Oceania Care Company Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00603)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man at a rest home and hospital (the rest home), when he suffered two falls early in the morning.

2. The first fall occurred when a Health Care Assistant (HCA) assisted the man to the toilet, and left him unaccompanied. The second fall occurred when the man fell out of his bed and onto the floor when reaching for something on his bedside table. It was found that there were deficiencies in the risk assessment and care planning for the man, the call-bell system at the rest home, and the documentation by the rest home staff members.

3. The man was diagnosed with a fractured right ankle, and he died approximately one week later.

Findings

4. The Deputy Commissioner found that there were serious issues with the care the man received at the rest home whilst it was owned by Oceania, including the lack of critical thinking around the man's risk of falling by multiple rest home staff; the faulty call-bell system, which was not communicated to staff; and the deficiencies in the documentation of the man's care on the night he fell and after his falls. Accordingly, the Deputy Commissioner found that Oceania Care Company Limited breached Right 4(1) of the Code.

5. Adverse comment was made about Ms C's decision to leave the man alone on the toilet, and for the deficiencies in her documentation of the events.

Recommendations

6. The Deputy Commissioner recommended that both Oceania Care Company Limited and Ms C provide the man's family with a written apology.

7. The Commissioner recommended that the current owners of the rest home share HDC's anonymised opinion with nursing and care staff at the rest home for educational purposes; complete a review of the last ten newly admitted patients to hospital-level care to ensure that staff are completing appropriate assessments and care plans where indicated; complete a review of registered nurses' and healthcare assistants' documentation of recent fall incidents; and confirm that there are appropriate protocols in place to ensure that registered nurses and healthcare assistants are fully aware of the mobility and toileting requirements of hospital-wing residents at the beginning of each shift.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs B raising concerns about the services provided to Mr A by the rest home. The following issue was identified for investigation:

- *Whether Oceania Care Company Limited (trading as [the rest home]) provided Mr A with an appropriate standard of care in Month1[1] and Month2 2018.*

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

10. The parties directly involved in the investigation were:

Mr B	Complainant
Mrs B	Complainant
Rest home	Rest home/provider

11. Further information was received from:

Ms C	Health Care Assistant (HCA)
Current owner of the rest home	
District health board	

12. Also mentioned in this report:

Mr D	HCA
RN E	Registered nurse
Ms F	HCA

13. In-house clinical advice was obtained from Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

Background

14. This report concerns the care provided to Mr A in the early hours of 5 Month2, when he suffered two falls. Mr A passed away on 13 Month2.

15. Mr A had a medical history that included poor balance, severe fatigue, impaired hearing, and end-stage renal failure. He had resided at the rest home since 31 Month1 for hospital-

[1] Relevant months are referred to as Months 1–2 to protect privacy.

level care. At the time of events, Mr A had been a resident at the rest home for only five days.

16. The rest home is an aged-care facility that can provide rest-home, dementia, and hospital-level care for up to 75 residents. At the time of Mr A's falls, the rest home was owned and operated by Oceania Care Company Limited (Oceania). However, subsequently it was sold to another company.

Falls risk and care planning

17. On admission to the rest home, an Initial Person Centred Care Plan was completed. Under "Continence/Toileting", it was ticked that Mr A required one-person assistance for toileting. Under the "Mobility" section, it was ticked that Mr A required two-person assistance for mobilising. Included in this section is an option to tick "Falls Risk" but this was left unticked. A Falls Risk Assessment was not completed for Mr A on admission, as required by the Fall Management Policy.[2] As such, a falls prevention plan was not in place as the time of events. The nurse did not respond to requests for comment on this issue.

18. A Falls Risk Assessment was not completed at any other time leading up to Mr A's falls.

Staffing levels

19. Mr A resided in a hospital-level wing. The staff rosters provided to HDC show that on the overnight shift of 4 to 5 Month2, the following three staff were on duty in the hospital wing: Health Care Assistants Ms C and Mr D, and RN E.

20. For other shifts, where a staff member was sick or unable to complete a shift, this was also shown on the roster. However, for the overnight shift of 4 to 5 Month2, there is no indication that any staff were absent. In contrast to this, Ms C later told HDC[3] that the wing was one staff member down.

Mr A's recollection

21. In their complaint to HDC, Mr and Mrs B stated:

> "On [4 Month2], [Mr A] requested assistance to go the toilet … He was left alone on the toilet and told to ring the bell when he finished. [Mr A] informed us this was about 8.30–9.00pm at night … When he was finished, [Mr A] attempted to ring the bell, but it did not work. After waiting a period of time, he tried himself to get up off the toilet but fell. He was found on the floor much later … [Mr A] told us that he was on the floor for five hours before he was found."

4 Month2

22. At 9.15pm, Ms F documented in the progress notes that Mr A was "assisted onto toilet at 2100". She then documented: "[Mr A] remains in clothes as he didn't want to get changed,

[2] The policy stipulated: "All residents are assessed using a falls risk assessment tool … within eight hours of admission."
[3] On 28 April 2020.

too cold." Ms F also documented: "[P]ull-up changed [and] groin washed. Settled back into bed." However, this was then crossed out by Ms F and noted as an "error".

23. HDC attempted to contact Ms F to ascertain why the latter part of this note was crossed out, but she did not respond to these requests.

5 Month2

First fall

24. Although not documented, in an undated statement written after the events, Ms C said that at 1.30am she checked on Mr A and he was sleeping and settled.

25. Ms C also stated that at 3am, she assisted Mr A from his bed to the toilet; however, in the progress notes, this was documented at 4.30am. Ms C documented:

> "I assisted [Mr A] to the toilet but I went to go to answer another resident's bell. On return to [Mr A], he was on toilet floor. Bell in his toilet doesn't work, informed RN on duty."

26. Also at 4.30am, RN E documented that Mr A had been "[r]esettled and neuro obs done".

27. Ms C told HDC that she does not remember whether at the time of events she was aware of Mr A's requirements for one-person assistance whilst toileting. When questioned about the differences in the timing, Ms C told HDC that she "possibly got the times mixed up", but she cannot remember.

28. A post-fall assessment form was completed by RN E. RN E documented the time of the fall as 3am, and noted: "[Mr A] states he has been lying on toilet floor for 5 hours … Should have been supervised." On the form, the questions, "Was the resident identified as having a high risk of fall?" and "Were appropriate nursing interventions recorded and in place at the time of the fall?" were both ticked "yes".

29. RN E noted that she gave Mr A pain relief and that there were no obvious injuries. His post-fall observations were recorded to be mostly normal,[4] and he was assisted back to bed.

30. RN E also completed an incident form for the fall. She noted the details of the event as:

> "0300 Found [Mr A] lying on his left side on the floor of his room's toilet. Physically lifted by HCA and RN. No obvious injuries. Cold, shaken and some degree of shock. [Patient] talking and complaining that his toilet bell does not work."

Second fall

31. Approximately 5 to 10 minutes after being assisted back to bed, Mr A suffered another fall out of his bed and onto the floor when reaching for something on his bedside table. He rang the call bell in his room to alert staff, and Ms C attended before informing RN E.

[4] Blood pressure 124/80mmHg, pulse 95 beats per minute, respiratory rate 26 breaths per minute.

32. In RN E's progress note of 4.30am, she documented: "10 minutes later rang his bell and found lying on the floor on [right] side of bed. Neuro obs continued." RN E also noted that between 4.30am and 6am, she specialled[5] Mr A. At 6am, RN E documented that she dressed a skin tear on Mr A's right hand. Mr A's wife was informed of the falls at this time.

33. Following the second fall, RN E completed another incident form. In the details of the event, she noted: "1st fall 0300. Manually lifted off floor. 2nd fall 0330. [Manually lifted off floor.] Skin tear [right] hand. No [short-term care plan]." However, a post-fall assessment form was not completed for Mr A's second fall.

34. Neurological observations were documented on Mr A's chart every half hour from 3.00am to 5.00am, and then hourly until 8.00am. It was noted that Mr A was "confused".

Subsequent events

35. Around midday, it was noted that Mr A was grimacing strongly when his right leg — especially the right ankle, calf muscle, and knee — was being touched. Following a review by a nurse, an ambulance was arranged to transfer Mr A to the public hospital.

36. In response to the provisional opinion, the family told HDC that Mr A's wife was asked by rest-home staff if an X-Ray should be taken and an ambulance called. Mrs A said that the staff did not seem to be in a hurry to do anything and were hesitant to do this. Mrs A felt that they should have organised this before she was asked.

37. The Ambulance Care Summary documented that the ambulance was called at 12.37pm, and Mr A arrived at the hospital at 1.33pm. On the ambulance summary, the "Incident History" was documented as: "[Patient] went to toilet unassisted. Has had an unwitnessed fall, not found for approximately 5 hours after. Complains of sore right ankle."

38. Similarly, in Mr A's hospital admission notes, the "Triage Assessment and History" notes: "Resident from the rest home. Unwitnessed fall 1/7. Was found approximately 5 hours later." When assessed on the ward, a registrar documented: "[D]ifficulty [in obtaining history] due to memory [impairment]. Had fall overnight at the rest home. Stated was on the floor for 5–6 hours." Mr A was diagnosed with a fractured right ankle. Subsequently, his health deteriorated, and he died approximately one week later.

Documentation

39. Oceania told HDC:

> "The gap in contemporaneous notes between 9.15pm on 4 [Month2] and 4.30am on 5 [Month2] demonstrates that the staff on duty were not following our progress notes policy … or best practice and documenting an ongoing transcript of care as it pertains to an individual resident."

[5] 1:1 watching of a patient.

The call-bell system

40. The previous facility manager of the rest home stated that the call bells in the facility were checked monthly by the maintenance team, and that technicians were called in to address any issues that were found during those tests. Call-bell maintenance records provided to HDC show that the call bells in the rest home were checked on 11 Month1, and were all noted to be working, including in Mr A's toilet.

41. However, a Ministry of Health provisional audit undertaken on 30 Month1 noted:

> "Issues with the malfunction of the call bell system were evident on the day of audit. These had already been identified at an internal audit. These have yet to be rectified and meantime provide a risk to residents and to staff …"

42. The audit stated that the facility was to resolve the call-bell issues within 90 days of the audit date, to ensure that residents could summon assistance when required.

43. Oceania was unable to provide HDC with any evidence that staff were fully informed of the call-bell issues, but noted that often it was rest-home staff who went into the attic to reset the call-bell main switch in the event of a malfunction when the technicians were not readily available.

44. The next monthly call-bell check was undertaken on 20 Month2. The record for this check noted that the call bell in Mr A's room was not working and needed to be replaced.

45. After these events, technicians visited the rest home to address the ongoing issues with the call-bell system. The technicians advised that there was not a lot they could do to fix the issues as the current system was obsolete, and subsequently the entire call-bell system was replaced by the new owner.

Further information

Mr A's family

46. Mr and Mrs B told HDC that when Mr A was told that his ankle was broken, he was very upset. Mr B stated:

> "[Mr A] was now bedridden and in pain. He could no longer be turned in his bed without acute pain from his broken ankle … we strongly believe this event impacted drastically on his wellbeing and quality of life in his final week."

47. Mr A's family concluded: "We would hate for another family to go through what [Mr A] and we as a family went through due to the lack of care [Mr A] received at the rest home."

Ms C

48. On 24 September 2018, Ms C completed a "Reflective Practice Form" for these events. Under the heading "what else could you have done?", Ms C noted that she could have had another HCA watch Mr A while he was in the toilet, or have another HCA check the other residents. As an action plan in the event that this should ever happen again, Ms C noted: "I would make sure that I am present throughout assisting [the resident], make sure I have

assistance from another HCA [and] that call bells work in their rooms and toilets." Ms C noted on the form that she was "a bit stressed" being on the wing by herself, and that she was tired from starting her shift early.

49. Ms C told HDC:

> "I don't make a habit of leaving someone unattended when toileting them, we were one staff member down and I had started early so was doing a 12 hr shift and the wing was reasonably full, so I didn't have another person to answer the call bell for me in the wing I worked in, I had to call another HCA from another wing to help me with the other resident."

50. Ms C stated that she "deeply regrets" the decision she made that night, and apologises to Mr A and his family for the unfortunate incident.

Oceania

51. The General Manager of Oceania told HDC:

> "On behalf of Oceania Healthcare I wish to convey my sincere apology to the family of [Mr A] for not meeting [Mr A's] care needs which [led] to his fracture and acute hospitalisation."

Responses to provisional opinion

52. Mr A's son and daughter-in-law were given the opportunity to comment on the "information gathered" section of the provisional opinion, and their comments have been incorporated into this report where relevant.

53. Oceania was given the opportunity to comment on the provisional opinion, and stated that it supports the findings made regarding the inadequate care planning, the unreliable call bells, and the deficiencies in documentation. Oceania said that it takes any complaints of this nature seriously, and will continue to present the findings of these complaints to the clinical nursing teams so that learnings can be shared.

54. Ms C was given the opportunity to comment on the relevant sections of the provisional opinion, and confirmed that she had no comments to make.

Opinion: preliminary comment

55. It is clear through reports from Mr A's family and the contemporaneous documentation from RN E and ambulance and hospital staff that after the events, Mr A consistently reported that he had been left on the floor for approximately five hours.

56. If Ms F's amended documentation is accepted as a correct account of events, then it would appear that Mr A was toileted around 9pm, and it is unclear whether he was settled back

into bed at that point. However, HDC has been unable to verify this as Ms F cannot be contacted.

57. Ms C's recollection, albeit undocumented, is that Mr A was settled in bed at 1.30am when she checked him and, more importantly, she admitted that regrettably she left him on his own on the toilet to attend to other patients. I note that this admission is consistent with the rest of Mr A's reports to family and care staff about what happened. Therefore, I accept that Mr A sustained his first fall whilst being cared for by Ms C, rather than Ms F.

58. In Ms C's statement, she said that she assisted Mr A to the toilet at 3am and left him unattended for at least 30 minutes. Both the post-fall observation form and both incident forms document that the first fall occurred at 3am, and the neurological observations chart also indicates that observations started at 3am. However, Ms C's progress note documents the events as occurring at 4.30am. Accordingly, it is unclear exactly when the fall occurred.

59. Given that it is clear that Mr A's toileting, fall, and discovery occurred at different times in the night, it is concerning and illogical that the clinical notes show all three events occurring at the same time. Therefore, in light of all the discrepancies in the notes, I am unable to determine the precise time at which Mr A fell, or when he was discovered. However, I consider that the exact timing of Mr A's fall and subsequent discovery are not relevant in assessing the omissions of Oceania and its staff to mitigate his falls risk and to supervise him adequately whilst toileting.

60. My report focuses on the omissions of Oceania and its staff to mitigate risk for Mr A and keep him safe and comfortable during his time at the rest home.

Opinion: Oceania Care Company Limited — breach

Introduction

61. The New Zealand Health and Disability Services Standards (NZHDSS) require that aged-care facilities ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers. Oceania had overall responsibility to ensure that Mr A received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Services Consumers' Rights (the Code), and this included responsibility for the actions of its staff.

Care provided to Mr A

Falls prevention and care planning

62. Mr A was admitted to the rest home on 31 Month1 and suffered two falls five days later. Although an initial care plan was completed, which noted that he required additional assistance when mobilising, this did not trigger a falls risk assessment. A falls risk assessment was not completed at any other time leading up to Mr A's fall.

63. Oceania's Falls Management Policy includes that "[a]ll residents are assessed using a falls risk assessment tool … within eight hours of admission", and that "[a] resident mobility assessment for safe handling is undertaken using the Oceania form for this purpose".

64. My in-house aged-care advisor, RN Hilda Johnson-Bogaerts, advised that in reviewing the admission documentation and initial care plan, it appears that in relation to Mr A's fall prevention, the admission process, assessments, and care planning were inadequate. In particular, she noted that because Mr A required two people to assist with mobilising, a falls risk assessment seemed indicated. RN Johnson-Bogaerts advised: "If the admitting registered nurse did not complete a falls risk assessment this would be at odds with the organisational policy and accepted practice."

65. RN Johnson-Bogaerts considered the falls prevention planning for Mr A to be a "moderate to significant" deviation from accepted practice, and I agree. I note that the registered nurse who completed Mr A's initial care plan has not responded to requests to comment on this issue, and therefore I am unable to verify what, if any, steps she took to assess Mr A's falls risk, but would be concerned if this did not occur in line with the rest home's Falls Management Policy and accepted practice.

66. I note that Mr A's mobility issues would have been apparent to multiple staff between 31 Month1 and 5 Month2, and at no other point did this trigger an assessment of his falls risk. In my view, it is crucial that staff observe newly admitted patients carefully for any risks that require proactive intervention. For Mr A, this meant being alert and responding to his mobility issues, completing a falls risk assessment, and planning for prevention. I am concerned by the apparent lack of critical thinking around Mr A's risk of falling by multiple rest-home staff who cared for him across 31 Month1 and 5 Month2.

Call bells

67. The previous facility manager of the rest home told HDC that the call bells in the facility were checked monthly by the maintenance team, and that technicians were called in to address any issues that were found during the tests. My in-house advisor stated that "the monthly routine checks of all call bells and checking the bells at the time of admission is accepted practice in the aged care sector", which I accept.

68. Whilst call-bell maintenance records provided to HDC show that the call bells in the rest home were checked on 11 Month1, and were all noted to be working, including in Mr A's toilet, a Ministry of Health provisional audit undertaken on 30 Month1, less than three weeks later, noted the following:

> "Issues with the malfunction of the call bell system were evident on the day of audit. These had already been identified at an internal audit. These have yet to be rectified and meantime provide a risk to residents and to staff …"

69. RN Johnson-Bogaerts advised that in the event of call-bell issues, to ensure resident safety, it is good practice to ensure that it is known to all that a call bell is broken, and to organise an alternative method for residents to alert staff.

70. There were significant issues with the call-bell system at the rest home, and, as evidenced by the Ministry of Health audit on 30 Month1, the issues were alerted to Oceania six days before Mr A's falls. Despite this, Oceania could not provide HDC with evidence that staff were fully informed of the call-bell issues, and an alternative mechanism for residents to alert staff was not implemented. As such, Ms C had no reason to believe that the call bell in Mr A's toilet was not working when she left him on the toilet on the morning of 5 Month2.

71. Criterion 1.4.7.5 of the NZHDSS states that an appropriate call system must be available to summon assistance when required. It is concerning that the call system in place at the rest home at the time of these events was faulty — it placed its residents at risk of not being able to call for help, and these issues were known to Oceania before Mr A's fall. The faulty call bell in Mr A's toilet meant that when he had completed toileting and tried to call for assistance, no staff attended, which led to him attempting to get off the toilet himself, and falling. In my view, this is a clear operational failure that created an unsatisfactory environment for Ms C to respond to Mr A's needs, and placed Mr A at significant risk.

Staffing levels

72. At the time of these events, the rest home housed residents receiving hospital-level care, rest-home care, and dementia services. The rosters provided to HDC for the overnight shift of 4 to 5 Month2 show that Ms C, HCA Mr D, and RN E were on duty on the hospital wing. The roster does not show any staff away for the overnight shift in question; however, in Ms C's response to HDC after the events, she reported that the wing was down one staff member. Given the time that has lapsed and potential issues with recalling information, I am more inclined to rely on the rest home's account and its accompanying roster, and accept that there were two healthcare assistants and one registered nurse rostered to work in the hospital wing at the time of the events.

73. RN Johnson-Bogaerts advised that this was in line with accepted practice night duties within long-term care with a relative average workload and case mix. I accept this advice.

Post-fall care

74. Ms C notified RN E after each of Mr A's falls were discovered. RN E monitored and documented Mr A's neurological observations every half hour from 3.00am to 5.00am, and then hourly until 8.00am. After Mr A's second fall, RN E documented that she dressed a skin tear on Mr A's left hand, and stayed with him to ensure that he would not attempt to get out of bed again.

75. RN Johnson-Bogaerts advised that the actions taken by both Ms C and RN E were appropriate, and in line with Oceania's Fall's Management Policy at the time. I also note that there is no record of Mr A reporting pain in his leg until midday, shortly after which he was transferred to hospital.

Documentation

76. I am concerned about the level of documentation by rest-home staff following Mr A's falls. Oceania accepted that the gap in contemporaneous notes between 9.15pm on 4 Month2 and 4.30am on 5 Month2 demonstrated that staff on duty were not following best practice

and documenting an ongoing transcript of the care as it pertained to Mr A. There were also discrepancies in the documentation around when Mr A sustained his falls.

77. RN Johnson-Bogaerts noted the following additional deficiencies in the documentation on 5 Month2:

- A Post-Fall Assessment Form relating to Mr A's first fall was completed but the form was not dated or signed.
- A Post-Fall Assessment Form was not completed in relation to the second fall.
- On the Post-Fall Assessment Form it was noted that Mr A "felt warmish", which contradicts the Incident Form completed for the fall, which documented that Mr A was "cold, shaken and some degree of shock".
- The Progress Notes include a very short account of the events of the first fall by the healthcare assistant, followed by a very short account of the second fall by the registered nurse.

78. RN Johnson-Bogaerts considers the documentation to be inadequate and not in line with good practice for clinical documentation, and to be a "moderate deviation from accepted practice". I accept this advice. I add that the conflicting documentation in this case made it difficult for all involved to ascertain exactly how long Mr A had been left on the toilet by himself (and subsequently on the floor) and provide this clarity to his family, who not unreasonably wish to understand what happened to their father.

79. Clear, comprehensive, and contemporaneous documentation is vital in all aspects of health care, especially when there has been an incident or adverse event, and I am critical that there were deficiencies in multiple aspects of the documentation in Mr A's case.

Conclusion

80. In my view, Oceania had the ultimate responsibility to ensure that Mr A received care that was of an appropriate standard and complied with the Code. Overall, there were serious issues with the care Mr A received at the rest home whilst it was owned by Oceania. In particular:

a) There was a lack of critical thinking around Mr A's risk of falling by the multiple rest-home staff who cared for him across 31 Month1 and 5 Month2;

b) The call-bell system in place was faulty, and this was not communicated to staff nor a temporary workaround implemented. This created an unsatisfactory environment for Ms C to respond to Mr A's needs, and placed Mr A at significant risk;

c) There were deficiencies in multiple aspects of Oceania staff's documentation of Mr A's care on the night he fell and after his falls.

81. Accordingly, for the reasons above, I find that Oceania Care Company Limited failed to provide Mr A with services with reasonable care and skill, in breach of Right 4(1) of the Code.[6]

Opinion: Ms C — adverse comment

Care provided to Mr A

82. As set out above, Ms C accepts that she left Mr A unattended on the toilet in the early hours of 5 Month2 for at least 30 minutes.

83. My in-house aged-care advisor, RN Johnson-Bogaerts, advised:

> "In the case that the HCA was waiting for [Mr A] to ring the [call bell] for assistance back to bed, it would still be unreasonable not to check back on him in [the] first instance after 30 minutes and before attending to the next resident. In these circumstances the standard of care would be seen as inadequate and a moderate deviation from accepted practice."

84. I am concerned by Ms C's decision to leave Mr A alone on the toilet. Mr A was clearly frail and had called for assistance to toilet, which should have alerted her to the fact that leaving him unattended could place him at risk of falling. I accept RN Johnson-Bogaerts' advice that Ms C should have checked on Mr A in the first instance after 30 minutes and before attending to the next resident. Whilst I acknowledge that Ms C was relying on a functional call-bell system to alert her to attend Mr A, and that she was experiencing a stressful shift with other residents, her actions were unwise, as they left Mr A unsupported and in a vulnerable position.

85. I also note that Ms C does not recall whether she was aware of Mr A's need for one person to assist him to the toilet. I remind Ms C of her responsibility to ensure that she reviews newly admitted patients' care plans, and stays abreast of the safety requirements of the patients to whom she provides care.

Documentation

86. There is conflicting documentation around the events of Mr A's falls, in particular around the timing of the falls. Ms C documented Mr A's fall in the progress notes at 4.30am, but in her statement, the incident reports, and the post-fall assessment, the fall is noted to have occurred at 3am. In addition, I note that she stated that she checked on Mr A at 1.30am and he was asleep, but there is no documentation of this.

87. Owing to the time that has passed since these events, and the fact that I have been unable to clarify with the staff involved which of the documented times regarding Mr A's falls were correct or incorrect, I am unable to ascertain whether the documentation failures in relation

[6] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

to the timing of Mr A's falls are attributable to Ms C. However, RN Johnson-Bogaerts stated that overall she found the documentation in this case to be inadequate and not in line with good practice for clinical documentation and, in particular, noted that the events of the first fall documented by Ms C were a "very short account". I remind Ms C of the importance of clear, comprehensive, and contemporaneous documentation, especially in the event of an incident or adverse event.

Changes made since complaint

Ms C

88. Ms C told HDC that since these events, she has received a regular update of her competencies as well as ongoing training, and she now ensures that she writes her notes within an appropriate timeframe.

Rest home

89. The current rest-home owner told HDC that as a result of these events, it ensures that there are at least two healthcare assistants in the hospital wing at all times.

90. As the previous owner of the rest home, Oceania told HDC that since this incident, it has made a number of policy recommendations and clinical governance structure changes, as well as a complete restructure of the clinical services within Oceania. As part of the restructure, Oceania now has an Education and Research Manager who leads all education and training programmes to improve clinical quality across the company.

91. Oceania has also made changes to its education for healthcare assistants and registered nurses via mandatory training days, where topics include falls prevention, observation and monitoring, the ageing process, assessment and care planning, and evaluation.

92. Additionally, recently Oceania rolled out a resident management system (eCase) across all sites, to ensure that nursing assessments are undertaken in a timely manner, and that falls assessments are completed upon admission.

Recommendations

93. I recommend that Oceania Care Company Limited provide Mr A's family with a written apology for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

94. I recommend that the current owner of the rest home:

a) After the report has been published on the HDC website, share HDC's anonymised opinion with nursing and care staff at the rest home, for educational purposes. The current owner should provide evidence that this has occurred within one month of publication.

b) Complete a review of the last ten newly admitted patients to the rest home's hospital-level care. Initial care plans and the first five days of progress notes should be reviewed to ensure that staff are completing appropriate assessments and care plans where indicated. The current owner should report back to HDC on the results of this review and what, if any, remedial actions have been taken for any non-compliance identified, within four months of the date of this report.

c) Complete a review of registered nurses' and healthcare assistants' documentation of recent fall incidents, including ensuring that documentation across progress notes and post-fall and incident forms are accurate and consistent, and report back to HDC on the results of the review and what, if any, remedial actions have been taken for any issues arising from this, within four months of the date of this report.

d) Confirm that there are appropriate protocols in place to ensure that registered nurses and healthcare assistants are fully aware of the mobility and toileting requirements of hospital-wing residents at the beginning of each shift. The current owner is to verify the effectiveness of the protocols with an audit over a four-week period and report back to HDC on the results of this and what, if any, remedial actions have been taken for any issues arising, within four months of the date of this report.

95. I recommend that Ms C provide Mr A's family with a written apology for the failings in care identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

96. A copy of this report will be provided to the current owner and operator of the rest home.

97. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited, will be sent to HealthCERT (Ministry of Health), the New Zealand Aged Care Association, the Health Quality & Safety Commission, and the district health board, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from RN Hilda Johnson-Bogaerts:

"1.Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the rest home] owned at that time by Oceania and since purchased by [another company]. 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. Specifically I was asked to review the clinical documentation and provide clinical advice on:

a. Adequacy of falls prevention

b. The standard of care provided by [Ms C] when leaving [Mr A] on the toilet to attend another resident

c. The adequacy of monitoring of [Mr A] after his falls

d. The adequacy of incident reporting, including whether the progress notes, statement of [Ms C], and the incident reports to be consistent with one another

e. Other than [Mr A's] account reflected in the incident report, do you consider there is any supporting evidence that [Mr A] was left on the toilet floor (after the first fall) for five hours?

f. The adequacy of the call bell maintenance regime

g. The adequacy of changes made at [the rest home] following this event.

2. **Documents reviewed**

- [The rest home's] response 30 May 2019
- Oceania letter of response 10 October 2019
- Copy of the roster for the week starting 30 [Month1]–5 [Month2]
- Falls Management Policy dated January 2017
- Call Bell Policy dated [Month1]
- Copy of [Mr A's] clinical care notes

3. **Review of documentation and clinical advice**

[Mr A] (aged [in his eighties]) became a resident at [the rest home] on 31 [Month1]; he transferred there from another provider to receive hospital level care. A few days after moving into [the rest home], during the night of 4/5 [Month2] he had two falls. The handover documentation from the previous provider included for night cares: 'to use urinal/commode chair only at night.' And for sleeping pattern: 'needs sleeping pill for sleep'.

At the time of his falls [Mr A] had been at [the rest home] for five days therefore no long term care plan was in place. As is common practice, initial nursing assessments were completed followed by a condensed nursing care plan valid for the first few weeks. In long term care it is accepted practice for the admitting registered nurse to complete

a holistic albeit slightly abbreviated assessment of the new resident within the first day and develop based on the risks identified a nursing care plan. This allows for the first few weeks to be a settling in and observational period (max 21 days) after which the comprehensive interRAI assessment is completed.

I note that in this situation some of the documentation completed at the time of [Mr A's] admission i.e. the Resident Admission Checklist, Resident Orientation Checklist and Pain Assessment, Initial Person Centred Care Plan were either incomplete or were not signed off by the nurse who completed these. It would appear that the assessments did not include some essential assessments as for example a falls risk assessment and skin integrity assessment both relevant to [Mr A].

The Initial Care Plan (dated 31 [Month1]) in the format of a tick list states that [Mr A] needs 2 persons to assist with mobility and a wheel chair was marked as needed to mobilise. 'At risk of falls' was not marked off. Because [Mr A] was identified as 2 person assist with mobilising a falls risk assessment seems indicated. No falls risk assessment was included in the provided clinical documentation. The care plan indicated 1 person to assist for toileting. No use of restraint or enablers was identified.

On admission, [the rest home] found that the toilet in [Mr A's] room was too low, and so a toilet frame was placed over the toilet for him, and an air mattress was provided for pressure injury prevention. He was prescribed medication to aid with sleep. During the night of 4/5 [Month2] at 1pm [Mr A] was checked by the Health Care Assistant (HCA) and was reported sleeping. At 3 am he rang his bell and was assisted by the HCA to go to the toilet. The HCA was then called away to assist two other residents which she says would have taken her over 30 minutes. Hearing [Mr A] banging on the wall she went to check on him to find him lying on the floor. She called for help from another HCA and the Registered Nurse (RN). The RN checked [Mr A] for injuries and he was assisted back to bed. About 10 minutes after they left him in his bed he rang his nurse call bell. When the HCA entered the room, he was found lying on the floor and had sustained a skin tear on his right hand. The RN was called again and after he was further checked for injury he was helped back into his bed. The RN decided to stay with him for a period making sure he was okay and not trying to get out of bed again by himself.

a. The adequacy of staffing overnight on 4/5 [Month2]

As a principle, staffing levels are to be sufficient to meet the needs of each resident as identified in their care plan and when necessary. The Age-related Residential Care Services Agreement includes in its service specifications part the minimum staffing levels for each level of care (rest home, hospital, dementia care). [Mr A] was residing in the hospital wing.

Unfortunately the provider was not able to recall the number of residents in the care home at the time of the falls. A Ministry of Health Audit was conducted on 30 [Month1], 5 days before the event. At that time it was noted in the audit report that at [the rest home] there were 56 residents across the three areas providing rest home, dementia, and hospital level care.

Reviewing the staffing roster of that night, there were 2 HCA and 1 RN allocated to work in the hospital wing. In addition that night there was 1 HCA allocated to the Dementia care wing and 1 HCA to [the rest home] wing. This staffing level is in line with the ARC agreement and accepted practice for night duties within long term care with a relative average workload and case mix.

Deviation from accepted practice — nil.

b. Adequacy of falls prevention

The provider's Fall's Management Policy includes that '*All residents are assessed using a falls risk assessment tool … within eight hours of admission*' and '*A resident mobility for safe handling is undertaken using the Oceania form for this purpose*'. I did not find a falls risk assessment among [Mr A's] clinical notes and admission documentation provided. In the initial care plan he was not identified as at risk for falls. He was however identified as needing two care staff to assist with mobilising. It seems unlikely that a person who is not at risk of falling would need two persons to assist with mobilising. If the admitting registered nurse did not complete a falls risk assessment this would be at odds with the organisational policy and accepted practice. Reviewing the admission documentation and initial care plan, it appears that in relation to [Mr A's] fall prevention, the admission process, assessments and care planning was inadequate. There did not appear to be a falls prevention plan in place.

Deviation from accepted practice — moderate to significant.

c. The standard of care provided by [Ms C] when leaving [Mr A] on the toilet to attend another resident

[Ms C] reported that she had left [Mr A] after having assisted him to the toilet to respond to another call. She reports that it had taken her at least 30 minutes to attend to this call after which she went to check on another resident when hearing [Mr A] banging on the wall. [Mr A] was identified in his care plan as needing two persons to assist with mobility therefore it would not be expected that he would walk back to his bed by himself. In addition I note that [Mr A] was taking medication to aid with sleep which increases a person's risk of falling. It is not clear from the statements if the HCA knew that the call bell in the toilet was faulty. In the case that the HCA was waiting for [Mr A] to ring the nurse call for assistance back to bed, it would still be unreasonable not to check back on him in first instance after 30 minutes and before attending to the next resident. In these circumstances the standard of care would be seen as inadequate and a moderate deviation from accepted practice. In the circumstances that the HCA knew that the nurse call bell was faulty and has left him waiting on the toilet for this extended period of time would be seen as a significant deviation of accepted practice.

d. The adequacy of monitoring of [Mr A] after his falls

The provider's Fall's Management Policy includes that '*All residents who fall must be assessed for injury by the most senior staff member on duty prior to moving their position. The senior staff member notifies the family/EPOA and the doctor if needed. …*

Unwitnessed falls or fall that involves injury to the head must have neurological observations taken.'

The HCA who discovered [Mr A] had a fall near his toilet at 3.00 hrs acted appropriately notifying the RN on duty and her colleague for assistance. She did same after his second fall.

The RN checked for injuries at that time and took [Mr A's] observations including his neurological observations. He continued to be monitored and his observations were within normal range. After his second fall the RN applied a dressing to the skin tear on his right hand and decided to stay with him for a period to make sure he was not trying to get out of bed again. This was an appropriate decision.

Deviation from accepted practice — nil.

e. The adequacy of incident reporting, including whether the progress notes, statement of [Ms C], and the incident reports to be consistent with one another

The provider's Fall's Management Policy includes that for all falls, '*An unwanted Event Form is completed …; A post fall assessment is completed to identify contributing factors and further corrective actions to be take*n'. Good practice requires for the person with first-hand knowledge to complete the incident form and sign it. The incident should be documented accurately and truthfully including any unusual occurrences witnessed, details of what happened and consequences for the person. Following an incident the Progress Notes are to be completed including the clinical details of the incident making sure the descriptions on the incident reports and the progress notes mirror each other. It must be complete, accurate, timely completed and include initial assessments, further nursing actions, communications, resident response, statements the resident made regarding his condition and care, resident comfort levels, safety measures, resident compliance to interventions.

The provider response included a completed Post-Fall Assessment Form relating to the fall that happened in [Mr A's] toilet near his room at 3 am. It is not clear from the form who completed this or when. The form is not dated or signed. The comments include that [Mr A] said that he had been lying on the toilet floor for five hours. The nurse added that '[*he] felt warmish, lifted back to bed. Given Panadol 1 G and Mogadon 2.5m*g' and added the comment '*should have been supervised*'. This report includes a tick next to 'Yes' for being identified as high risk of falling and a tick next to 'Yes' for appropriate nursing interventions recorded and in place at the time of the fall — this seems to contradict the statement on the form that he should have been supervised. I did not find a Post-Fall Assessment Form relating to the second fall.

The Progress Notes include a very short account of the events of the first fall by the HCA, followed by a very short account of the second fall by the RN. The RN added a note the next day: '*4.30 to 6.00 specialised by [RN E]*'.

The provider's response included the Incident/Accident Forms for both the falls completed by RN E. The first Incident Form relates to the 3.00 hrs fall and includes how

[Mr A] was found describing the situation as follows: 'No obvious injuries. Cold, shaken and some degree of shock. Pt talking and complaining that his toilet bell does not work'. The statement 'cold' varies from the statement 'warmish' on the Post Falls Assessment Form. A second Incident Form was completed relating to the second fall at 3.30hrs. This form included [Mr A's] injury i.e. a skin tear on right hand which was dressed. As part of corrective action the nurse included 'specialised by RN'. Both incident reports were reviewed and further completed by [a nurse] with corrective actions and follow up actions.

The different reports seem to use different wording describing what happened but are largely consistent with each other. While I did not find significant inconsistencies between the documents I found the documentation inadequate and not in line with good practice for clinical documentation as described at the beginning of this paragraph.

Deviation from accepted practice — moderate.

f. Other than [Mr A's] account reflected in the incident report, do you consider there is any supporting evidence that [Mr A] was left on the toilet floor (after the first fall) for five hours?

I did not find any supporting evidence that [Mr A] was left on the floor for five hours.

g. The adequacy of the call bell maintenance regime

Documentation was provided of the monthly call bell checks relating to the checks 11–18 [Month1] and the 20 [Month2] check. The provider explained that maintenance records show that the call bell in [Mr A's] room was shown to be working the day he moved into [the rest home]. Following the incident a technician was called and was onsite the next day to carry out necessary repairs. The monthly routine checks of all call bells and checking the bells at the time of admission is accepted practice in the aged care sector. As soon as the defect was noted the provider arranged for the call bell to be repaired. It is good practice in the meantime and to ensure resident safety to put a note on the broken call bell making sure that it is known to all, and to organise for an alternative as for example a hand bell or supervise a resident while on the toilet.

Deviation from accepted practice — nil.

h. The adequacy of changes made at [the rest home] following this event.

The changes made as listed in [the rest home's] response of 30 May 2019

- The call bell system was replaced

The changes made by Oceania as included in the response dated 10 October 2019

- The HCA completed a Reflective Practice 24 September 2019

In addition to the focus on the Call bell system and the actions of the HCA I recommend that the provider reviews the Admission Process to include a more comprehensive set of

nurse assessments and an improved Initial Care Plan. Further I recommend a focus on improving the standard of documentation by the registered nurses involved with this file.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor, Health and Disability Commissioner"