Radius Residential Care Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01581)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, aged 86 years at the time of events, was admitted to a rest home on 26 February 2016. It was identified on admission that he had a high risk of falling. A number of interventions were put in place, but they were not successful at mitigating his risk of falling, and Mr A sustained 97 documented falls from February 2016 to November 2016 inclusive. Of these, 55 were reported on an accident/incident form, and it was documented that his next of kin was informed about 23 of the falls.

2. On 11 May 2016, staff observed that Mr A had been trying to get outside, and that even after he was taken for a walk, he wanted to go out "again and again". At approximately 1pm, Mr A was found on a road near the facility. At approximately 1.10pm, Mr A was found to have left the facility a second time. He was not seen leaving the premises on either occasion.

Findings

3. The Deputy Commissioner found that the rest home did not take sufficient action to reduce Mr A's falls risk, and did not supervise Mr A adequately on 11 May 2016. It was found that the rest home did not provide Mr A services with reasonable care and skill, and, accordingly, that Radius Residential Care Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

4. The Deputy Commissioner was also critical of poor communication with Mr A's family.

Recommendations

5. It was recommended that Radius Residential Care Limited (a) provide evidence that its policies and procedures on falls management, incident reporting, client assessment, and care planning are current and reflect best practice, with reference to the reviews and updates that have been undertaken over the past three years; (b) provide evidence of audits that have been undertaken to assess compliance with the policies and procedures referred to above; and (c) apologise to Mr A's family for the deficiencies outlined in the report.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs A and Ms B, through the Nationwide Health and Disability Advocacy Service, about the services provided to Mr A by Radius Residential Care Limited. The following issue was identified for investigation:

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

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- *Whether Radius Residential Care Limited provided Mr A with an appropriate standard of care between February 2016 and November 2016 (inclusive).*

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

8. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Consumer's wife
Ms B	Consumer's daughter
Radius Residential Care Limited	Provider

Also mentioned in this report:

RN C	Registered nurse
RN D	Registered nurse
RN E	Registered nurse
Dr F	Doctor
Dr G	General practitioner

9. Independent expert nursing advice was obtained from registered nurse (RN) Jan Grant and is included as Appendix A.

Information gathered during investigation

10. Mr A, aged 86 years at the time of these events, had Alzheimer's disease,[2] macular degeneration,[3] and severe advanced dementia. On 3 February 2016, Mr A was assessed as being mentally incapable. This activated his Enduring Power of Attorney appointing his wife, Mrs A, as his attorney in relation to matters of personal care and welfare. The progression of Mr A's dementia and his decline in mobility meant that Mrs A had difficulty caring for him in their home at the retirement village, and consequently Mr A was admitted to the rest home on 22 February 2016.

11. The rest home is owned by Radius Residential Care Limited.

Communication expectations

12. As part of Mr A's admission documentation, Mrs A completed the Client Incident Notification form and asked to be notified at any time of the day or night in the event that

[2] A degenerative brain disease of unknown cause. Usually it starts in late middle age or in old age, and results in progressive memory loss, impaired thinking, disorientation, and changes in personality and mood, and is marked histologically by the degeneration of brain neurons, especially in the cerebral cortex.
[3] Progressive deterioration of the macula resulting in a gradual loss of the central part of the visual field.

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Mr A experienced a serious injury as a result of an accident/incident. She asked to be notified between 7am and 9pm if the injury was minor or if Mr A experienced a non-life-threatening change in health status.

Care planning

Initial Assessment Care Plan — 22 February 2016

13. On 22 February 2016, RN C developed an Initial Assessment Care Plan for Mr A. RN C ticked a box in the care plan to indicate that it included information obtained from Mr A's family. Mrs A had completed a personal history profile for Mr A, in which she provided information about his normal routines and preferences. The form stipulated that this information would be used to form the basis of Mr A's care plan and his daily activity routine. The care plan detailed that Mr A had issues with weight bearing, and a tendency to fall, and that he mobilised with a walking frame but required two-person assistance to mobilise and for transfers.

14. Mr A was noted to be "confused at times". It is further documented that Mr A had poor vision, wore glasses, and had aphasia.[4] Under "Special Settling Routines", RN C wrote that Mr A required a "low-low bed, bell mat and crash mattress when in bed".

Falls Risk Assessment — 26 February 2016

15. On 26 February 2016, Mr A was identified as a high falls risk on the Falls Risk Assessment for Ambulatory Clients. RN D noted on a separate falls assessment form that Mr A experienced falls on a daily basis, and was experiencing loss of balance as a result of cognitive loss. RN D recorded that Mr A had "no insight" and did not worry about falling or losing his balance. He was assessed as being very unsteady and unsafe when walking.

Physiotherapy assessment — 26 February 2016

16. A physiotherapy assessment was also completed for Mr A on 26 February 2016. The onsite physiotherapist recorded that Mr A had variable mobility and required one to two persons to assist him when mobilising. As part of this assessment, a Berg Balance Score was completed. Mr A scored 0 out of 56, indicating that he had severely impaired balance. The physiotherapist noted that hip protectors had been purchased.

17. RN E recorded on a separate physiotherapy assessment form that Mr A required assisted walking regularly. The rest home clarified that this meant that Mr A was to go on three supported walks per week with a physiotherapist assistant.

Initial Assessment Care Plan Review — mobility/falls prevention — 15 March 2016

18. On 15 March 2016, RN E completed a review of Mr A's Initial Assessment Care Plan. RN E detailed that Mr A utilised a walking frame with a belt, and required one-person assistance when active, and two-person assistance when tired. It was also noted that Mr A required a standing hoist when lethargic or tired. The assessment goal was documented as: "[Mr A]

[4] Loss or impairment of the power to use or comprehend words, usually resulting from brain damage.

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will be assisted with mobility needs as required to ensure that maximum level of mobility is maintained."

19. RN E documented that Mr A could get restless when not toileted within four hours, and that walking also helped to settle him. Mr A was not considered at risk of wandering at this time, as he was "unable to walk unassisted".

20. On 11 May 2016, the care plan was updated to state that Mr A was at risk of wandering, now that he was able to mobilise with his walker without further assistance.

Further physiotherapy assessments — 6 July 2016 and 2 September 2016

21. The onsite physiotherapist reassessed Mr A's mobility on 6 July 2016 and on 2 September 2016. The outcome of these assessments was to continue physiotherapy assistant input with a walking programme three times weekly.

Family input into care planning and multidisciplinary meetings

22. Mr A's family frequently visited Mr A at the rest home. They told HDC that they had no opportunity to participate in the care planning process, and that they were not provided with, or consulted about, Mr A's care plan.

23. The rest home stated:

> "[Mrs A] had input in the creation of the admission care plan. [Mr A] was not due for a formal review of care planning until the end of August 2016. This is the time that [Mrs A] would have been invited to participate in a full care plan review … however [Mrs A's] complaint arrived in August and subsequently a further one arrived in September. The complaint took priority as it related to [Mr A's] care …"

24. In response to the complaints, the rest home met with Mr A's family on 1 August 2016 and 2 September 2016. The rest home stated that one of those meetings included a four-hour discussion covering all aspects of care, and was "effectively a multidisciplinary meeting".

25. The rest home also told HDC that Mr A's next of kin, Mrs A, was provided with informal and extensive information about Mr A's care, including clinical assessments, GP visits, and Mental Health visits. The rest home explained that these were not always documented, as "corridor conversations" are rarely captured in the notes.

February and March 2016

Falls

26. At 6.45am on 23 February 2016 (the day after admission), a healthcare assistant documented in the multidisciplinary progress notes (MDP notes) that Mr A "fell out of bed while taking off his clothes". The healthcare assistant completed an accident/incident form for the fall and indicated that the next of kin (NOK) was not informed. It was noted that Mr A was new to the facility. Confusion, disorientation, and a lack of familiarity with the room were thought to have contributed to his fall.

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27. At 2.45pm, RN E documented that Mr A was very restless in the morning and fell twice, at 7.40am and 9am. RN E further documented that the NOK had been notified. An accident/incident form was completed for the 7.40am fall. In the corrective actions section on the form, RN E noted that Mr A had a bell mat and crash mattress in place, hip protectors on 24/7, and that a low-low bed had been requested.

28. Mr A's fall at 9am was not recorded in an accident/incident form.

29. On 10 March 2016 at 5.45pm, a nurse documented that Mr A had an unwitnessed fall from his chair to the floor in the dining room. An accident/incident form was completed and Mr A's NOK was informed. The nurse recorded that she looked into Mr A's toileting regimen to work out why he tried to get out of his chair. The documented corrective action was: "Try to keep [Mr A] interested when in a chair to avoid falling when unattended. Put the fallout chair[5] in the correct position."

30. On 11 March 2016 at 4.45am, a healthcare assistant found Mr A on his bottom in the hallway outside his room. It was noted on the accident/incident form that the NOK was not informed. It was noted in the corrective action section that the healthcare assistants were to be reminded that Mr A was a falls risk.

31. On 22 March 2016, a healthcare assistant detailed in an accident/incident form that Mr A was walking around the table when he started to fall slowly backwards, and that she supported him to the floor. It is not recorded whether or not the NOK was informed. RN D recorded that Mr A had lowered cognition and was very unsteady.

32. On 29 March 2016, Mr A was noted to have fallen at 11.40am. An enrolled nurse completed an accident/incident form for the fall. This stated that when Mrs A was notified of the fall, she reiterated the importance of constant supervision and regular walks. The documented corrective actions were to walk and toilet Mr A regularly, and to change his position.

33. Rest home staff did not observe any injuries resulting from these falls.

Walks

34. MDP notes state that Mr A was taken for assisted walks on 15 March, 17 March, 18 March, 24 March, and 25 March 2016. According to the accident/incident form for 29 March 2016, Mr A went for a walk with the physiotherapist approximately half an hour before his fall.

April and May 2016

Falls

35. On 5 April 2016, a nurse documented in an accident/incident form that Mr A had a fall in the dining area at 6.45pm. He sustained a small skin tear on the left elbow, which was dressed. It is not documented whether or not Mr A's NOK was informed. The form reiterated that Mr A had dementia and was restless, as documented in his care plan.

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[5] A chair designed to prevent pressure sores.

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36. At 1.30pm on 8 April 2016, RN D found Mr A in the hallway, having fallen in an attempt to sit down. She completed an accident/incident form and detailed that there were no apparent injuries, and that Mr A's next of kin was informed. It was documented that Mr A was very restless, and mobilising alone as he had poor insight.

37. At 1.15pm on 14 April 2016, Mr A was witnessed falling out of his chair as he attempted to stand. No injuries were noted. A nurse completed an accident/incident form and documented that the NOK had been informed.

38. The rest home has a Post Falls Assessment and Action Plan that is to be completed for residents who fall more than twice in one month. An Action Plan for Mr A was first commenced on 19 April 2016.

39. Between 19 April 2016 and 25 April 2016, 16 falls are documented on the form. Accident/incident forms were completed for three of these falls. The accident/incident forms all state that Mr A's NOK was not informed, and that he had been put on a falls assessment and action plan.

40. A second action plan was commenced on 26 April 2016. The action plan records that Mr A had seven falls from 26 April 2016 to 2 May 2016. No accident/incident forms were completed for these falls.

41. The plan stated the significant pattern or contributing factors to Mr A's falls as: "[Mr A] gets restless and would like to walk independently. Not very stable with mobility and [loses] balance and land[s] on [the] floor. He [does] have poor judgment."

42. The action plan identified a number of contributing factors to Mr A's falls, including his restlessness and desire to walk independently. It also noted that he loses his balance as he is not very stable with mobility, but is too confused to request assistance. A number of interventions to reduce the risk of repeat falls were detailed on the action plan, including a low-low bed and high impact mat, bell mat, ensuring that Mr A wears glasses and proper shoes at all times, removing clutter from his surroundings, keeping his walker within reach, putting brakes on all the chairs, and having a behaviour chart in place. The plan noted that these measures were already in place.

43. Between 4 May 2016 and 31 May 2016, Mr A had 33 documented falls, 19 of which were reported on an accident/incident form. Seven of the accident/incident forms for Mr A's falls over this period state that Mr A's NOK was notified. Many of the completed forms associated Mr A's falls with his wandering behaviour. The forms also show that staff considered that Mr A needed to have a more secure area to mobilise in. In light of this, Mr A was referred to the Mental Health Service for Older People (MHSOP) for a reassessment of his needs.

44. An hourly rounding log[6] was commenced on 27 May 2016.

[6] A record of regular checks.

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Walks

45. On 1 April 2016, RN C documented that Mr A had “moments of restlessness but [was] settled when walked around the wing”. The MDP notes for 2 April 2016 indicate that Mr A walked well with his frame.

46. On 6 April 2016, it was noted that Mr A had a “period of unsettledness but managed with walking and toileting”. In the evening, he walked well with his frame and belt with one person assisting. Similarly, on 7 April 2016, a healthcare assistant documented that Mr A was walking well with assistance.

47. On the afternoon of 9 April 2016, Mr A went for a walk with his daughter and a healthcare assistant. The MDP notes for 10 April 2016 state that Mr A was unsettled despite being taken for lengthy walks at 2pm and at 7pm. The notes further state that Mr A was very restless and made repeated attempts to walk independently. It is documented that Mr A was walked with assistance at 1pm and 3pm on 11 April 2016.

48. On 13 April 2016, RN C documented: “[Mr A is] [v]ery restless this morning since start of shift. Toileted and walked him many times with no effect. Settled slightly around 10am as was tired of walking.” On 14 April 2016, Mr A was taken for an afternoon walk. At 10pm, RN E documented that Mr A was very restless and attempted to walk by himself. He was provided with one-on-one care for safety.

49. Entries in the MDP notes on 17 April 2016 state that a healthcare assistant assisted Mr A to walk several times, and that he continued in his attempts to walk independently.

50. Mr A was noted to be restless and walking around “a lot” on the morning of 18 April 2016. An enrolled nurse wrote: “He seated himself on the floor and then started crawling around. [Mr A] was left on [the] floor for a short time until staff [were] able to help and supervise [him].” At 2.10pm, RN E documented that Mr A was observed walking around the wings, independently using his walking frame. The entry further stated: “No staff available for one-on-one, had at least six walks from one end to [the] other.”

51. It is documented on 27 April 2016 that Mr A went for a walk with the physiotherapist and also had an independent walk.

52. There are numerous entries in the MDP notes of Mr A walking with his frame around the hospital wings in May 2016. There is no mention of any assisted walks, aside from an accident/incident form dated 11 May 2016, which stated that Mr A was taken for a walk as he “wanted to go out again and again” (more information below).

Wandering behaviour

53. On 22 April 2016, Mr A was found sitting on the floor in another resident’s room. Mr A was also found in other residents’ rooms on 8, 9, and 17 May 2016. Accident/incident forms were completed on all these occasions. The forms for 22 April 2016, 9 May 2016, and 17 May 2016 state that his NOK was not informed. On the occasion on which Mrs A was

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informed, Mr A had sustained a fall while in another resident's room. It is not clear whether the location of the fall was conveyed to Mrs A.

54. On 19 May 2016, RN E documented in an accident/incident form that Mr A had been very restless and "tried entering other [residents'] rooms". Mrs A was not informed. On 22 May 2016, a staff member documented in the behaviour monitoring chart that Mr A had been found in another resident's room, touching the resident's possessions. There is no record of Mrs A being notified of this.

GP review — 3 May 2016

55. On 3 May 2016, Mr A was reviewed by GP Dr G. Dr G observed that Mr A had good power in his legs, but that "[o]n standing he had postural issues. Leaning back, legs are flexed and in front of his centre of gravity." Dr G also noted that Mr A's falls risk was exacerbated by his poor vision.

Leaving the rest home unobserved — 11 May 2016

56. On 11 May 2016, staff recorded in the MDP notes that Mr A kept going outside and did not want to return indoors. It was noted in an accident/incident form that Mr A wanted to go out "again and again" despite being taken for a walk, and that he was behaving in an aggressive manner towards staff. At 1pm and 1.10pm, he was found to have left the facility without being observed by staff.

57. The accident/incident form for the 1pm incident stated: "Absconding from [facility]." The second form stated: "In less than few minutes [Mr A] had once again absconded from [the facility]. Found up [the road]." Both forms documented "No injury, no fall" and that a message was left for Mrs A on her home telephone. Under "Corrective Actions", it was suggested that Mr A could be moved to a more appropriate residence that would allow him freedom to walk around but in a safe manner.

58. An entry in the MDP notes at 3.30pm stated that Mrs A was visiting, and that she was aware of the incidents.

Assessment by Dr F — 19 May 2016

59. On 19 May 2016, Dr F from the MHSOP assessed Mr A. In his report to Dr G, dated 25 May 2016, Dr F noted that Mr A had been found several times in other residents' bedrooms and going through their possessions, and that he would fall up to five times or more a day. Dr F wrote:

> "Given [Mr A's] wandering behaviour in the hospital unit and the effect this has on the other residents, I am recommending that he be reassessed for Secure Dementia Care. He does not have particularly high care needs and falls risk and continuing pattern of falls are going to exist at the same level wherever he goes. A trial of medication to stop [Mr A] from wandering is very much likely to increase his [risk of falls] further."

60. Mrs A told HDC that she was informed on 2 May 2016 that Mr A would be assessed on 17 May 2016, and that the aim of this assessment was to determine whether he would be

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better suited for a rest home level of care. She said that she asked to be present for Dr F's assessment, and that it was agreed that a staff member would call her to confirm the time. Mrs A stated: "They knew that I lived [nearby] and could be there in a matter of minutes."

61. An update to an accident/incident form on 12 May 2016 stated: "To be reassessed by MHSOP this coming Tuesday [17 May 2016] for ? reassessment." The rest home stated that Dr F did not attend on 17 May 2016, and that there was no opportunity for Mrs A to be present for his assessment on 19 May 2016, as he gave no prior notice. The rest home said that although Dr F regularly visited the dementia units on Thursdays, he did not usually attend the residents in the hospital.

62. Mrs A told HDC that the rest home did not provide her with a copy of Dr F's assessment despite numerous requests, and that she had to contact Dr F, who sent her the report on 7 June 2016. Mrs A stated that on reading the report, she learned for the first time that Mr A had been falling as frequently as five times in a day. She also stated that previously she had not been informed of Mr A's tendency to wander into the rooms of other residents, or of the recommendation that he be reassessed for secure dementia care. When this concern was raised with the facility, the rest home met with Mrs A and her daughter. This was later followed up by a letter from the Facility Manager, who stated:

> "We fully acknowledge our communication was not to the standard we expect and as we discussed we will review how we provide information to families' right from admission day and including how we have those important discussions with families, such as reassessments. Primarily, how we deliver this information, what that information means and how can we be of support through this time."

June and July 2016

Falls

63. Mr A sustained 12 falls in June 2016. Accident/incident forms were completed for eight of these falls, and Mrs A was notified on three occasions. It was noted that Mr A was waiting to be reassessed again, and that a behaviour monitoring chart had been put in place, as well as a rounding log. The accident/incident form for Mr A's fall on 22 June stated that Mr A's NOK was well aware of his high falls risk and repetitive behaviour.

64. In July 2016, Mr A fell on eight occasions. Accident/incident forms were completed for three of these falls, and Mrs A was notified on two occasions. Some of the falls were recorded on the behaviour monitoring form instead of an accident/incident form. Corrective actions across these three forms mentioned having a bell mat and impact mat in situ, having Mr A sit in a recliner chair in a visible location, hip protectors, intentional toileting, and the implementation of a rounding log and behavioural chart.

Walks

65. The MDP notes for 1 to 6 June 2016 refer to Mr A's wandering behaviour in the early hours of the morning. He was noted to be walking well with his walking frame up to 8 June 2016,

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when it was documented that he was weak when standing, and required two-person assists for standing.

66. An entry in the MDP notes for 11 June 2016 stated that Mr A was no longer mobilising independently. Mr A was assisted for a walk on 18 June 2016, as he was "wanting to stand up all the time".

67. The MDP notes for 10, 12, and 13 July 2016 refer to Mr A's attempts to stand and his inability to do so. However, an entry on 15 July 2016 stated that Mr A went for walks with the physiotherapist and a healthcare assistant, and was walking "well and strong" that day.

GP review — 10 June 2016

68. Mr A was reviewed by Dr G on 10 June 2016. He noted that Mr A's mobility had decreased, but found no clear infective cause for his deterioration.

Dr F — Treatment Planning

69. On 13 June 2016, Dr F wrote to the Needs Assessment and Service Coordination Service to advise that Mr A's mobility had decreased since his last assessment, "to the extent he can no longer individually mobilise at all". Dr F recommended that Mr A be reassessed as requiring hospital-level care again, and stated that Mr A's daughter agreed with this recommendation.

Mobility/falls prevention evaluation — 29 July 2016

70. On 29 July 2016, RN C documented in the mobility/falls prevention evaluation (which is an extension to the original assessment) that Mr A was less mobile and restless because of his dementia, and that he remained a high falls risk. By way of interventions, RN C noted that Mr A had a low-low bed, impact mat, and bell mat in place. RN C further wrote that staff were to ensure that Mr A wore glasses and proper shoes to prevent slipping and falling, and for clutter to be removed from his surroundings. Instructions were left for staff to toilet Mr A when he became restless, noting that often he was restless when he wanted to move his bowels or urinate.

August to September 2016

Falls

71. According to the MDP notes, Mr A sustained nine falls between 18 August 2016 and 30 August 2016. Accident/incident forms were completed for eight of these falls, and Mrs A was notified on six of those occasions.

72. A post-fall nurse assessment form was completed on 18 August 2016. It was suggested that Mr A be provided with a seat alarm, if feasible. This was implemented on 31 August 2016. Other than this, no new interventions were noted.

73. Mr A had seven documented falls in September 2016. Accident/incident forms were completed on five of these occasions. Two of the falls were documented on the behaviour

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chart. Mrs A was notified of four of these falls, including one that resulted in a gash on the back of his head.

74. Despite Mrs A's request to be notified of minor injuries between 7am and 9pm, she was not informed of the bruise that Mr A had sustained from a fall at 8pm on 2 September 2016. The accident/incident reporting form for this fall indicated an intention to inform Mrs A in the morning, but there is no documentation to confirm that this was done. The form stated that family were aware of his frequent falls, and, under corrective actions, referred to a sensor alarm on the chair, frequent toileting, and distraction techniques such as toys. A post-fall nurse assessment form recorded that Mr A had dementia and urinary frequency, and that he was not safe to walk alone.

75. Another post-fall nurse assessment form was completed for a fall on 12 September 2016. It was documented that Mr A was safe with one-person assists, but was unaware of his own limitations.

Walks

76. There are no records of Mr A being taken on assisted walks in the first three weeks of August 2016. Entries in the MDP notes on 14 August 2016, 17 August 2016, 21 August 2016, and 23 August 2016 state that Mr A made no attempts to walk. It is documented on 24 August 2016 that Mr A was unsettled but that he became less restless after being toileted and walking with staff. He attempted to stand and walk when Mrs A visited on 26 August 2016.

77. MDP notes for most of September refer to Mr A being settled. It is documented that he was taken for a walk on 30 September 2016.

Evaluation of mobility and falls risk

78. On 4 August 2016, RN C wrote in the memory cognition/behaviour evaluation that Mr A was no longer at risk of wandering, given his decline in mobility. RN C also recorded in the mobility/falls evaluation on 5 August 2016 that Mr A remained a high falls risk, and that he required one person to assist him with a belt and the walker for transfers.

79. On 31 August 2016, RN D noted that Mr A's mobility had improved, and that he was attempting to mobilise without assistance, which increased his falls risk.

October to November 2016

Falls

80. During October 2016, Mr A had five falls, which occurred between 18 October and 26 October 2016. Only two accident/incident forms were completed. The first stated that Mr A's NOK had been informed, while the second form, which documented a fall at 8.30pm that had resulted in a cut on Mr A's head, stated that his NOK would be informed in the morning. There is no confirmation on the accident/incident form, communication with family form, or in the MDP notes, that this was done.

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81. On the accident/incident form for the fall on 22 October 2016, frequent toileting, offering of food and fluids as a distraction technique, and everyday walks were listed as corrective actions.

82. A post-fall nurse assessment form was completed for the fall that resulted in a cut to Mr A's head. It noted that Mr A needed prompt toileting, that he was unsafe to walk alone, and that he was unaware of his limitations.

83. From 8 November 2016 to 12 November 2016, Mr A fell four times. Mrs A was informed on two of those occasions. On 16 November 2016, Mrs A was notified about Mr A's multiple falls from his chair. On 19 November 2016, Mr A had a fall after his daughter's visit. It is not recorded whether or not Mrs A was informed. The MDP notes refer to the NOK being informed of a further fall on 21 November 2016. A single accident/incident form was completed for the month of November 2016. It noted that Mr A had hip protectors on, that there was a chair mat in place, and that he was on a long-term care plan.

Issues with chair mat

84. On 19 October 2016, RN White documented:

> "[Mr A] is very fidgety and restless. He stands up and often will take the chair alarm mat from under him and fiddle with the mat and pulls the wires out. He then becomes very unsafe due to high falls risk and needs constant monitoring throughout each shift. Alarm mat is often away getting fixed."

Walks

85. The MDP notes for Mr A state that he was "walking a lot with carers" on 4 October 2016. Mr A was noted to be restless and repeatedly standing on 6 October 2016. On 17 October 2016, when Mr A was next observed to be restless, he was taken for a long walk, with good effect.

86. On 1 November 2016, it was noted that Mr A was restless at times, but this would resolve once he was toileted. On 6 November 2016, RN D documented that Mr A's mobility was improving, and that he was regularly walked by care staff. The MDP notes state that Mr A was taken for walks on 14 and 15 November 2016, in response to further restless behaviour.

87. Mr A was transferred to another facility on 30 November 2016, at the request of his family.

Further information

88. The rest home considered that Mr A's changing needs were managed appropriately by staff at the facility. It noted that when his dementia progressed in May 2016, it arranged for a GP review and an assessment from Dr F. It also stated that further physiotherapy review was sought on 6 July 2016 and 2 September 2016.

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89. The rest home noted that Dr G and the physiotherapist did not recommend any changes to Mr A's management. It also noted Dr F's view that Mr A's falls risk would remain at the same level "wherever he goes", and that a trial of medication would likely increase his falls risk.

90. In relation to the frequency and timing of Mr A's assisted walks, the rest home stated that Mr A did not require daily walking by physiotherapy assistants as he was mobile independently for most of his time at the facility. The rest home commented:

> "Given the busy and changing environment of aged care, set walking times are unrealistic due to factors such as onsite emergencies, acute situations and staff workload in relation to patient needs."

91. The rest home also noted that Mr A would have been walked daily by care staff to and from the bathrooms.

92. The rest home informed HDC that it has made the following changes since these events:

- It has formalised its process for multidisciplinary meetings and now provides written formal invitations to residents' families.
- In April 2017, it implemented an electronic management, assessment, and care planning software tool that supersedes paper documents.
- It has since worked with MHSOP to create an appropriate and formal referral pathway, and has engaged a Mental Health Nurse Specialist to co-ordinate Dr F's visits.

Rest home policies

Falls Assessment and Intervention policy

93. The rest home had a "Falls Assessment and Intervention" policy in place at the time of these events. The policy stated: "[W]e believe that thorough and accurate assessment of clients who fall is extremely important in minimising injury and ensuring adequate care of clients following a fall." It provided the following instructions:

> "5.10. Following a fall an incident/accident form must be completed, and documentation of the fall, injuries, treatment and on-going monitoring of the client documented in the multidisciplinary progress notes.
>
> 5.11. The client's family/whānau must be notified — per open disclosure policy and procedure.
>
> 5.12. If client falls more than two times in four weeks, a falls assessment and review of care plan is required."

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Accident/Incident Event Reporting policy

94. The scope of the "Accident/Incident Event Reporting" policy was to ensure that "[a]ppropriate action is taken to ensure individual well-being, and these events are reported promptly and brought to the attention of the Facility Manager for investigation and for any corrective action that may be need to be taken". The policy stated:

> "Residents/Visitor
>
> … Any employee that identifies an incident should report it by completing an incident form …
>
> The incident form should be completed as soon as possible and before the end of the working duty …
>
> All NOK/EPOA/whānau/family must be informed of the incident on that shift or at the nearest appropriate time but must be within 24 hours. This needs to be filled in the form, documented in the progress notes and in the 'communication with family form'. The progress note must describe the incident, the care delivered and the incident number put at the top of the Incident form."

Responses to provisional opinion

95. Mr A's family was provided with an opportunity to respond to the "information gathered" section of the provisional opinion. Mr A's daughter, Ms B, stated:

> "The statistics provided by the HDC investigation into number of falls and failure to document correctly and timely by Radius is unacceptable, extremely concerning and distressing. The family was not being told the true extent to which these falls were having on [Mr A's] well-being while in their care."

96. Ms B also expressed disappointment at how few of the falls were disclosed to the family, and commented: "At no time was [Mrs A] or the family invited to sit down and discuss a formal [c]are [p]lan for managing his safety needs and reviewed together on a regular basis."

97. Radius Residential Care Limited stated that it accepted that the general care provided for Mr A was in breach of the Code and accepted the recommendations and follow-up actions in the provisional report.

Opinion: Radius Residential Care Limited — breach

98. In accordance with the Code, the rest home had a responsibility to ensure that Mr A received an appropriate standard of care. This included having in place adequate systems to support the safe and appropriate management of Mr A's falls and associated risk, and ensuring compliance with those policies.

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Management of Mr A's falls risk

99. Mr A's high falls risk was detailed in the Initial Assessment Care Plan on the day of his admission to the rest home (22 February 2016). Further assessments on 26 February 2016 stated that Mr A experienced falls on a daily basis, and attributed his lack of balance to cognitive loss. It was also noted that he lacked insight into his risk of falling.

100. As an outcome of these assessments, a low-low bed, bell mat, and crash mattress were put in place. Additionally, hip protectors were purchased for Mr A, and a plan was made for him to be taken on three assisted walks a week. At that stage, his care plan noted that Mr A mobilised with a walking frame but needed a two-person assist to mobilise and for transfers.

101. In the period between 23 February 2016 and 11 March 2016, Mr A had six falls. There is no record of Mr A going on assisted walks over this time.

102. On 15 March 2016, Mr A's Initial Assessment Care Plan was reviewed. It was documented on the updated plan that Mr A could get restless if not toileted within four hours, and that walking helped to settle him. It was noted that Mr A utilised a walking frame with a belt and required a one-person assist when active and a two-person assist when tired.

103. According to the documentation provided by the rest home, Mr A was taken on assisted walks on 15, 17, 18, 24, 25, and 29 March 2016. He also walked with assistance on 1, 6, 7, 9, 10, 11, 13, 14, 17, 18, and 27 April 2016. Entries in the MDP notes mention that Mr A had continued restlessness despite going on several assisted walks in a day.

104. Mr A fell on five occasions between 22 March 2016 and 14 April 2016. A Post Falls Assessment and Action Plan (to be completed when a resident has two or more falls in a month) was initiated on 19 April 2019. It is recorded on this form that Mr A sustained 16 falls between 19 April 2016 and 25 April 2016.

105. A second action plan was completed on 26 April 2016. This documented that Mr A had seven falls between 26 April 2016 and 2 May 2016. The action plan cited Mr A's restlessness, confusion, lack of stability, and desire to walk independently as contributory factors to his falls. A number of interventions were listed on the action plan, including a low-low bed and high impact mat, a bell mat, ensuring that Mr A wears glasses and proper shoes at all times, removing clutter from his surroundings, keeping his walker within reach, putting brakes on all the chairs, and having a behaviour chart in place. It noted that these measures were already in place.

106. On 3 May 2016, Mr A was seen by Dr G. Dr G noted that Mr A had postural issues, and that his falls risk was exacerbated by poor vision.

107. On 11 May 2016, Mr A's care plan was updated to state that he was at risk of wandering, now that he was able to mobilise with his walker without further assistance. Documentation shows him taking independent walks from around mid April.

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108. Between 4 May 2016 and 31 May 2016, Mr A had 33 documented falls. Many of the accident/incident forms associated Mr A's falls with his wandering behaviour. They also show that staff considered that Mr A needed to have a more secure area to mobilise in, so he was referred to the MHSOP.

109. Mr A was seen by Dr F from the MHSOP on 19 May 2016. Dr F considered that Mr A's falls risk and pattern of falls would remain the same regardless of where he was placed. He wrote that a trial of medication to stop Mr A from wandering was very likely to increase his risk of falls further. He recommended reassessment for secure dementia care.

110. On 10 June 2016, Dr G and Dr F noted that Mr A's mobility had decreased, with Dr F noting that Mr A could no longer mobilise individually at all. Entries in the MDP notes reflect that from 8 June 2016 Mr A was no longer able to mobilise independently.

111. In the month of June, Mr A sustained 12 falls and was taken on one documented walk. In July, Mr A fell eight times, and went on one documented walk. Corrective actions on the accident/incident forms for July refer to having a bell mat and impact mat in situ, seating Mr A in a location where he could be supervised, using hip protectors, intentional toileting, and implementing a rounding log and behavioural chart.

112. On 29 July 2016, RN C documented in Mr A's mobility falls/prevention evaluation that he was less mobile so he was no longer at risk of wandering. RN C also recorded that Mr A was restless as a result of dementia and remained a high falls risk. Instructions were left for staff to ensure that Mr A wore glasses and proper shoes, and for clutter to be removed from his surroundings. Instructions were also left for staff to toilet Mr A when he became restless, as this was usually because he wanted to move his bowels or urinate. These were all interventions that had been documented previously.

113. Mr A had nine documented falls in August 2016 and seven in September 2016. As a result of a post-fall nurse assessment completed on 18 August 2016, Mr A was provided with a seat alarm on 31 August 2016. There are two documented walks over August 2016 and September 2016.

114. In total, 55 of Mr A's 97 documented falls from February 2016 to November 2016 were reported on an accident/incident form, and it was documented that Mrs A was informed of 23 of those falls. Some of the accident/incident forms referred to Mr A's wandering behaviour and noted the corrective actions in place or made suggestions such as trying to keep Mr A occupied.

115. My expert advisor, RN Jan Grant, advised that patients such as Mr A will always present a challenge to nursing staff. However, she stated:

> "[T]here could have been a more thorough analysis or interpretation of the information amassed from the many assessments and incident forms completed in the course of [Mr A's] stay at [the facility]. This would have then led to the

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identification of contributing factors, which would have in turn, led to the introduction of interventions designed to reduce the frequency of his falls."

116. RN Grant considered that the assessment and management of Mr A's ongoing falls lacked the robustness required. She noted:

> "In some instances the care plan was altered but then not always re-evaluated to see if these measures had been effective. There seemed to be little analysis of his many falls over the course of his stay at [the facility]. [Mr A] was identified early as a high falls risk and the large number of falls he had certainly bears this out. This should have suggested to the multidisciplinary team that the interventions in place were not effective. It is accepted that eliminating falls completely in patients such as [Mr A] is not feasible, but nevertheless there may have been alternative ways to manage his mobility."

117. RN Grant advised that staff could have specified in the care plan set times for walking and toileting Mr A, and referred Mr A for specialist input. She noted, for example, that a nurse practitioner may have viewed Mr A's frequent falls with a fresh perspective and given advice on different interventions. RN Grant also stated that she would have expected a family multidisciplinary meeting with the GP and physiotherapist in attendance, but there was no evidence of multidisciplinary discussion of Mr A's falls. RN Grant stated:

> "I am of the opinion that the lack of a detailed analysis of [Mr A's] falls, a lack of planned walking times, a failure to refer to a specialist, as well as a failure to hold a multidisciplinary meeting that included the family, would be viewed as a moderate departure from expected standards by my peers."

118. The rest home noted that when Mr A's dementia progressed in May 2016, it had arranged for a GP review and an assessment from Dr F. It also stated that further physiotherapy review was sought on 6 July 2016 and 2 September 2016. The rest home noted that Dr G and the physiotherapist did not recommend any changes to Mr A's management. It also noted Dr F's view that Mr A's falls risk would remain at the same level "wherever he goes", and that a trial of medication would likely increase his falls risk.

119. The rest home stated that Mr A was independently mobile for most of his time at the facility, and did not require daily walking. The rest home commented:

> "Given the busy and changing environment of aged care, set walking times are unrealistic due to factors such as onsite emergencies, acute situations and staff workload in relation to patient needs."

120. The rest home also noted that Mr A would have been walked daily by care staff to and from the bathrooms.

121. I accept RN Grant's advice. Rest home staff were aware that Mr A presented a high falls risk, and this risk was often realised. I acknowledge that some steps were taken to reduce

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the number of falls, including assisting Mr A on walks and installing a low-low bed, a high impact mat, a bell mat, and, later, a seat alarm, and that Mr A was reviewed by a physiotherapist, a GP, and a doctor from MHSOP. However, there is a lack of detailed analysis and interpretation of the information contained in the various assessments and evaluations completed by staff. Further, as detailed by RN Grant, a more robust falls prevention approach would have included referral to other specialists such as a nurse practitioner (who may have been able to provide falls management advice from a different perspective), multidisciplinary meetings, and planned walking and toileting times in the care plan. This was important given that the existing strategies did not appear to be effective.

122. I am also critical that the recommended programme of walking Mr A three times a week does not appear to have been carried out consistently. While I note the submission that Mr A was independently mobile for most of his time at the facility, I also note that assessments of Mr A's falls risk and the progress notes in fact reflect variable mobility, and that he remained a high falls risk at all times. I am also mindful that this walking programme remained in place after further physiotherapy assessments on 6 July 2016 and 2 September 2016. As Mr A's restlessness was consistently identified as a major contributory factor to his falls, I would have expected staff to ensure that he was walked regularly.

123. I acknowledge that strict compliance with set walking and toileting times, as suggested by RN Grant, is not always practicable given the factors cited by the rest home. However, I do not consider that these factors justify the lack of a structured approach to assist Mr A with walking and toileting; the possibility of acute situations arising and unexpected demands on staff time will always exist. In my view, more specificity around walking and toileting arrangements would have helped to ensure that Mr A's needs were being met in these areas.

124. Further, I am concerned by poor compliance by a number of staff with the facility's policies. The specified purpose of the incident reporting policy is to ensure that events are reported promptly and escalated to the Facility Manager for investigation and any corrective actions. This was not always done. Accident/incident forms for Mr A's falls were completed approximately 57% of the time. Further, contrary to the falls policy, which requires a falls assessment and review of the care plan to be actioned if the resident falls more than twice in four weeks, a post-falls assessment and action plan was first implemented on 19 April 2016, after Mr A had sustained ten falls in less than six weeks. A second action plan was put in place on 26 April 2016, but no further plans followed, despite the continued high incidence of falls. It is my view that the lack of compliance with these policies likely contributed to the lack of detailed analysis of Mr A's falls.

Supervision

125. On 11 May 2016, staff observed that Mr A had been trying to get outside, and that even after he was taken for a walk, he wanted to go out "again and again". At approximately 1pm, Mr A was found on a road near the facility. At approximately 1.10pm, Mr A was

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found to have left the facility a second time. He was not witnessed leaving the premises on either occasion.

126. RN Grant noted the challenging nature of managing a patient with dementia. She said that ideally staff should walk with such patients or at least closely supervise them, but acknowledged that there are times when this will not be realistic, for example because of staffing workloads or acute situations or emergencies. However, she advised:

> "I am of the opinion that [Mr A] leaving the building was a fault of poor supervision and would be viewed as a mild departure from acceptable standards by my peers."

127. I agree with RN Grant's advice. While I accept that management of clients with dementia can be difficult, rest home staff were aware that Mr A had been attempting to leave the facility on 11 May 2016 before he managed to abscond the first time. He was then able to abscond a second time. That he was able to leave on two occasions within minutes suggests that rest home staff did not supervise Mr A adequately on that day.

Communication with family

Care planning

128. Mr A's family told HDC that they were not provided with, or consulted about, Mr A's care plan.

129. RN Grant advised:

> "Family participation in the care planning process is vital to both the staff at the facility and to family members. Open communication and discussion provides an opportunity for learning more about the patient, for improving understanding on all sides and for the development of better care plans."

130. RN Grant also stated that a multidisciplinary meeting involving the family should have been initiated with all staff involved in Mr A's care (including the GP and physiotherapist), to enable his family to ask questions and to be kept informed of his progress.

131. The rest home maintained that the care plan on admission was created with Mrs A's input. The rest home also told HDC that as Mr A's next of kin, Mrs A was provided with informal and extensive information about Mr A's care, including clinical assessments, GP visits, and Mental Health visits. The rest home explained that these were not always documented, as "corridor conversations" are rarely captured in the notes.

132. Mr A's initial care plan has a ticked box to confirm that information was obtained from his family. Mrs A had also completed a personal history profile for Mr A. It is stated on the form that this information would be used to form the basis of the care plan and daily activity routine.

133. A formal review of the care plan was due to occur at the end of August 2016. The rest home stated that Mrs A would have been invited to participate in this review, but that

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responding to the family's complaints took precedence. The rest home told HDC that staff met with the family on 1 August 2016 and 2 September 2016, and that one of those meetings included a four-hour discussion covering all aspects of Mr A's care. The rest home considers that this was "effectively a multidisciplinary meeting".

134. It is clear that Mrs A was asked to provide information that would be used to form the basis of the initial care plan, and that she did so. However, I am critical that the meetings with Mr A's family in August and September 2016 appear to have been considered a substitute for family consultation in the review of Mr A's care plan. These meetings were held in response to concerns that had been raised by Mr A's family about the standard of communication from staff, and therefore served a different purpose. In my view, the rest home needed to make it clear to Mr A's family that these discussions would be used to inform the review of Mr A's care plan, including how that was to be done.

135. I share RN Grant's view that the rest home should have held a multidisciplinary meeting involving Mr A's family to discuss his care planning generally. As Mr A's GP and the facility's physiotherapist were not in attendance at either of the meetings with Mr A's family in August and September 2016, I do not accept that one of these discussions was effectively a multidisciplinary meeting.

Mr A leaving the facility unobserved

136. Mr A's family raised concerns about the rest home's standard of communication after he left the facility unobserved by staff twice on the afternoon of 11 May 2016. It is documented on the accident/incident forms that a message was left for Mrs A on her home telephone. An entry in the MDP notes at 3.30pm states that Mrs A was visiting and that she was aware of the incidents; however, there is no further detail about what information was provided to Mrs A.

137. Based on the evidence before me, I am satisfied that Mrs A was contacted about the incidents, and that they were discussed with her when she visited Mr A later that day. It is, however, disappointing that there is no record of what was discussed, and whether Mrs A was satisfied with the explanation provided. I suggest that the rest home reflect on this incident and consider how effective communication could be ensured in future, and how documentation could be used to assist that.

Timing of Dr F's assessment

138. The rest home did not inform Mrs A when Dr F attended the facility to assess Mr A on 19 May 2016. Mrs A was initially told that the assessment would occur on 17 May 2016, but she was not made aware of the change in assessment date.

139. The rest home explained that there was no opportunity for Mrs A to be present for Dr F's assessment, as his visit on 19 May 2016 was unannounced. An update to an accident/incident form on 12 May 2016 confirmed that rest home staff expected Dr F to visit on 17 May 2016, the date originally provided to Mrs A.

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140. It is concerning that despite Mrs A's express wishes to attend Mr A's assessment, she was not notified of Dr F's visit on 19 May 2016. I accept that the rest home did not expect Mr A to be assessed on this date; however, I consider that staff ought to have communicated with Mrs A when he visited. I note that Mrs A lived in the retirement village and may have been able to attend at short notice. Alternatively, she might have asked Dr F to assess Mr A at a later date.

Information arising from Dr F's assessment

141. Mrs A stated that the rest home did not provide her with a copy of the report (which was typed on 25 May 2016), and that she obtained a copy through Dr F on 7 June 2016. Mrs A also stated that it was on reading Dr F's report that she learned for the first time that Mr A had been falling as frequently as five times in one day. She told HDC that she had not previously been informed of Mr A's tendency to wander into the rooms of other residents, or of the recommendation that he be reassessed for secure dementia care.

142. Mrs A's assertion that she was not aware of the frequency of Mr A's falls is supported by documentation. There is written confirmation of Mrs A being notified of 23 of his 97 falls (24% of his falls). Similarly, there is little evidence to suggest that Mrs A was informed of the extent of Mr A's wandering behaviour. Although he was found in other residents' rooms on five occasions (and made repeated attempts to enter on 22 May 2016), Mrs A was informed on only one occasion, and it is not clear whether she was told only of the fact that he had sustained a fall.

143. I am critical that key information in Dr F's report, namely the frequency of Mr A's falls and his tendency to wander into the rooms of other residents, was not discussed with Mrs A prior to the assessment. It is disappointing that these matters were made known to Mrs A only when she procured a copy of Dr F's report. I would have expected Mrs A to have been informed of Mr A's falls and wandering behaviour, and note that this is required by the rest home's policy on incident reporting.

144. I also consider that communication of the outcome of Dr F's assessment was suboptimal. As Mr A's attorney for personal care and welfare, Mrs A had the right to access Dr F's report. While I note that she received a copy from Dr F on 7 June 2016, the rest home was aware of its importance to Mrs A, and, in my view, ought to have provided the report to her and explained its significance at the earliest reasonable opportunity, and at least after she requested it.

Timeliness of communication

145. On Mr A's admission to the rest home, Mrs A requested that staff contact her at any time of the day or night in the event that Mr A experienced a serious injury as a result of an accident/incident. She also asked to be notified between 7am and 9pm if the injury was minor or if Mr A experienced a non-life-threatening change in health status.

146. I note that there were two occasions where Mrs A was not informed of minor injuries to Mr A as result of falls within those hours, yet decisions were made to inform Mrs A in the

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morning. On both these occasions, there was no written documentation to confirm that she was in fact told of these falls. In my view, the failure to adhere to Mrs A's expectations around the reporting of Mr A's injuries is yet another indication of unsatisfactory communication with his family.

Conclusion

147. Aged care facilities are responsible for the operation of clinical services they provide, and can be held responsible for any service failures. In my view, the rest home's management of Mr A's falls risk was inadequate. While some interventions were implemented and some reviews were completed, there was no detailed analysis of the data collected about Mr A's falls. I am guided by my expert advisor, and consider that the analysis of Mr A's falls was not sufficiently robust, that staff could have included set times for walking and toileting Mr A to minimise his restlessness, and that staff should have requested input from additional specialists and held multidisciplinary meetings.

148. It is possible that had a multidisciplinary meeting occurred at an early stage, the suitability of the strategies in place for managing his falls and ultimately the type of support Mr A was receiving could have been canvassed and alternative options considered. Possibly some of the falls Mr A experienced over this extended period could have been avoided.

149. As noted above, it appears that there was also poor compliance with Mr A's programme of assisted walks. The pattern of non-compliance with the rest home's policies on falls and incident reporting by staff is also very concerning, and suggests that there was a culture of non-compliance with these policies. Compliance with the policies may have assisted in more thorough analysis of Mr A's falls and additional strategies to manage his falls risk. It was the responsibility of the rest home to ensure compliance with the facility's policies.

150. I agree that Mr A was a challenging individual to manage for the staff involved; however, the rest home did have ultimate responsibility for meeting Mr A's needs and putting strategies in place to mitigate the risk of him falling. Unfortunately, staff persevered with strategies that had been proven ineffective. Although challenging and difficult, Mr A's circumstances are not unique in aged care, and I am critical that the rest home did not take sufficient action to reduce his falls risk.

151. In addition, I consider that staff did not supervise Mr A adequately on 11 May 2016. I note that despite being put on notice that Mr A had been attempting to leave the facility, he managed to abscond on two occasions within the space of 10 minutes without staff being aware.

152. These deficiencies lead me to conclude that the rest home did not provide Mr A services with reasonable care and skill. Accordingly, I find that Radius Residential Care Limited breached Right 4(1) of the Code.[7]

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

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153. I am also critical of poor communication with Mr A's family in his time at the rest home. It is evident that Mrs A wished to be involved in Mr A's care and to be kept informed about his health status. This was hindered by a lack of communication about his falls and his wandering behaviour, a lack of multidisciplinary meetings, and the lack of formal consultation when re-evaluating Mr A's care plan. I am concerned that the majority of Mr A's falls were not reported to Mrs A, and that Mrs A's request to be informed of minor injuries between 7am and 9pm was not complied with. In relation to Dr F's assessment, I consider that it would have been reasonable to contact Mrs A when he arrived at the facility unexpectedly. I am also of the view that the rest home ought to have furnished Mrs A with more information about the impact of Dr F's assessment, given her concerns.

Recommendations

154. I recommend that Radius Residential Care Limited:

a) Provide evidence that its policies and procedures on falls management, incident reporting, client assessment, and care planning are current and reflect best practice, with reference to the reviews and updates that have been undertaken over the past three years. This is to be sent to HDC within three months of the date of this report.

b) Provide evidence of audits that have been undertaken to assess compliance with the policies and procedures referred to above. This is to be sent to HDC within three months of the date of this report.

c) Apologise to Mr A's family for the deficiencies outlined in this report. The apology letter is to be sent to HDC for forwarding to the parties, within three weeks of the date of this report.

Follow-up actions

155. A copy of this report with details identifying the parties removed will be sent to the district health board, and it will be advised of Radius Residential Care Limited's name.

156. A copy of this report with details identifying the parties removed, except the name of Radius Residential Care Limited, will be sent to HealthCERT (Ministry of Health) and the Health Quality & Safety Commission, and will be placed on the Health and Disability Commissioner website (www.hdc.org.nz), for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Jan Grant, a registered nurse with 30 years' experience in Aged and Community Care. RN Grant has represented the New Zealand Nurses Organisation and the Aged Care Sector on a number of working parties. RN Grant has also been involved in setting standards for Practice for Gerontology Standards.

Expert Opinion Report One

"**Background:**

[Mr A] was admitted to Hospital Level Care on the 22.2.16. Previously he had been living with his wife and had been admitted to [the public hospital] on the 20.2.16 following a fall and worsening mobility. His medical background was listed as Macular Degeneration and Dementia. While at [the rest home] he had numerous falls.

I have been asked to comment on:

1. **The management of [Mr A's] falls risk**
2. **The management of [Mr A's] wandering**
3. **The appropriateness of [Mr A] being unsupervised in the lounge**
4. **The appropriateness of [Mr A's] care plan and whether this was adhered to**
5. **[Mr A's] fluid management**
6. **The adequacy of relevant policies and procedures in place at [the rest home]**
7. **The documentation**
8. **Any other matters in this case that you consider warrant comment**

[Mr A] was admitted on the 22nd February, 2016.

His admission documentation included:

- Admission checklist — completed and signed with dates when assessments were undertaken.
- Client orientation checklist — signed and dated 22.2.16.
- Initial assessment/Care plan — This was completed and signed. This document identified cares needed short term until a full care plan could be completed.
- Individual assessments included: Sleeping assessment, Personal hygiene and grooming assessment, Nutritional assessment which included a Dietary requirement form and Mini Nutritional Assessment, Elimination Assessment, Continence Assessment, Pain assessment, Communication Assessment, Behavioural assessment, Social History Assessment, Pain Assessment for Dementia Clients, Activity Assessment, Pressure Area Assessment and Skin Assessment.
- Mobility Assessment included a Physiotherapy Assessment. This was completed by a Registered Nurse and consisted of a mobility assessment, a Berg Balance Scale, a falls risk assessment (3 pages) and a falls risk screening.
- Appropriate consent information.

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- Personal History Profile.
- An interRAI assessment was completed on the 25.2.16.

Overall, the admission documentation was thorough and completed in a timely manner. Documentation included relevant information to support the care of [Mr A].

The documentation also included Multi-disciplinary progress notes. These are a record of cares and support given to [Mr A]. They commence on admission and are documented on each shift. Each entry is signed with a signature and the designation of the person entering the information.

The clinical long term care plan was commenced on the day of admission and completed on the 15.3.16. The first part of the plan lists baseline recordings and current medical problems. It then goes through activity of daily living areas and starts with an assessment page for each category and evaluation pages which are used for updating and evaluating any observed changes and documenting if goals are met. The areas which are covered include:

- Communication
- Cultural Needs
- Elimination
- End of life needs
- Hygiene and Personal care
- Memory/Cognition/Behaviour
- Mobility/Falls Prevention
- Nutrition/Hydration
- Pain Management
- Physiological Requirements
- Activities and Recreational Wellbeing
- Rest and Sleep
- Sexuality and Intimacy Needs
- Skin Integrity
- Spiritual Requirements
- Family/Significant Other Links
- Other needs

Other charts which support and assess individual areas:

- Wound Assessment & Care Plan
- Acute/short term care plans
- Rounding Log
- Monthly Weight and Blood Pressure Recordings
- Neurological Observation Chart
- Bowel Record
- Daily Personal Cares Chart

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New Patient Medical Summary notes/Medical Progress Notes:

[Mr A] was seen on the 26.2.16 for his admission by the GP. Other visits during his stay took place on:

- 23.3.16
- 2.5.16
- 20.5.16
- 10.6.16
- 1.7.16
- 4.7.16
- 22.7.16
- 17.10.16

Other forms were presented with the clinical notes. The *Communication with Family Record* lists the occasions that staff have communicated or left messages with family. The majority of the communications with the family were about the falls [Mr A] was experiencing.

There are also tick sheets which cover daily activities attendance register, bowel record sheets, and daily personal care charts.

Also included in the documentation was a form to monitor behaviour. This form appeared to be completed when there was an event such as a fall, or when [Mr A] was displaying a particular behaviour. The form was not completed for all falls. There was a section for staff to complete to indicate what may have caused, or contributed to, the event or behaviour. The reasons that staff listed for the falls, relate to '*restlessness', 'wanting to walk', 'wanting to get up'* and '*wanting to go to the toilet'.*

Incident forms which describe any incidents/accidents that [Mr A] may have had throughout his stay are included with the documentation.

1. <u>The management of [Mr A's] falls risk</u>

The frequency of falls is listed as one of the reasons for admission to both [the public hospital] and later to [the rest home] for long term hospital level care. The mobility/falls prevention care plan outlines clinical interventions. Hip protectors were provided. The falls risk assessment undertaken on the 26.2.16, 4 days after admission, identifies [Mr A] as a High Falls risk. Interventions listed are using a low bed and crash mattress, a walking frame and support belt with one person assist, and two persons when [Mr A] was observed to be tired. A standing hoist was available when he was very lethargic or tired. The care plan states '*regular walks with physiotherapist assistant'*.

The evaluation in the nursing care plan, following the documentation of the care plan, was on the 15.3.16. It states, '*[Mr A] is having frequent falls since admission, due to poor mobility … for frequent fall monitoring chart.'*

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Approximately 5 weeks later on the 26.4.16, following a further evaluation, a Post Falls Assessment and Action Plan was documented. Interventions clinically listed were appropriate.

Another evaluation dated 29.7.16, i.e. approximately 5 months after admission, stated *'[Mr A] now less mobile and restless due to dementia. Still high falls risk. Low, low bed, impact mat ???? in situ when in bed, make sure [Mr A] is wearing proper shoes all the time. Behaviour chart in place. Put brakes on all chairs, prevent from slipping and then falling. Eye glasses all the time. Make sure we remove all clutter from his surroundings. Toilet [Mr A] when he becomes restless — most of the time he wants to move bowels or urinate. On physio walking list. Family are aware of this.'*

When this evaluation was done at the end of July, [Mr A] had had approximately 78 falls. On many days, he had had more than one fall. The majority of the time it is reported that [Mr A] sustained '*Nil injury'* but there are times when he sustained skin tears and bruising.

The *Communication with Family Record* shows that family (wife) was either left a message or informed of the fall. Evidence from this record indicates that family were not informed of every fall.

Medical notes indicate that in May, 2016, the Doctor has written: '*walking more. High falls risk … good power in legs. On standing he has postural issues leaning back, legs are flexed and in front of his centre of gravity'*.

Summary

My opinion of the assessment and management of ongoing falls in this particular case is that it lacked the robustness required.

Patients such as [Mr A], always present a challenge to nursing staff.

There was, in my opinion, never a right answer. However, I feel in this case there could have been a more thorough analysis and interpretation of the information amassed from the many assessments and incident forms completed in the course of [Mr A's] stay at [the rest home]. This would have then led on to the identification of contributing factors, which would have, in turn, led to the introduction of interventions designed to reduce the frequency of his falls.

Staff have documented in the progress notes that [Mr A] was attempting to walk to the toilet. At other times he was observed to be restless in his chair. It seems that his restlessness was attributed at times for his need to go to the toilet. The progress notes show that when he did walk and exercise with supervision, he became more settled and less likely to fall. This indicates to me that staff were aware of [Mr A's] falls and had even identified probable contributing factors. In addition, the doctor was aware of the falls and had observed abnormal stance and gait. However, there is no evidence that any multidisciplinary discussion took place, or that a referral to a clinical specialist was initiated

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to discuss the issues around the multiple, ongoing falls. A nurse practitioner, for example, may have viewed the events with different eyes and advised different clinical pathways/interventions to decrease the falls.

I believe staff could have included in the care plan, set times when [Mr A] was walked with supervision and toileted on a regular basis, in an effort to prevent certain observed behaviours such as restlessness. Although the care plan indicated that there would be regular walking with a physio assistant, there is limited information as to how often or on how many days this took place.

Family communication is listed in the Family record sheet but it does not elaborate on any discussion senior staff had with family. I would have expected to see notes from a family multidisciplinary meeting with GP and physiotherapist in attendance.

I am of the opinion that the lack of a detailed analysis of [Mr A's] falls, a lack of planned walking times, a failure to refer to a specialist, as well as a failure to hold a multidisciplinary meeting that included the family, would be viewed as a moderate departure from acceptable standards by my peers.

1. **The management of [Mr A's] wandering**
2. **The appropriateness of [Mr A's] being unsupervised in the lounge**

Multidisciplinary progress notes and supporting documentation show that [Mr A] was prone to mobilise independently any time of the day or night. Staff identified that often the reason for this was that he wanted to go to the toilet, or that he wanted to get up out of his chair. However, there were other times when he had just been walked and assisted to sit down, but within a short time would get up, walk and fall (incident report dated 30.3.16).

The documentation includes a Daily Personal Cares Chart. Each page of this chart covers daily cares given in the AM and PM as well as a night report. It appears that [Mr A] spent most of his time in the lounge. There are very few days where he remained in bed.

During [Mr A's] admission, the notes indicate he had poor judgement secondary to his dementia and poor vision secondary to macular degeneration. There were also issues with abnormal posture (medical progress notes). These were all contributing factors to his high falls risk.

As previously stated, patients like [Mr A] present a challenge to nursing and care staff. He was unsafe when he was mobile but yet he constantly attempted to walk. However, there were times documented, when [Mr A] was able to walk around with his walking frame without falling.

[Mr A] left the building/facility on the 11.5.16. Notes state that at 1300hrs, [Mr A] kept going outside and that staff found it difficult to redirect him as he became aggressive towards them. Again at 1300hrs he left the building and was found. He then left again at 1400hrs and was found on a road near the facility. There are 4 incident forms completed

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for the 11.5.16 (numbers 75, 77, 79, 80). Two of the incident forms relate to [Mr A] absconding from the facility and the other two relate to 3 falls he had at 1740hrs, 1930hrs and 2000hrs. Corrective action comments state:

'for review and reassessment by MHSOP team on Tuesday. ? Secure unit'

Clinical management of dementia patients is a challenge. They should not be prevented from walking but it is important to acknowledge that this in itself creates risk. Ideally staff should walk with these patients, or at the least closely supervise them. There are times that this is not realistic, however. This may be due to staffing workloads in relation to patients' needs or due to acute situations and emergencies. There are times of the day when staff are extremely busy with personal cares and there will also be times when there is no staff in common areas such as the lounge. However, even taking this into consideration, patients should not be left in the lounge against tables to prevent them from mobilizing. When nursing/care staff were unable to be present in the lounge areas, staff such as the activity and physiotherapy assistants would have provided a good alternative.

[Mr A] was admitted to the hospital wing of the facility. It is noted that this is not a secure unit and that it would have been possible for him to leave the facility unseen. Although I have noted the challenging nature of the patient with dementia, I believe that a multidisciplinary approach to ensuring supervision as often as possible, would have prevented some of [Mr A's] falls and episodes of absconding. I am of the opinion that [Mr A's] leaving the building was a fault of poor supervision and would be viewed as a mild departure from acceptable standards by my peers.

3. <u>The appropriateness of [Mr A's] care plan and whether this was adhered to:</u>

[Mr A's] care planning was commenced at his admission with a short term care plan and individual assessments. The long term care plan was completed on the 15.3.16. I am of the opinion the long term care plan was accurate and well documented. The care plan shows that an individual assessment was undertaken and documented. There were areas where more could have been written and at times some of the goals could have been more personalised, eg:

In the Mobility/Falls Prevention Plan, the goal was listed as '*[Mr A] will be assisted with mobility needs as required to ensure that maximum level of mobility is maintained*'. It appears that the goal is a template and the name of the patient is added. There is no mention of reduction in the number of falls in the goals. The clinical interventions, however, are hand written and are more personalized.

<u>Summary:</u>

Overall the care plan is adequate and very typical of what is used in an aged care facility. I am of the opinion that the care plan documentation would meet the requirements for certification.

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4. [Mr A's] fluid management

The care plan identified the Nutrition/Hydration goal as '*[Mr A's] nutrition and hydration intake will be sufficient to meet body requirements*'. On admission [Mr A's] body mass index was listed as 18.5. This indicates he was underweight and staff have documented he was mal-nourished. He ate a soft meal. His initial assessment showed that he was dependent on staff for all meals. The progress notes indicate that at times he fed himself and at other times he required full assistance.

Staff have entered in the progress notes in the first couple of weeks after admission comments such as '*Eating and drinking well', '[Mr A] was very sleepy this shift not interested in food drank well', 'Ate and drank well', Assisted with meals good food and fluid intake', 'good food and fluid intake no concerns'.*

Notes from the 24.3.16 indicate that the GP had discussed the use of the nutritional supplement, 'Ensure' and states that '[*Mrs A] happy with [Mr A's] current eating habits'.*

Throughout April and May, the comments in the progress notes indicate he was eating and drinking well. Around early June notes indicate that [Mr A] was holding food in his mouth when he was eating and drinking. On the 9.6.16 he had minimal food and fluid intake. By mid-June he was described as eating and drinking well and the notes indicate this continued up until November.

It is noted that the complaint by [Ms B] indicates that family felt fluids were being limited to manage toileting and only experienced staff were monitoring fluid intake.

From the documentation presented, I can find no evidence of this, but in saying that, it is very subjective as to what a 'good fluid intake' is. If family have concerns that a patient is not drinking adequately, then staff should commence a strict fluid balance chart for a week to assess more precisely how much fluid a patient is drinking. Half a cup of tea 3 times a day does not equate to a 'good' fluid intake, and a fluid balance chart over a period of days will provide more accurate information.

All patients should have fluids within reach at all times and there should be some monitoring of their intake if concerns are raised. In addition, clinical signs of poor fluid intake should be looked for. These may be concentrated urine, dry mouth, recurrent urinary infections, constipation, and a change in usual behaviours, such as increasing drowsiness and confusion.

I am of the opinion that [Mr A's] fluid intake was evaluated in the clinical notes on a regular basis. However, a formal fluid balance record was not kept at any stage. I believe this should have been done at the time he was observed to be eating and drinking poorly, and also as a way in which concerned family members could be reassured.

5. The adequacy of relevant policies and procedures in place at [the rest home]:

I was not presented with any policy and procedures to review.

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6. The documentation:

The documentation used by Radius Care is very typical of what is found in many aged care facilities. As previously stated the initial documentation was thorough and included other assessments which would assist in developing the long term care plan. Apart from the lack of analysis of [Mr A's] many falls which I have commented on under Question one, I find the documentation adequate and completed to the required standard to meet certification and DHB requirements.

7. Any other matters in this case that you consider warrant comment:

Communication is vital when providing care and support to patients. In the letter of complaint it is noted that family were not kept informed of assessment times. Nor were they kept up to date on issues of [Mr A] wandering into other people's rooms. There is limited evidence that family were told of the large number of falls. Family has also noted that there was no opportunity to read or participate in the care planning process. Family participation in the care planning process is vital to both the staff at the facility and to family members. Open communication and discussion provides an opportunity for learning more about the patient, for improving understanding on all sides and for the development of better care plans.

[Mr A's] management was not easy due to his dementia and the number of falls he was having. This is not an uncommon scenario for long term care facilities to deal with — i.e. a patient with dementia who is trying to maintain his continence and to remain independently mobile, but lacks the insight to recognise the risks involved. It is important to keep family members informed and to encourage open communication. Family members then become more aware of the challenges faced by the staff working in the long term care environment. This in turn provides an opportunity for the development of realistic outcomes.

My other comment and recommendation is that a Multidisciplinary meeting should have been initiated with all staff involved in [Mr A's] care and his family present. This type of meeting allows families to ask questions and to be kept informed on progress. It provides a forum for all participants to express concerns and have questions answered. This did not appear to happen in [Mr A's] case. [Mr A's] family were not kept informed of the review process. Families must be given the option to attend all reviews. These reviews may be regular in-house patient reviews, or reviews by DHB specialist services. Open communication is vital for the well-being of all patients and their family members.

I have stated that the initial assessment and care planning process was of an acceptable standard. There was a lot of documentation around the multiple falls [Mr A] had. In some instances the care plan was altered but then not always re-evaluated to see if these measures had been effective. There seemed to be little analysis of his many falls over the course of his stay at [the rest home]. [Mr A] was identified early as a high falls risk and the large number of falls he had certainly bears this out. This should have suggested to the multidisciplinary team that the interventions in place were not effective. It is accepted that

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eliminating falls completely in patients such as [Mr A] is not feasible, but nevertheless there may have been alternative ways to manage his mobility. One suggestion I have already made was to request the opinion of a specialist service such as a Nurse Practitioner or Geriatrician. It is important that long term care staff are given the knowledge and skills to examine all the information gathered, analyse it and adjust plans of care accordingly.

My recommendation is that [the rest home] considers the introduction of Multidisciplinary meetings to be held at regular intervals. Family members should be invited to attend, thus providing them with an opportunity to raise any concerns. These meetings should be documented, changes in care noted, goals outlined and time frames for review agreed upon. I also recommend that [the rest home] develops a process when patients are to be reassessed; family is consulted and given the opportunity to attend the reassessment.

I also suggest that some education takes place around the analysis and understanding of information gathered in various assessments and observations. Improving knowledge of staff members around these procedures, will contribute to providing better care.

Failure to include family in the care planning process and reassessments would be, in my opinion, viewed as a moderate departure from acceptable standards by my peers."

Expert Opinion Report two

"I have been asked to review and provide additional expert advice to the Health and Disability Commission following further information and feedback from Radius Care.

Questions

1. **Identify any individuals (if any) responsible for the departures you have identified in your advice dated 22June 2017**

My original advice stated that patients such as [Mr A] always presented a challenge to nursing staff. He had a history of frequently falling prior to admission and continued falling following admission to Radius. In reviewing the case as a whole, I do not find any one individual to be wholly responsible for the care [Mr A] received. A number of staff were on duty consistently over the period of time during which [Mr A] was with the facility.

My comments regarding communication with the family have been noted and commented on by [the Chief Operations Officer] in her letter to the Deputy Commissioner dated 9th February 2018. Radius do not accept my opinion that it did not communicate adequately with [Mr A's] family.

It is worth noting that, through the complaints procedure that Radius followed with [Mr A's] family, senior management acknowledged and apologised for lack of communication.

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A letter written by [the] Relief Facility Manager, dated 3rd August 2016 states '*Your summary of the events clearly demonstrates a lack of formal communication from the team to you as a family, and for this we sincerely apologize'.*

Again, in a letter written by [the] Facility Manager, to [Ms B] dated 16th September 2016, it is stated:

'We fully acknowledge our communication was not to the standard we expect and as we discussed we will review how we provide information to families right from admission day and including how we have those important discussions with families, such as reassessments.'

I have not changed my opinion of the communication with [Mr A's] family.

In the letter written by [the Chief Operations Officer] dated 9th February, she states that Radius will implement formal written invitations for families to attend six monthly care conferences. This will ensure family meetings are fully documented and that the facility and staff are able to fully comprehend families' understanding of the needs, cares and challenges of their loved ones.

2. <u>Comment on the appropriateness and adequacy of the policies listed at number 8 above.</u>

Policies and procedures presented relate to:

- Falls
- Assessment and care planning
- On call emergency
- Challenging Behaviour
- Self-care
- Accident incident reporting
- Medical service
- Communication

It is noted that the Falls Prevention policy has been updated. Other policies were due to be update in June 2016.

Policies and procedures presented in my opinion would meet the requirements for certification.

[…]

My original opinion was that there was a lack of detailed analysis of [Mr A's] falls. There is documented evidence that [Mr A] had over 80 falls in the months between his admission in February 2016 and November 2016. I acknowledge that there was adequate assessment, admission information, data collection of falls, progress notes stating falls etc. I acknowledge that [Mr A] was visited by medical specialists re assessment. I am still of the

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opinion that expert nursing advice could have supported nursing staff and that there was not a robust analysis of the falls.

I have not changed my opinion. […]

It is my opinion, that the falls management in this case would be viewed as a moderate departure from acceptable standards by my peers.

The management of [Mr A's] wanderings and left unsupervised in the lounge.

As previously stated [Mr A] was in the hospital wing which is not a secure unit. Hence it is possible for patients to leave the building unseen. It is noted that on the 11.5.16 [Mr A] left the building once at 1300 hrs, and following his return, he left again at 1400 hrs. My opinion is that this would be viewed as a mild departure from acceptable standards by my peers and I am still of that view. I accept that the first time [Mr A] left without staff knowledge, but to do so a second time one hour later indicates that he was unsupervised when there had already been a risk established.

The appropriateness of [Mr A] being left unsupervised in the lounge

As previously stated [Mr A] spent much of his day up and in the lounge. This would have been appropriate as he was able to mobilise, although unsafely at times. Radius used a Rounding Log for a period of time as a data collection tool to show when [Mr A] was restless, sitting or mobile. It is noted on the Rounding Log when [Mr A] was in bed, whether he was settled and/or sleeping.

Most of the night time he was described as asleep, except for a few occasions when he was described as restless or unsettled. There are periods where it is noted that he went to other patients' rooms. During the morning shift [Mr A] was described as sitting in the chair in the lounge, while at other times he was described as watching TV, snoozing or wandering.

In my opinion it was completely appropriate to settle [Mr A] in the lounge as he would have been otherwise isolated in his room, making him a higher risk of falls because of the isolation. Generally, there is more activity happening in communal areas than in each individual room. As previously stated there will be times that patients are unsupervised in the communal areas while staff attend to patients' needs e.g. toileting etc. It is also noted that after dinner many patients tend to retire to bed at the same time and this can be a very busy time for staff. I am not aware of the total number of hospital patients that spent time in the lounge, but generally most enjoy the company and it does allow staff to supervise patients and for activities to take place.

One comment I wish to make is that the Rounding Log showed [Mr A] sitting for long periods of time. Initially the log showed when [Mr A] was walked, toileted and what action he was doing. However, as the time and data collection increased it is evident that he was sitting for long periods of time. For example, on the 7th September 2016 he was noted to be asleep from 0900 until 1400 hrs. On the 9th September he is noted to have been sitting

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in a chair from 0800 to 1400 hrs. On the 22nd September cares were done at 0900 hrs and he was then sitting in a chair until 1200 hrs. On the 27th June 2016 he was sitting from 0800 until 1200hrs and on the 1st September he was sitting in a chair from 0800 until 1400 hrs. Other Rounding Log pages show when [Mr A] was toileted/and or walked.

It would not be acceptable for patients to be left in the chair for up to 4–5 hours without being moved in some way, such as being toileted or walked. It may be that staff have not filled in the log correctly. However, a review of the data available suggests that [Mr A] was left sitting for long periods of time. If [Mr A] was left sitting in the lounge for these periods of time without the chance to mobilise, this may have led to his attempts to walk without supervision. It should also be noted that it is not acceptable to place a chair beside a table which does not allow an individual to move. This would be classed as a form of restraint.

Overall it is, in my opinion, acceptable for [Mr A] to be seated in the lounge with the general supervision that was offered. It would mean, however, that there would be times when staff would not be able to directly observe [Mr A]. As previously noted, staffing numbers decreased over the time from February to November, 2016. Hence there would have been less staff on the floor and because of this the degree of supervision and provision of cares required by [Mr A] would have been difficult, even impossible, to achieve.

[Mr A's] fluid management

Nothing in the extra documentation provided leads me to change my comments or view. I do not believe there is evidence to show that staff limited [Mr A's] fluid intake but as previously stated a fluid balance would have confirmed for family the actual amount of fluids [Mr A] was taking. It would not have been an onerous task to complete a fluid balance chart for a short period of time.

Comment on any others matters you consider relevant

Following the extra documentation viewed I have not changed my original opinion."

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