistance from the care team. However, on 16 March 2019 Mrs A reportedly walked unaided to the toilet, with reports noting the sensor mat was not triggered to alert the care team as she transferred from bed. On 19 March Mrs A experienced a further fall event, resulting in her bed being moved against the bedroom wall, allowing her to exit from one side only. It is unclear whether the care home team reviewed equipment use or considered bed safety products such as a perimeter guard mattress, bed (or chair) sensor alarms to monitor bed movement, in addition to the safety monitoring strategies in place at the time. I note there appears to be little discussion evidenced in fall event evaluation with minimal updates in relevant resident care plans.

Summary
While the available equipment reportedly complied with sector standards, it appears the wider decision-making regarding equipment suitability was not person-centred, nor responsive to family concerns. Mrs A was provided with a low-low bed in July 2019, and I concur with my colleague's previous advice that based on the multiple fall events this intervention could have been provided at an earlier stage.

b). Has there been a departure from the standard of care or accepted practice? *If so, please identify how the care departs from standards or accepted practice, and the extent of that departure.* From the information reviewed and summary comments I consider there to be mild to moderate departures from accepted practice in the circumstances.

Departure from accepted practice: *Mild to moderate*

c). How would the care be viewed by your peers?

It would be viewed similarly by my peers in the circumstances.

Question 4. Communication

Please comment on the communication with Mrs A's family following all falls, specifically relating to the ankle fracture; whether discussions regarding interventions and risk mitigation are evidenced and aligned with Summerset's adverse event reporting policy.

What is the standard of care/accepted practice?
The organisation's policies clearly discuss expectations for communication with the consumer and/or their nominated representative following resident events, including related documentation and reporting responsibilities, acknowledging service provider obligations to open disclosure. As discussed in a previous question, the care record including event information and related documents indicates that regular communication and interaction occurred between the care home and Mrs A's nominated representative during her admission. File information shows that Mrs A experienced two fall events on 1 March 2019. It appears from the post-fall documentation that communication about the fall events with Mrs A's nominated representative was delayed. The reviewed file information states: 1/3/19: Fall event at 1530hrs: "to be notified." 1/3/19: Fall event at 2324hrs: "to be notified." 2/3/19:

0620hrs: Mrs A transferred to hospital. Voicemail message left. 2/3/19: 0920hrs: Follow up phone call to Mrs A's EPOA by duty RN.

The ARRC service agreement (D16.3f) states … *that each resident and if applicable, his or her family/whānau or nominated representative will have the opportunity to have input into the resident's care planning process …* Records show that Mrs A returned to the care home on 12 March 2019 for ongoing care. Progress notes on 13 March 2019 provide a detailed account of a family meeting in response to raised concerns. It appears that a further meeting was held on 23 July 2019. It does not appear that care plans were reviewed and updated in response to identified meeting discussion points. It is unclear whether nursing assessments and related care plans were discussed with Mrs A's nominated representative at the time of concern in March 2019, or following successive fall events in line with adverse event management practice and quality improvement principles. It does not appear that Mrs A's EPOA was updated on findings from any serious event investigations, offered an apology or invited to meet with care home leaders in line with policy recommendations.

Summary.
While progress notes reflect that communication occurred between the care home and Mrs A's EPOA, there are opportunities for improvement in responsibilities to incident management processes, open disclosure and delivery of feedback.

Do you consider the facility response in relating to the consideration of bed rails aligns with the restraint standards relevant in 2019; and frailty care guideline (if these guidelines were applicable at the time of care)

What is the standard of care/accepted practice?
The organisation's Restraint and Enabler policy (2018) discusses the purpose and principles of restraint use, in line with the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards: NAS 8134.2.208 that were in place at the time of Mrs A's admission. The policy clearly discusses the rationale for use, consent, assessment criteria, documentation responsibilities, risk factors for consideration, care and safety needs. Relevant templates for use are included, with reference to role responsibilities, education and competency requirements, monthly reporting and audit tools. The care record reflects that communication occurred between Mrs A's family and the clinical team on 13 March 2019 regarding care concerns and request to use bedrails as a safety feature. The entry discusses risk factors regarding the use of bedrails in line with the organisation's Restraint and Enabler policy, noting use of other safety strategies. Research shows that the use of restraint is not a method of falls prevention, noting that bedrail use in people with cognitive decline can increase the risk of fall-related harm (HQSC,2019; HQSC, 2020; HQSC, 2023).

Summary.
From the evidence reviewed to respond to this question I concur with the advice provided by the clinical team at the time.

Do you consider the documented communication between Summerset and Mrs A's family provided adequate explanation of the rationale for use of the bedrails to enable informed decision making.

What is the standard of care/accepted practice?
The Restraint and Enabler policy provides guidance about communication with nominated representatives and the consent process required for restraint use if the intervention has been assessed as clinically indicated by qualified health professionals. Progress notes state that a discussion was held between the clinical manager and Mrs A's family on 13 March 2019 regarding bedrail use. The entry provides a reflection of health education provided to family with discussion points noted from the telephone conversation. This did not appear to be a formal meeting therefore the documentation process in the care record may have been considered adequate in the circumstances. However, given the content appeared to relate to communication of care concerns it would be considered appropriate to respond in a more constructive manner as outlined in the organisation's feedback and complaints policy. To support care, communication and documentation standards it would be recommended to provide the resident and their nominated representative with a summary of the discussion points and agreed outcomes, and reference the interaction in the LTCP, in line with evidence-based practice and quality improvement processes.

Summary.
I consider the actions taken by the care home team to be appropriate in the circumstances, and as a comment note opportunities for improvement in documentation standards.

d). Has there been a departure from the standard of care or accepted practice? *If so, please identify how the care departs from standards or accepted practice, and the extent of that departure.*

From the information reviewed and summary comments I consider there to be mild to moderate departures from accepted practice in the circumstances.

Departure from accepted practice: *Mild to moderate*

e). How would the care be viewed by your peers?

It would be viewed similarly by my peers in the circumstances.

Question 5. Pain Management

a). Please comment on the nursing oversight of pain assessments, analgesic administration and effectiveness monitoring from 28 February–27 August 2019 for Mrs A, and whether this aligned with Summerset's pain management policy.

What is the standard of care/accepted practice?
The Pain Assessment and Management policy in place at the time of Mrs A's admission provides guidance regarding criteria for completion of pain assessments, evaluation of pain, and approaches to pain management. The policy discusses signs and symptoms, including verbal and non-verbal cues, refers to the use of the Abbey and Iowa pain

assessment tools, and care plan responsibilities. The policy states that pain assessments will be completed on admission, six monthly, following resident incidents, any changes in behaviour, any significant change in health and wellbeing, on return from hospital, and medication changes including administration of new and as-required (PRN) medications to monitor effectiveness. The policy also states that people with cognitive impairment may not effectively communicate pain and to seek input from whānau/ family and other members of the care home team to inform a holistic assessment. Reviewed file evidence shows an inconsistent use of pain assessment tools during Mrs A's admission. Assessments were completed on 28 February 2019 with a score of (3), 13 April (1), 16 May (3), 20 June (2), 2 July (0), 28 July (3), 18 August (3;0) The care record reflects completion, but there is limited discussion of clinical reasoning to inform nursing actions or evidence of evaluation in line with policy guidance. Progress notes reviewed during the timeframe in question indicate that carers and RNs were observant with multiple statements describing no signs of pain, however there is limited evidence of pain assessment scores to support this opinion. An entry in the care record 22 August 2019 reflects RN review with a reminder to complete pain assessments using the IOWA tool. Given Mrs A's reported cognitive decline with communication difficulties the observational Abbey pain scale may have been a more appropriate and reliable tool for use in the circumstances.

While a STCP was commenced for the ankle fracture, there is limited evidence of regular nursing assessment and management of pain, and related care planning responsibilities for Mrs A's clavicle, lumbar and pelvic fractures. There also appears to be limited evidence of clinical leadership and senior nurse oversight of the RN and care team during the timeframe in question. It would be considered accepted practice to ensure that the care of a resident with a fracture is prioritised on each shift with evidence of regular senior nurse involvement in care evaluation. It would be reasonable to expect that fractures would be painful, particularly given the fall involvement. Medication records show that Mrs A was regularly prescribed Paracetamol during her admission for the management of pain, with an opioid medication introduced in August 2019 in response to the lumbar spine (L3) fracture. It is unclear from the reviewed documentation if pain was routinely assessed by nurses and prescribed analgesic medication administered prior to any care interventions. Accepted practice would be to ensure that a resident's health, wellbeing, functional status, pain assessment scores and medication administration records were reviewed ahead of GP rounds to ensure that appropriate, person-centred care was in place.

Summary.
It appears that the management of Mrs A's pain was not in line with policy guidance in the circumstances, with identified practice gaps in pain assessment, application of clinical reasoning, evaluation of actions and related documentation standards.

b). Do you consider the escalation of pain issues to the GP on 29 August 2019 following Mrs A's return to Summerset on the 27 August, timely and appropriate?

What is the standard of care/accepted practice?
The Pain Assessment and Management policy provides guidance regarding assessment, care, documentation and reporting responsibilities. RNs are required to complete

nursing assessments to inform evidence-based clinical decisions. Where concern is raised regarding a resident's wellbeing, and a deviation from their baseline presentation is identified, it would be considered accepted practice for the RN to seek assistance from a senior nurse, GP/NP, in line with professional nursing standards of practice. Health records show that Mrs A had been medically cleared for discharge from hospital on 27 August 2019. Usual practice as part of the discharge process from acute care would be for the hospital team to review medication use during the admission period to inform the discharge prescription and the ongoing plan of care. It is unclear whether a verbal handover of care occurred between the discharging RN and care home RN which is considered vital in the transfer of care process. This is a key opportunity for the care home RN to gather essential information about the hospital stay and ask additional questions to clarify care requirements prior to accepting the resident back to the care home. It is unclear whether the duty RN was required to complete a specific care home document to support the handover process. The file shows that a discharge summary with prescription accompanied Mrs A. It is unclear whether a nursing transfer letter with key nursing information was included. As part of the transfer of care process, the duty RN is required to inform the GP/NP of a resident's return to the care home and where indicated clarify instructions from the discharge summary in line with service provider responsibilities. It is unclear from the nursing notes if the GP was informed of Mrs A's return or what communication occurred regarding her clinical plan of care which would be considered accepted nursing practice. Good practice would include the use of a communication tool, such as ISBAR, to evidence interaction between health professionals and provide a record of related care instructions.

Progress notes reflect Mrs A's return to the care home on 27 August 2019. The RN entry refers to completion of nursing assessments with a comment of "no reports of pain". It does not appear that a STCP was commenced to guide Mrs A's care requirements this time, including a need for increased observation, regular RN review and GP escalation which is concerning. A pain assessment was completed at 1849hrs, scoring (4), severe pain lumbar back. There is no record of actions or further pain assessment at this time. It is unclear what information was communicated to the next shift with no evidence of revised care plan guidance at this time. Nursing entries 28 August describe delivery of care, noting full assistance was required with activities of daily living, and "*no reports of pain"*. Nursing notes refer to "*monitoring for signs of pain"* but there is no evidence that a pain assessment tool was completed across shifts on 28 August. Carer entries 29 August describe Mrs A as "*in a lot of pain … spitting out food … always moves … clearly uncomfortable"*. PT assessment notes describe Mrs A as "*still in significant pain and discomfort"*. It is unclear what clinical communication and escalation steps occurred between professional colleagues at this time. Progress notes provide no evidence of RN involvement, pain assessment, administration of prescribed medications, comfort measures, or consideration of care escalation to the clinical manager or GP/NP. There is no nursing evidence of GP/NP consultation regarding Mrs A's presentation, medication review, commencement of a new medication and related assessment and care responsibilities, in line with policy guidelines. There also appear to be delays in timely communication with Mrs A's nominated representative regarding the medication changes.

Summary.

From the information reviewed it appears that interactions with Mrs A's GP were not completed in a timely manner. It is unclear whether RNs recognised that Mrs A was experiencing pain, with limited evidence provided of nursing assessment, communication and collaboration with other members of the care team to inform nursing practice and care escalation.

c). Please comment on the analgesic administration between 29 August–17 September 2019 for Mrs A in relation to pain management and functional capacity, and whether this aligned with Summerset's pain management policy.

What is the standard of care/accepted practice?

The Medication Management policy provides clear guidance regarding administration of medications, and related responsibilities. I consider the policy to be clinically appropriate and consistent with recognised standards in the circumstances. As stated above, Mrs A was discharged from hospital on 27 August 2019 following a fall with fracture event. Discharge information discussed a proposed plan of care for the L3 compression fracture, and management of pain. Medications were reviewed by Mrs A's GP in response to RN concerns with additional opioid pain relief charted. It appears that regular pain assessments were not completed at this time, in line with policy guidelines for a new medication. There is limited discussion regarding the care of a resident on opioid medications, such as dizziness, nausea, fatigue, constipation, changes in cognition, increased falls risk, or delirium risk. File information between 29 August and 17 September discuss signs of change in Mrs A's wellbeing, such as a decline in food and fluid intake, weight loss and drowsiness. It is unclear whether side effects of controlled drug medication were considered by the RN team and discussed with the GP. It would be considered accepted practice to ensure that Mrs A's daily routines and care requirements were prioritised across each shift to ensure coordination of care and medication management to minimise risks of discomfort.

Medication administration records reflect that Mrs A received regular and PRN doses of pain relief as prescribed, however MediMap records do not report the outcome/effectiveness of the medication, which is considered accepted practice. Progress notes describe care occurring, such as assistance with meals and personal care, with reports episodes of discomfort. It is unclear from the varied range of administration times if PRN medication was given prior to delivery of resident care. GP records reflect involvement in care with entries 30 August, 3, 10, 17 September 2019, discussing resident presentation, adjustment of medications and administration of subcutaneous fluids to support rehydration. As a comment, I note that at this time a medication incident occurred which involved dispensing and administration errors. The clinical team appears to have responded appropriately in line with serious event practices. It is disappointing that the same diligence was not applied to the fall with harm events in the circumstances.

Summary.

I consider the management of Mrs A's pain and related administration of prescribed medications to be of the minimal standard. While progress notes indicate that care was occurring, there are identified gaps in nursing assessment and care planning, timely

administration of medications and evaluation of effectiveness in line with policy guidance.

d). Has there been a departure from the standard of care or accepted practice? *If so, please identify how the care departs from standards or accepted practice, and the extent of that departure.*

From the information reviewed and summary comments I consider there to be moderate departures in the management of Mrs A's pain and related care responsibilities in the circumstances.

Departure from accepted practice: *Moderate*

e). How would the care be viewed by your peers?

It would be viewed similarly by my peers in the circumstances.

Clinical advice

Thank you for the opportunity to respond to these questions. I have based my advice on recognised Aotearoa New Zealand health resources developed from current research which are highly respected guidelines used to inform policy and practice in the aged residential care setting. Research shows that falls are the leading cause of unintentional injury in older people, are often a consequence of frailty, and can result in significant injury, functional decline and death (HQSC, 2020; Abey-Nesbit et al, 2021; HQSC, 2023). The literature also shows that older people are at risk of deconditioning and related health decline following hospitalisation, which requires nurses to use assessment tools to identify changes from their preadmission presentation, and develop relevant, person-centred care plans, in partnership with the resident, whānau/family and the healthcare team (HQSC, 2019; HQSC, 2023 BPAC, 2024). In summary, from the evidence reviewed I concur with my colleague's opinion that the organisation's policies and processes met the recognised standard of care in the circumstances. Based on my review, I consider there are identified opportunities for improvement regarding the application of policy information to nursing practice, transfer of care process, and related responsibilities to the delivery of safe resident care.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

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Request for additional advice received 13 February 2025

'Thank you for the opportunity to review my advice, 9 April 2024 and provide clarification for my decisions. I have been asked to consider the following questions.

1) Falls related care

Under question 1 (a–c) and question 2 (a to g) you have noted several concerns relating to Mrs A's falls management and care. Then under summary for each sub-question, you have stated a departure. Under question 1 summary you state that there is a moderate departure. Under question 2 summary, you state that there are mild to moderate departures.

Could you confirm whether you consider there to be a cumulative mild–moderate departure for falls related care, or whether these are separate mild to moderate departures for each sub-question?

- On review of my advice in response to this question I consider there to be mild to moderate cumulative departures in the application of falls processes in the circumstances.

2) Pain Management

You have also noted several concerns relating to pain management — such as pain scores not being assessed post analgesia, and lack of pain assessments between 28 February 2019 and April 2019.

Please clarify what the level of departure is for pain management.

- Based on the discussion points raised I consider there to be moderate departures in the management of Mrs A's pain during the timeframe in question.

3) Care Planning

You have also noted some concerns relating to care planning — such as STCP not being commenced for the clavicle fracture, and lack of updating of care plans.

Please clarify what the level of departure is related to the care planning aspects of Mrs A's care.

- Based on the discussion points raised I consider there to be moderate departures in care planning in the circumstances.

4) Care Escalation

You have stated on 28 February, RNs waited for an x-ray referral, rather than proactively seeking GP guidance for Mrs A's increased ankle swelling.

Please clarify whether the delay in seeking GP guidance is a departure from the accepted standard of care, and if yes, what the level of departure this is.

- As outlined in my response to Question 1(b), I consider the delay in seeking GP guidance to be a moderate departure from accepted processes in the circumstances.

5) Provider response

Summerset has also responded to your advice. Please could you review this response and let me know if this changes any of your advice.

Thank you for the opportunity to review the provider's response with additional information. I acknowledge the review process has been distressing for all parties. I agree that significant changes have occurred across the aged care sector since 2019, with the implementation of new health and disability standards and quality improvement processes to strengthen service delivery and resident care.

Query with selected health resources

As outlined in the ARRC agreement, service providers are required to have clinical and operational policies and processes in place to guide resident care, with a system of regular review.

The provider's Falls Prevention and Management Policy (2018) was reviewed and reissued in August 2019. The policy editions (2018;2019) reference respected resources which were used to develop the Health Quality & Safety Commission's Frailty Care Guides. These resources are intended to support clinical decision-making, in partnership with organisational policies and procedures. I acknowledge the Frailty Care Guides were published during the latter part of Mrs A's admission.

As reported in my summary I consider that the organisation's policies and processes met recognised standards in the circumstances. My clinical review identified opportunities for strengthening the application of their policy information to nursing practice. The referenced Frailty Care Guides were used to provide additional context to policy steps as discussed within my review.

Feedback on clinical practice

No change to my original advice.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner'

Appendix B: Advice provided to Summerset by Ms D

Independent Clinical Review Report

Prepared for: Summerset Group

Prepared by: [redacted]

Date: 28 April 2025

1. Executive Summary
- Key findings at a glance

2. Introduction
- Purpose of the report
- Scope of this review
- Methodology used in the review

3. Clinical Care & Complaint Summary & Policy Review
- Clinical Summary
- Complaint Review
- Summerset falls and pain policy review

4. Appendices
- Summary and Timeline of Falls
- Documented Family Communication

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- Summary of Care Plans
- Summary of assessments and Actions

1. Executive Summary – Findings

On reviewing all of the documentation provided it is my opinion that the complainant raised genuine concerns regarding his aunt's care. She had multiple falls and required complex care management over a sustained period of time. I believe that the issues raised by [redacted] were addressed in the family meeting and the subsequent documentation that he received. The Clinical Care Manager was sincerely apologetic where care elements were not satisfactory, and I believe there was a genuine intention by the team to improve care practices. The team's ability to prevent [redacted] from falling was hampered by her general condition, including her age, physical health status, and cognition.

I can also see that communication generally occurred in a timely and appropriate way with the enduring power of attorney (EPOA) [redacted] and subsequently [redacted] and that as [redacted] condition declined, the family were kept informed and involved in her care.

There were some departures from the expected standard of care against policy, such as using an IOWA pain assessment tool vs an Abbey Pain tool, and one incident where neuro observations weren't taken in an unwitnessed fall, and two times where falls were not notified in a timely way to EPOA and one episode where care should have been escalated for assessment by the GP. However, in the elements I reviewed I believe that whilst there has been in some cases a mild departure from the acceptable standard of care, in general the care that was provided to [redacted] during her time at Summerset Falls was of an acceptable standard, at that time. There were 10 short term care plans and 2 long term care plans during [redacted] stay. The care was evaluated regularly as evidenced in the daily progress and handover notes. There were occasions where short term care plans did not consider all elements of care required, such as in pain management for her fractured right clavicle, I view this as a mild departure of the expected standard of the day.

The review of [redacted] pain assessment, management and evaluation, showed evidence of all of these elements occurring, however it was inconsistent, and therefore not at the expected standard.

I was able to review the advice provided by [redacted] dated 22 April 2021, her general view was that care was delivered of a standard that was mainly in line with accepted practice of the time. Bearing in mind the elements of care she was asked to review (i.e. not all care), I agree with her opinions. I also reviewed Jane Ferreiras' report, whilst I agree with her opinion regarding the falls management

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and service provision, including the non-completion of a root cause analysis post Category A reportable incident, I believe that there has only been a mild departure from accepted practice of the day here.
The limiting factor in this review has been that the documentation available to the reviewer may not reflect the actual care that was provided.

2. Introduction

Purpose of the report

I have been asked to review the complaint and the provisional findings in relation to the standard of care provided to [redacted] at the Summerset Falls Retirement village in Warkworth, from her admission to the care centre, at the end of November 2018 until her passing on [redacted] 2019. I have been asked to provide an opinion as to whether the care she received was of an acceptable standard, taking into account the policies and standards of the day.

Scope of this review

The review has been based on the documents made available to me by the Summerset team on the late afternoon of 14th April 2025, including some HDC correspondence and Summerset responses, Summerset clinical policies (falls prevention & management, pain assessment and management) [redacted] progress notes, care plans, fall events, hospital notes and communication with the family.

Methodology used in the review

For the purpose of this review, I systematically reviewed and logged all of the relevant documentation (see Appendices).
I focused on:

- the communication between the village and the resident and her family, particularly the EPOA
- the assessments undertaken by the whole multidisciplinary team,
- the care plans developed and the delivery and evaluation of care against those
- the documentation of care provided in the daily progress and handover notes
- the incidents that were reported, the escalation and management of those, including falls management, medication errors and skin integrity issues.

I have compared the care received against the Summerset policies I received for Falls prevention and Management and Pain assessment.

After my initial review of the documentation, I also reviewed [redacted] review and advice, and then subsequently reviewed Jane Ferrier's advice and the provisional HDC findings.

I also kept in mind the Health and Disability Services Standards 2008, which was the required standard for this period, as well as Health Quality & Safety Commission frailty care guides, 2019 (which didn't come into effect until mid-2019).

3. Clinical Care & Complaint Summary & Policy Review

[redacted] 1920- [redacted] 2019 resided at Summerset Warkworth from 29 November 2018- [redacted] 2019.

Clinical Summary

[redacted] was a 99-year-old petite (154cm) lady with a history of left frontal subdural haematoma with expressive aphasia, secondary to fall that occurred on the 3 of November 2018 in her home. [redacted] had severe dementia- cognitive impairment: ACE 73/100, CHF, Osteoporosis and Atrial Fibrillation.

When she arrived at the Summerset Warkworth care centre, from hospital, she was 44.8kg, with a recent right middle lobe pneumonia she was independent and walked with a lower walking frame. She had episodes of confusion, but did not complain of pain. She had an initial FRAT of 13 and was rated as medium risk, although assessments completed by the Physio and GP at that time refer to her as high falls risk.

During [redacted] time in the facility her general condition deteriorated over the subsequent 10 months. Her deterioration was mainly reflected in her worsening cognition, continence status and her determination to remain mobile. Her nutritional status fluctuated, but generally her nutrition improved, and her weight did peak at 51.5kg in July 2019.

During her stay she experienced a Category A medication error. She was charted Metoprolol 47.5mg for Atrial Fibrillation post her hospital stay on the 27 August 2019. The pharmacy, however, only added 23.75mg dose to her blister pack. The pharmacy picked up the error after medical review on the 10 September 2019. None of the Registered Nurses who were administering her daily medication picked this up. A root cause analysis (RCA) was completed by the Clinical Care Manager which outlined a plan for improvement.

During her stay she had 18 documented falls over the care period, of which three were classified as Category A, meaning falls with injury. No RCAs were completed for these. Given she had 3 or more falls within a 30-day period, she met the criteria of a frequent faller, which meant she would have been notified to the RQM for Summerset. Each of the Cat A falls required a hospital stay which generally impacted on her condition and level of frailty.

Her first Cat A fall occurred early in her time in the care centre on 28/02/2019 and resulted in a fractured left ankle and a fractured right Clavicle, which required [redacted] to be in plaster for 6 weeks, it is unknown when specifically the fracture occurred as she had 3 falls over that two-day period, two of which may have been related to the fractured ankle. She was sent to hospital and returned on the 12 March 2019 with her leg in plaster. She was to be non-weight bearing for 6 weeks, a short-term care plan was developed for her care during this time. On the 29 April 2019 her cast was removed and had a moon boot in place. Her weight on the 15 April was 48.1kg. During her period of having a cast on she had four falls. Whilst she had a moon boot on, she had one fall. It was documented that [redacted] level of cognition limited her understanding of what her level of mobility was at this time.

Her last fall which occurred on the 18 August 2019 resulted in a compression fracture of her L3 lumbar spine. On her return to the care centre from hospital on the 27 August 2019, her overall condition declined.

She weighed 47.5kg on the 17 September and then 45.9kg on the 3 October 2019, and she was requiring full assistance with two care givers to undertake most of her care. On the 10th of September she was commenced on sub-cut fluids. Her long term care plan was updated on the 1 October 2019 which didn't seem to reflect her general condition as was described in her progress notes. A family meeting was held on the 22 October 2019, post a written complaint from the husband of the EPOA. Several concerns were raised regarding care and communication, with a particular focus on falls and pain management, at this time, end of life plans were also

discussed. There was a hope that [redacted] would be able to die at home and make it to her 100th birthday. A short-term care plan for end-of-life care was documented on the 7 November 2019, [redacted] subsequently passed away in the care centre [redacted] 2019.

Complaint Review

Summary of the key elements of the original complaint received by the Care Centre on the 30 September 2019.

Complaint was sent from [redacted], husband of [redacted] who was the residents niece. [redacted] had an activated EPOA (13 May 2019) for [redacted] care but had been overseas in the UK from [redacted] July 2019 to [redacted] October 2019. All communication was to be directed to the husband during that time.

The complaint consisted of three parts.

a. Care- Reference to a visit that had occurred by a relative on the ?29 September 2019, stating [redacted] was "in a pool of her own excrement", and that it took the family member 10 minutes to find someone to assist. A comment was made by [redacted] that [redacted] had "obviously been left in that state for far too long".
b. Communication- On returning to the Care Centre post hospital stay (from 19 August 2019 to 22 September 2019) for a compression fracture L3, they wanted her pain relief reviewed. They stated they had reviewed her hospital notes and saw she had been on oxycodone in hospital and now was only on paracetamol. They felt there was an unacceptable delay in the GP review on her return to the Village. Concerns were also raised regarding the different team members' interpretation of what occurred when [redacted] fell in the bathroom when she was out for lunch with her family.
c. Care- They raised the number of falls [redacted] experienced during her time in care. They felt this was a major concern and focused in on the type of bed she should be using, and the effectiveness of the "pressure pad". They also commented on [redacted] sleeping during the day and being awake at night, "breaking the normal day night pattern of sleep…".

Summerset's Response to the letter of Complaint

A family meeting was held on 22 October 2019, present were [redacted] and [redacted] and the CCM [redacted]. The discussion focused on the key concerns raised in [redacted] letter, as well as the plan for [redacted] end of life. Her goals of dying at home and reaching 100 years old were discussed, with a plan agreed by the attendees to try and achieve this. Other issues raised at the meeting were North

Shore Hospital's lack of communication regarding [redacted] discharge from hospital, and a comment around staffing ratios in the care centre.

Formal letter of response to the complaint was sent on 5 December 2019. This was focused point by point and more formally on the response to the 30 September 2019 complaint letter from [redacted]. This included a genuine apology, with clear improvement plans outlined to improve care that was not provided to standard.

a. Care- this included an apology and an explanation as to why staff were not available as well as an improvement plan to ensure this wouldn't happen again.
b. Communication- this included an overview of the time line of communication and events that occurred in relation to oxycodone prescription and pain assessment. Gaps in [redacted] assessment were identified and a plan for improvement was documented. This included better documentation of care and actions taken by the team. The letter clarifies the context around [redacted] fall resulting in ankle fracture, and an apology and a plan was outlined to ensure the team provide appropriate factual information.
c. Care- The number of falls [redacted] experienced was reviewed in depth by the CCM, noting of the 13 falls reviewed only 3 had resulted in injury. Also outlined was that [redacted] had the full suite of fall prevention care, including assessments, such as Lo-Lo bed in July 2019, hip protectors, intentional rounding, sensor mat and fall out mats. Comment was also made about the potential use of restraint which was discounted as the team felt this would provide a greater risk for her. Strategies were in place to encourage [redacted] to stay awake during the day and sleep at night, only two of her falls occurred at night.

Summerset Policy review

Summerset Policy	Practice against policy	In line with Policy
April 2018- Falls prevention and Management Policy. August 2019- Falls prevention and	[redacted] was assessed for her risk of falling within 12 hours on being present in the care centre (Appendix 3), and then she had regular FRATs completed, and many different mitigations were used. Unfortunately, there was variability in the outcome of her risk assessment ratings, at different times she was rated medium, high and low. From what I can see the risk rating did not alter the mitigations or plan which was reasonably consistent. There was a multidisciplinary approach to her assessments and planning,	Whilst there were some areas where elements of the policy were not followed (see appendix 1), I

Management policy and procedure	all factors such as environment, physical status and cognition were considered. When [redacted] experienced a fall the relevant documentation was completed and actions taken according to policy. Except in a couple of cases where the family were not notified in a timely manner, and neuro OBs weren't taken for an unwitnessed fall (Appendix 1). The policy refers to Vitamin D use, I could find no evidence that [redacted] was taking this as a supplement. She did have other nutritional supplements that may have covered this. I note a root cause analysis was not done on the category A falls as mentioned in the policy. Whilst the falls risk scores varied over time, I can see that every effort was made to ensure the available risk management strategies were used. It is my view that over time all appropriate falls prevention interventions were utilised by the team in [redacted] care. <u>Falls strategies documented for [redacted]</u> Regular assessment and reporting Regular Multidisciplinary assessment, including GP (medication review), Physio, Nursing and Podiatry, diversional therapist, Regular nutritional status review, including close monitoring of hydration. Regular physio, strength and balance training, footwear review and mobility aid review Implementation of room safety set up: Summerset standard electric bed on low at all times, then a lo-lo bed in July 2019, hip protectors, floor alarm, fall out mats on both sides of her bed, decluttering of room Consideration of toileting and continence, hourly monitoring during the day and continence products over-night. Caring for her closer to nurses station to allow for greater visibility by the team Pain assessment and management.	believe that there has been a mild departure from the accepted standard.
May 2018- Pain Assessment and Management	[redacted] did have her pain assessed frequently, but inconsistently. References made in the LTCP, STCP and in the progress notes, as well as the separate documented IOWA Pain assessments (Appendices 3 & 4). The policy states the Abbey Pain Scale should be used in a resident unable to communicate, this was not done. I could not find a Pain	Abbey pain scale not used, Pain monitoring form not present but frequent

	monitoring chart in the records. She was mainly prescribed Panadol with some Oxycodone post fracture, the GP regularly assessed her pain. Other methods were used to help with her pain such as wheat packs, a lumbar cushion and regular repositioning, however this was not documented consistently in the care plans.	pain reporting in progress notes. Holistic management of [redacted] pain did not meet expected standard.

4. Appendices

1. Summary and Timeline of falls

Fall Number & location	Date & time	Actions & Injury	Clinical Review/plan updated	Incident form	Policy
1- Toilet- unwitnessed	06/01/2019 1445	Scalp Laceration- Sensor mat at night, 2 hourly monitoring, post fall assessment (PFA), CCM review. Neuro Obs commenced. Short Term Care Plan (STCP). Seen by GP 08/01/19 report Neuro OBs stable. Following up CXR that should have happened post discharge from hospital. 10/01/19 Physio reviewed re balance and mobility. NOK not notified until 09/01/2019	✓	✓	Minor deviation related to notification to NOK timeframe
2- Toilet - unwitnessed	28/02/2019 Afternoon tea out with family	Left ankle injury- Neuro Obs done. Falls checklist, PFA, physio reviewed on the day with family present, assessed her ankle as ligament damage not fracture. Iowa score 3, FRAT 14. Xray ordered but did not occur on that day.	✓	✓	✓
3- ?bedroom lazyboy- unwitnessed	01/03/2019 1545	STCP, PFA, xray referral sent, head to toe assessment done. Neuro obs done	✓	✓	✓
4- Bedroom - unwitnessed	01/03/2019 2325	Cat A-Head to toe assessment. Sent to hospital stayed 02/03/19-12/03/19. Night of 02/03 CCM phoned RN on duty at 0600 advised to send [redacted] to hospital as falls could be due to inability to weight bear. Result, recorded a #ankle and #right clavicle (# right clavicle not in care plan).	✓	✓	✓

5- Bedroom-unwitnessed	19/03/2019 0020 am	Bed moved against the wall, Neuro obs done, CCM review. NOK to be informed in mane. No record of niece being contacted.	✓	✓	NOK not notified
6- Bedroom-unwitnessed	04/04/2019 0730	PFA, Neuro obs, reviewed by GP 1147 that day. No further action.	✓	✓	✓
7- Dining room-witnessed	13/04/2019 1640	PFA, CCM review, GP notified 16/04. No further action	✓	✓	✓
8- Toilet - unwitnessed	18/04/2019 2120	PFA Skin tear right shin., CCM reviewed, Neuro obs. NOK notified 19/04/2019, they did raise any concerns.	✓	✓	✓
9- ?bedroom-unwitnessed	02/05/2019 1600	PFA, Neuro obs, Physio review as had moon boot on. Pain right knee.	✓	✓	✓
10- Hallway-unwitnessed	16/05/2019 1830	Cat A event - Admitted to hospital fractured pubic rami, CCM reviewed 26/05, Neuro obs completed, pain right leg, abrasion right elbow. contacted. Returned to care centre 05/06/2019, seen by GP 13/06/2019	✓	✓	✓
11- Bedroom-unwitnessed	13/06/2019 2240	PFA, FRAT, resident identified as high falls risk, Falls prevention measures in place, , Neuro Obs, Family not notified until 15/06/2019	✓	✓	Minor deviation related to notification to NOK timeframe
12- Bedroom-unwitnessed	20/06/2019 0050	PFA, No injury, , Falls prevention measures in place. Followed up by GP on 25/06	✓	✓	✓
13- Dining room-unwitnessed	14/07/2019 1250pm	Falls prevention measures, Falls risk assessment in LTCP. 23/07/19 Family meeting held. GP assessed 16/07. NOK notified. Neuro obs not done	✓	✓	Neuro Obs not done
14- Dining room/hallway-witnessed	24/07/2019	No injuries, informed NOK	✓	✓	✓

15- Bedroom-unwitnessed	25/07/2019 0555	Sprain of lumbar spine, Hospital attendance returned same day	✓	✓	✓
16- Bedroom-witnessed	28/07/2019 1420	Head strike, Neuro obs done, informed	✓	✓	✓
17- Bedroom-unwitnessed	29/07/2019 0610	No injuries, Neuro obs done, nil pain, reviewed by GP 30 July 2019- Discussion with 31/7/2019	✓	✓	✓
18- Hallway-Witnessed	18/08/2019 1645	Cat A – Post fall assessment completed by RN. Admit to hospital. L3 Compression fracture and cut on lip. Panadol for pain. Hospital stay until 27/08/2019 from. NOK notified.	✓	✓	✓

2. Documented Family Communication

Interaction no.	Date	Discussion
1.	01/12/2018	Neice came in with her on admission, discussed TV. Next day carer communicated re trousers
2.	15/12/2018	Conversation with "daughter". re boredom, TV for her room
3.	28/12/2018	Conversation with "daughter" re-keeping out of her bedroom and in the dining room.
4.	09/01/2019	EPOA was notified re fall from 06/01/2019
5.	18/01/2019	RN discussed with family reducing showers to x3 a week- Care Plan discussion
6.	22/02/2019	Email to family re stating her wallet was missing – no evidence of resolution.
7.	25/02/2019	Neice contacted CCM to check on – discussed weight increase 1kg, and increased confusion
8.	26/02/2019	EPOA contacted re: increasing urinary incontinence. Discussed pull ups vs pads, and purchasing of these.
9.	28/02/2019	Family present when fall occurred, present for physio assessment.
10.	02/03/2019	RN contacted that was in hospital and that she had a fractured left ankle, after hearing from North Shore Hospital (NSH).
11.	05/03/2019	Neice called CCM updating re condition at NSH, cast on ankle for fracture, will be in hospital for two weeks.

12.	13/03/2019	Phone call from Neice and her husband [redacted] and [redacted]. Documented. Tough discussion re assessment of fracture and plan to avoid further falls for [redacted] using side rails etc, setting bed to low at all times and updating LTCP
13.	18/03/2019	[redacted] updated re Dr [redacted] GP visit, decluttering room and hydration and pain relief
14.	20/03/2019	[redacted] contacted re broken spectacles
15.	27/03/2019	NOK & EPOA expressed concern re male caregivers looking after [redacted]
16.	01/04/2019	[redacted] called RN re [redacted] visit to ortho clinic on this day, updated re plan, no weight bearing elevating leg.
17.	04/04/2019	RN contacted [redacted] about fall on that day.
18.	08/04/2019	EPOA [redacted] notified regarding incident E026734 bruising soft tissue on left thigh.
19.	13/04/2019	EPOA [redacted] notified re fall in dining room
20.	16/04/2019	EPOA [redacted] notified re fall
21.	19/04/2019	EPOA [redacted] notified re fall, nil concerns voiced.
22.	27/04/2019	EPOA [redacted] notified re bruising on R} inner knee, incident form logged
23.	02/05/2019	EPOA notified about fall without injury
24.	13/05/2019	[redacted] visited, discussed with staff activation of EPOA, RN to advise GP and MOCA to be done by keyworker. Discussed use of hip protectors, [redacted] to provide
25.	14/05/2019	[redacted] informed [redacted] ambulance pick up for appointment.
26.	16/05/2019	Family informed of resident fall with injury, sent to hospital.
27.	18/05/2019	[redacted] contacted by RN to get an update on [redacted], sustained pubic fracture and on strong pain relief.
28.	05/06/2019	NOK informed of residents return to care centre from hospital
29.	15/06/2019	[redacted] updated re fall from 13/06/2019-
30.	20/06/2019	[redacted] notified re fall that day
31.	14/07/2019	[redacted] notified re fall that day
32.	22/07/2019	EPOA [redacted] notified she would be away in the UK for 8 weeks 26.7.2019- 2.10.2019 and that the contact would be husband [redacted]
33.	24/07/2019	EPOA [redacted] notified re Fall that day
34.	28/07/2019	[redacted] notified of fall as EPOA [redacted] away
35.	31/07/2019	Documented CCM discussion with [redacted] re increased concerns re falls, he wanted to know the falls care plan and suggested his own ideas like stimulants to keep her away during the day and orthotics review re L} foot. RN suggested review by physio re footwear
36.	19/08/2019	[redacted] notified of fall and hospitalisation
37.	05/09/2019	[redacted] contacted re [redacted] sleeping, not eating. Action GP messaged by SMS- for food and fluid monitoring.

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38.	10/09/2019	EPOA [redacted] contacted in UK about [redacted] declining condition, also notified about the Metoprolol drug error
39.	01/10/2019	GP discussed with [redacted] deterioration of [redacted] post hospital admission, informed she will be on 1l subcut NaCL daily, bloods daily stop oxycontin, [redacted] informed that [redacted] may deteriorate earlier.
40.	08/10/2019	GP discussed her status today, [redacted] requested we don't suddenly stop fluids
41.	22/10/2019	Family meeting, family request fluids continue. Meeting held post complaint received by family with [redacted], Care Manager.
42.	29/10/2019	GP and CCM discussed plan and food with EPOA [redacted]. Family having a pre-100 year birthday party on 09/11/2019 refer to hospice. [redacted] to stay with [redacted] this week.
43.	04/11/2019	EPOA [redacted] informed about the change in [redacted] condition by the RN
44.	05/11/2019	GP met with EPOA [redacted] regarding continued decline of [redacted], discussed home discharge and birthday party and stopping fluids.

Summary of Falls and Family Communication (Nov 2018 – Nov 2019)

- **18 falls** occurred between January and August 2019, most of which were **unwitnessed** and happened in the **bedroom or toilet**.
- **Post-fall assessments, neurological observations**, and **clinical reviews** were consistently documented.
- 3 falls led to **hospital admissions** for fractures or serious injury (e.g., pubic rami, compression fracture).
- **Policies and incident forms** were generally followed, though one instance noted no neuro observations completed.

Family Communication Insights

- **44 documented communications** between family and staff, with **increased frequency** following each fall.
- Family was often **informed promptly** after incidents, though there are notes of **delayed or missing notifications**.

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- Topics included fall-related injuries, care planning, hospital updates, personal care concerns, and end-of-life discussions.

- Evidence of family **engagement in care decisions**, including **physio input**, **equipment suggestions**, and **palliative care planning**.
- Family was contacted **within 1 day** of nearly all falls.
- Communication often led to **care plan updates**, such as **reducing shower frequency**, **implementing hip protectors**, or **changing room layouts**.
- **Proactive communication** seemed to increase following hospitalisations or major injury events.

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3. Summary of Care Plans

Date	Care Plan	Key actions changes
29/11/2018	Short Term Care Plan- Falls	High falls risk, post admission from hospital- updated 3 monthly- All interventions in line with policy. Reg checks, sensor mat, call bell, walker, toileting, food and fluid, physio, re-orient clutter free.
16/01/2019	Short Term Care Plan- update Falls	High falls Risk- all interventions in line with policy. Assist, walk with frame, clutter free, sensor mat, re-orienting, call bell, regular checks.
23/01/2019	Long Term Care Plan	Full Care Plan looks appropriate.
01/03/2019	Short Term Care Plan- update	Post fall "Sprain left ankle"
01/03/2019	Short Term Care Plan- update	UTI-

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29/03/2019	Short Term Care Plan- update Falls	3 monthly update and post # of left ankle. Immobile for 6 weeks. Positioning also pain plan completed
31/03/2019	Short Term Care Plan- Pain update	Specific Pain plan following on from fractured left ankle, activities include pain assessment and medication, repositioning and notification to GP
02/05/2019	Short Term Care Plan- Pain update	Pain, post fall on right knee, activities include heat pack, topical pain relief oral pain medication,
02/07/2019	Short Term Care Plan- Pain update	Pain post fall lower back, activities include assist with transfer, pain monitoring and medication.
26/07/2019	Long Term Care Plan Evaluation	6 Monthly evaluation. Mentions fall and hospital assessment lumbar sprain.
31/07/2019	Short term Care plan	Post fall possible head injury care plan
07/09/2019	Short term Care plan	Pain post fall due to L3 Compression fracture
30/09/2019	Short term Care plan	Pain lower back
01/10/2019	Long Term Care Plan Update	Care Plan looks appropriate. No End-of-life mention. 2 staff assist with all cares. Mainly asleep and unresponsive, visited by friends and family often. End of life updated 22 Sept
7/11/2019	Short Term Care plan	End of life Care. Main goal to die a peaceful death. No mention of communication with the family.

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4. Summary of assessments and actions

Assessment Date	Role/Assessment	Key Needs actions identified/ Policy
29/11/2018	RN Falls Risk Assessment Tool FRAT	Score 13 Medium risk- inconsistent with documented "high risk" notification.
03/12/2018	Physio	New admission. Identified Fast mobility & High falls risk. Plan PT input
27/12/2018	RN Initial Care Plan	Identified as High falls risk – sensor mat in situ. Required walker. No pain.
26/12/2018	RN Long Term Care Facility Assessment Interrai	Cognition Ace III Score 73/100 Sept 2018, impulsive but can be directed, walks with frame. Continent but wears pad. Had a fall at home on 03/11/18, head injury (before admission)
28/12/2018	RN FRAT	Score 8 Low risk- variance between FRAT and Initial Care plan main factor different, psychological score
30/12/2018	RN Mobility assessment	Score 4 (not totalled)
30/12/2018	RN Initial Care Plan	Requiring 1 person assist with cares, gets confused in the mornings. [redacted] identified as EPOA
03/01/2019	GP assessment	New admission note: OE looked well, plan continue reg meds discussed resus status, plan to discuss with family.
10/01/2019	Physio	Identified collapsing ankle, unstable on feet
21/01/2019	RN Long Term Care Facility Assessment	Short term memory loss, independent mobility, minimal assistance from care staff, mainly supervision. Independent toileting and Continent no pads required
29/01/2019	Podiatrist	Toenails cut, no problems review in 6 weeks
17/02/2019	RN Nutrition	Nutritional MUST score 2 assessments recorded High Risk.
26/02/2019	GP	Assessed new onset of confusion. ?UTI charted trimethorpim
28/02/2019	Physio	Post fall assessment, ankle swollen not able to weight bear
28/02/2019	RN FRAT	Score 14 Medium risk- treated as high risk in documents
28/02/2019	RN IOWA Pain assessment	Score 3
14/03/2019	RN Long Term Care Facility Assessment Interrai	Short- and long-term memory loss poor procedural and situational memory. Full assistance with all cares. Rapid decline in cognitive and physical function, still mobile. Incontinent

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17/03/2019	RN Nutrition	MUST score 2
04/04/2019	GP	Seen for review, stable, review 3 months. No mention of fall that day.
04/04/2019	RN FRAT	Score 15 Medium risk- LTCF assessment of 14/03/2019 had her at a high falls risk discrepancy between assessments
16/04/2019	GP	Seen for review post fall- no injury
18/04/2019	Physio	[redacted] not realising injuries, unable to mobilise until cast removed.
23/04/2019	GP	Seen for review post fall- no injury
23/04/2019	Podiatrist	Toenails cut review 6 weeks
09/05/2019	Physio	Assessment with resident now wearing moon boot, [redacted] very drowsy
16/05/2019	RN FRAT	Score 16 High Risk- main change Cognitive status now Severely impaired
06/06/2019	Podiatrist	Toenails cut review 6 weeks
13/06/2019	GP	Seen post hospital admission, EPOA to be activated
28/06/2019	RN FRAT	Score 14 Medium Risk
02/07/2019	RN IOWA Pain Assessment	Score 0 Right leg pain
09/07/2019	RN IOWA Pain Assessment	Score 0 right knee – paracetomol as required
11/07/2019	RN OWA Pain Assessment	Score 0 Iliosacral
18/07/2019	RN Nutrition	MUST score 1
23/07/2019	GP	3 monthly review no concerns plan, continue
26/07/2019	RN Mobility assessment & Safe handling	Score 12/18
28/07/2019	RN IOWA Pain Assessment	Score 3 Back of head pain relief as prescribed
30/07/2019	GP	Review post fall no new actions, continue with falls plan
30/07/2019	Podiatrist	Nails cut review 6 weeks
01/08/2019	Physio	Primary balance issue due to cognition and decision making, source ankle brace
07/08/2019	RN Nutrition	MUST score 1
18/08/2019	RN IOWA Pain assessment	F/up post 8/9/19 assessment, Score 3 Iliosacral "on regular pain relief"

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27/08/2019	RN IOWA Pain assessment	Score 4- lumbar back- paracetamol
27/08/2019	RN FRAT	Score 17 High Risk main change on one medication Severe cognitively impaired
29/08/2019	Physio	Assessed post fracture, in pain and able to sit independently. Mobilising within pain tolerance. Exercise programme under supervision to occur weekly.
31/08/2019	RN Pain assessment	Score 4 PRN pain relievers given
08/09/2019	RN IOWA Pain assessment	Score 4- Oxycodone (should have use Abby Pain tool)
10/09/2019	GP	Review, increase Oxycontin commence subcut NaCL, further review later in week.
10-13/09/2019	RN Long Term Care Facility Assessment Interrai	Fully chair and bed bound post fall and hospital stay. L3 Compression fracture
10/09/2019	Podiatrist	Nails cut review 6 weeks
17/09/2019	GP	Looking better, still on subcut decreased oxycontin, plan mobilise and drink
24/09/2019	GP	OxyContin nocte and trial off subcut fluids if can increase oral intake
01/10/2019	GP	Minimal oral intake- for palliative treatment discuss with family – No end of life plan initiated
08/10/2019	GP	Improved hydration, more alert eating and drinking try weaning off subcut fluids, monitor
15/10/2019	GP	Reduced food and fluid, continue NaCL 500mls/day for family meeting next week
22/10/2019	GP	Reviewed and family meeting. Early aspiration pneumonia, family request for fluids to continue
22/10/2019	Podiatrist	Nails cut
29/10/2019	GP	Review, end stage dementia, met with [redacted], refer to hospice.
05/11/2019	GP	Review End stage dementia stopping fluids tonight.

Assessment Summary for [redacted] (Nov 2018 – Nov 2019)

- **Initial Admission (Nov–Dec 2018):**
  - RN assessments initially inconsistent – FRAT scores ranged from **Low (8)** to **Medium (13)** risk, despite overall documentation of **high falls risk**.

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  - Physio identified **fast mobility** and **high falls risk** early on.
  - Cognition: ACE III score **73/100**; some confusion and impulsivity noted.
  - First fall occurred prior to admission (Nov 2018).
- **Early 2019:**
  - Continued mobility decline, unstable on feet noted (ankle weakness).
  - Mild cognitive deterioration with confusion episodes (e.g., Feb 2019 UTI).
  - Multiple falls and injuries recorded; FRAT scores fluctuated but treatment aligned to **high risk**.
  - **Pain assessments** (Iowa Pain Tool) initiated post-fall episodes.
- **Mid-2019 (March–August):**
  - Rapid cognitive and functional decline noted in March (InterRAI).
  - Falls continued; significant injury – fractured ankle and hospitalisation.
  - FRAT reassessments often scored **Medium to High risk** (scores 14–17).
  - MUST (nutrition) scores indicated **ongoing high risk** for malnutrition.
  - Increased drowsiness, decreased mobility; moon boot and ankle brace used.
  - Pain consistently monitored; ongoing podiatry and physiotherapy support.
- **Late 2019 (September–November):**
  - Post-hospital, became **chair and bedbound** (L3 compression fracture).
  - Transitioned to **palliative care**: subcutaneous fluids, opioid management.
  - Family meetings and care planning included decisions about hydration and end-of-life care.
  - Last GP notes confirmed **end-stage dementia**; fluids ceased Nov 2019.

Key Issues Identified:

- **Inconsistent risk assessments** early on (documentation vs FRAT scores).
- **Progressive cognitive decline** driving increased falls risk.
- **Responsive adjustments** made to falls prevention strategies, supervision, pain, and hydration.
- **Proactive family communication** around falls incidents and end-of-life care decisions.

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5. References

[redacted]

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