HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate care provided to woman in aged residential care facility

1. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the care provided to her mother, Mrs B, in 2021 by Arvida Group Limited (Arvida).[1] Mrs B was aged 90 years at the time. On 22 January 2019 Mrs B was admitted to an Arvida aged-care facility as a result of declining cognition. On admission, Mrs B and Ms A were advised that the demolition and reconstruction of the existing single-storey facility was pending and that Mrs B was likely to be transferred to a new multi-storey building on its completion. A week prior to the move to the new facility (20 January 2021), Mrs B was taken through the new facility to select a room, and she selected a room on the third floor.

2. In the weeks following the move, Mrs B's anxiety increased and progress notes detail that she had difficulties settling into the new room and navigating the new phone system and lifts. Mrs B required staff assistance to navigate the building, which Ms A said led to Mrs B feeling trapped and unable to leave the facility without the assistance and observation of staff. Ms A raised these concerns with staff, who advised her that Mrs B was free to leave the building at any time but that she required assistance to do so and needed to follow COVID-19 restrictions. Arvida told the HDC that it was unaware of any anxiety Mrs B had about her new room.

3. On 3 February 2021 Mrs B was seen by a nurse practitioner (NP) following a call from Ms A regarding Mrs B's increased anxiety, depression, and fatigue. A proposed treatment plan was discussed with Ms A. Mrs B's medications were reviewed, a low-dose antidepressant was started, and the notes show that behaviour monitoring charts commenced along with regular registered nurse (RN) review and NP evaluation. Progress notes from 4 and 5 February state that Mrs B voiced suicidal ideation to staff. Her behaviour was noted to be unusual and aggressive, and staff increased visual checks of Mrs B. An RN requested that staff encourage Mrs B to get involved in activities and monitor and report any suicidal tendencies. However, there is no evidence that a nursing risk management plan was commenced. Mrs B was seen again by the NP on 9 February, and notes state that Mrs B denied suicidal ideation. Progress notes on 10 February state that Mrs B again voiced suicidal ideation. She was given PRN[2] lorazepam[3] to help reduce her distress. It is unclear what nursing assessment occurred at this time or what other safety measures were commenced in light of these ongoing concerns about Mrs B's safety.

4. On the evening of 16 February 2021, a duty RN received a phone call from Ms A, who expressed concern about Mrs B's safety, as Mrs B had said that she had been touched

[1] The care was provided by two facilities, both owned and operated by Arvida Group Limited.
[2] Pro re nata (as needed).
[3] Medication used to treat anxiety and trouble sleeping.

inappropriately by an (unknown) person. The RN commenced hourly visual checks of Mrs B and escalated her concerns to an NP. It is unclear whether the clinical lead or village manager was informed at this point. However, the NP contacted the clinical and facility manager teams on 17 February 2021 and recommended that they conduct a thorough investigation into the allegations.

5. Arvida provided HDC with a brief investigation report into the allegations of sexual contact, which comprises an event background and timeline with a summary of findings and outcomes. It states that despite staff being interviewed, no information was gathered to substantiate the claims. There is no mention of Arvida's internal quality and risk team being consulted, and no corrective actions were recommended. Staff were in contact with Ms A during this time, but there is no record that the complaint was acknowledged, and there is no statement providing event follow-up.

6. Arvida told HDC that it believes that it did communicate with Ms A to acknowledge the allegation once it was made aware and that it provided further acknowledgement once the investigation report was sent to Ms A on 20 April 2021. However, there is no evidence that a meeting was held between Arvida's management team and Ms A and/or Mrs B to acknowledge their concerns, communicate the investigation process, or share the investigation findings. There is also no evidence of a staff debrief or clinical case review, or of additional education being provided to staff to prevent a similar event occurring in the future and/or how to manage such a situation.

7. In response to the provisional opinion, Arvida told HDC:

> '[I]t is clear that the complaint was taken seriously and investigated. Communication with the complainant and follow-up with the staff is documented, and the investigation report was provided as part of the response.'

8. Arvida stated that while the allegation was taken seriously and investigated, 'the decision was reached that Mrs B was experiencing stress and confusion, and there was no evidence that such an assault occurred'.

9. On 8 February 2021 Ms A requested that Mrs B be transferred to another facility to be on the ground floor and, following consultation with Ms A, Mrs B was transferred to the other facility on 18 February 2021.

10. At 2.45am on 24 February 2021, Mrs B was noted by staff to be feeling anxious, and a carer accompanied her to the lounge. At 3.30am, Mrs B was reported missing from the lounge. She was located in an inner courtyard garden a short time later and returned to the care home. It is unclear from the documentation whether Mrs B had sustained any injury, or if her health, care, or safety needs were at risk. She was not assessed by an RN immediately,[4] nor was an incident report completed. Ms A was not informed of the incident until two days later.

[4] Mrs B was reviewed by an RN later that day as part of her weekly review, but there is nothing in the clinical notes to suggest that the nurse was made aware of the incident.

11. Arvida told HDC that Mrs B was found in between the bushes in the courtyard by staff, who found no apparent injuries or any indication that she had fallen. In response to the provisional opinion, Arvida said that it was common for Mrs B to spend time in the courtyard, including amongst the foliage. Arvida said that it did not consider that what occurred amounted to an incident or adverse event, and it does not believe there was a delay in notifying Ms A. In response to the provisional opinion, Arvida told HDC that it takes care to document falls and to follow up with families when falls occur, and it carries out appropriate assessments and monitoring. However, it restated its view that in this case, Mrs B did not suffer a fall.

Relevant policies and legislation

12. Regarding the management of the sexual assault allegation, Arvida had in place an Incident Management Policy (March 2020). Section 19 states that in line with the Open Disclosure policy, residents and their whānau are notified of all incidents/accidents/near misses and provided with clear information about what happened, what the outcome was, what steps were taken immediately to minimise or manage the situation, what changes will be needed for the resident, and how recurrence will be minimised or eliminated.

13. Section 20 states that an investigation should be commenced to determine what happened, understand contributing factors, put in place appropriate corrective actions, and ensure proactive management to prevent or minimise the risk of recurrence.

14. Regarding the courtyard incident, relevant standards include the Age-Related Residential Care Agreement (ARRC) and the Health and Disability Service Standards. Both policies require service providers to acknowledge and involve the consumer and their nominated representative in all aspects of care, which includes notification of any adverse event. The Arvida Incident Management Policy (2020)[5] is also applicable and outlines interventions, documentation, and communication responsibilities following resident events. In response to the provisional opinion, Arvida told HDC that there are clear themes across the relevant[6] policies about transparency, acknowledging complaints, investigations, responding to complainants, providing information about advocacy, and other relevant agencies.

Responses to provisional opinion

Ms A

15. In response to the provisional opinion, Ms A told HDC:

> 'My family and I hope in good faith, that by sharing our experiences and consenting to the use of my mother's case for training, we can contribute to a system that better cares for its most vulnerable members and that my beloved mother's life and tragically, her suffering will contribute to future improvements in care.'

[5] The policy states that events are required to be reported and documented in the resident's progress notes and incident record within 24 hours. Point 13 of the policy refers to communication with nominated representatives and related documentation responsibilities.

[6] Open Disclosure policy; the Compliments, Concerns and Complaints policy; and the Abuse, Neglect and Discrimination policy.

Arvida

16. In response to the provisional opinion, Arvida told HDC that external audits took place at the first facility shortly before and following the alleged sexual assault incident.[7] The audits resulted in a four-year period of accreditation.

17. Arvida told HDC that it accepts that there were delays in completing the investigation into the alleged assault and communicating back to Ms A within the normal expected timeframe. However, Arvida said that it is confident that communication with Ms A continued during this time. Arvida told HDC: 'We also acknowledge that Mrs B had died between the time the complaint was made and the final outcome and appreciate this was a distressing time for the family.' Arvida said that it is now aware of the need to ensure that phone calls and ongoing informal communication with complainants during the period of investigation are documented in detail. Arvida disagreed that the delay, in this context, reflects a moderate departure from accepted practice.

Clinical advice

18. As part of my investigation of this complaint, I sought internal clinical advice from RN Jane Ferreria (Appendix A).

19. Regarding the management of Mrs B's escalating anxiety reported on 5 and 13 February, RN Ferreria advised that the lack of a specific, documented risk-management plan for potential intent to self-harm would be considered a moderate to significant departure from accepted standards. However, RN Ferreria acknowledged several mitigating factors, including that there was evidence of the provision of holistic support, appropriate escalation, regular observation, and communication with Ms A.

20. Regarding Arvida's management and investigation of the alleged sexual assault, RN Ferreria acknowledged that while staff generally did communicate with Ms A, Arvida failed to acknowledge the complaint and complete and share the investigation findings in a timely manner, and there was an apparent oversight by Arvida regarding adverse event documentation.

21. However, RN Ferreria also noted that Mrs B had transferred from the first facility to the second facility at the time of the investigation, which 'may have influenced the timeliness of post-event communication and reporting timeframes, as outlined in the Complaint Management policy'. In summary, RN Ferreria advised that while file information indicates that verbal and written communication occurred between the parties involved, there were deviations from the accepted standard of care relating to timely completion and sharing of the event investigation findings. RN Ferreria advised that this failure represented a

[7] Including a partial provisional audit on 15 December 2020 and a certification audit on 30/31 March 2021.

moderate departure from accepted standards and noted that the care did not align with the Incident Management Policy (March 2020)[8] and the Concerns and Complaints Policy.[9]

22. RN Ferreria advised that Arvida's management of the courtyard incident, including the delayed communication to Mrs B's family, did not meet accepted standards and represented moderate to serious departures from accepted standards owing to the delayed communication and lack of further assessment and incident reporting. While RN Ferreria was aware that Arvida did not consider that a fall had occurred, she advised that in light of Mrs B's history, documented concerns with her wellbeing, and identified risk factors, an incident report was required in line with service provider responsibilities and policy requirements. The care provided also did not align with the ARRC Services Agreement, Health and Disability Service Standards, or the Arvida Incident Management Policy (2020).

My opinion

23. Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) stipulates that every consumer has the right to have services provided that comply with professional and other relevant standards. In my view, by failing to follow internal policies in the management of the alleged sexual assault and by failing to follow both internal and external policies in its management of the courtyard incident (as discussed above), Arvida breached Right 4(2) of the Code.

24. I have also considered Arvida's lack of a specific, documented risk-management plan for Mrs B's potential intent to self-harm at the time of her increased anxiety. RN Ferreria advised that this would be a moderate to significant departure from accepted practice. However, she acknowledged several mitigating factors, including that there was documented holistic support from the care team; appropriate escalation to the NP; the care team was regularly observing and offering support to Mrs B and was responsive to her needs; and there is evidence of monitoring occurring and regular communication with the NP and Ms A 'amid the competing priorities with COVID-19 at this time'.

25. I accept RN Ferreria's advice. While I acknowledge and am critical that Arvida failed to have in place a risk-management plan for Mrs B's potential intent to self-harm, I also accept that there were several mitigating factors in this case. Accordingly, I do not consider that Arvida breached the Code in this respect, but I encourage Arvida to reflect on my comments and those of RN Ferreria.

26. Arvida told the HDC that, as a result of these events, it put in place an alert system so that senior clinical practitioners are alerted when an entry in progress notes indicates reference to alleged sexual assault; all clinical managers received training on incident response and management; and a policy was instituted whereby the Head of Clinical Governance will provide oversight of any investigation involving sexual allegations/assault.

[8] The policy notes that the standard is 'met' when events are reported and documented in the correct electronic system (resident's progress notes and incident record) within 24 hours. Event investigations steps are discussed, which include communication with family.

[9] The policy states that the standard is met when complaints are addressed, acknowledged, investigated and resolved promptly, and the complainant informed of the outcome.

27. I recommend that Arvida provide a written apology to Ms A for the failings identified in this report. The apology is to be sent to HDC, for forwarding, within three weeks of the date of this report. I also recommend that Arvida use an anonymised version of this report to provide additional training for staff at both facilities in relation to communication with families, incident reporting, and adverse event management, to ensure that staff are aware of internal and external policies and how to manage similar incidents in future. Evidence of this training is to be provided to HDC within six months of the date of this report.

28. A copy of this report with details identifying the parties removed, except Arvida Group Limited and my clinical advisor, will be sent to HealthCERT and Health New Zealand | Te Whatu Ora.

29. A copy of this report with details identifying the parties removed, except Arvida Group Limited and my clinical advisor, will be placed on the Health and Disability Commissioner website (www.hdc.org.nz) for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice

CONSUMER : [Mrs B]

PROVIDER : Arvida

FILE NUMBER : C21HDC01380

DATE : Wednesday 1 February 2023

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Arvida.
2. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

3. **Documents reviewed**
I have been provided with the following information to base my review on:

- Consumer letter of complaint dated 18 June 2021
- Response letter from first facility dated 10 September 2021
- Response letter from second facility dated 10 September 2021
- Clinical documentation from first facility dated 22 January 2019 to 18 February 2021, including care plans, observation charts, nursing progress notes and clinical records
- Clinical documentation from second facility dated 18 February 2021 to 4 March 2021, including care plans, observation charts, nursing progress notes and clinical records
- Additional evidence received 12 January 2023, including interRAI assessments, behaviour monitoring forms and case conference minutes

4. **Complaint**
A complaint was received from Mrs [B]'s daughter and EPOA [Enduring Power of Attorney] (not activated), Mrs [A], relating to care concerns from two care homes in the Arvida Group. Mrs [A] has expressed concern about the care provided to her late mother between 2019 and 2021. Her concerns relate to medication management, clinical care and communication. She has also expressed concern that her mother voiced accounts of sexual abuse while resident at the first facility.

5. **Review of clinical records**
For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

1. The interRAI and level of care assessment while Mrs [B] was in the first facility from 22 January 2019 to February 2021 and the appropriateness of the level of care provided.
2. The care provided by the first facility and assessment for dementia diagnosis and the process of cognition assessment in an elderly consumer.
3. The care provided by the first facility in regards to Mrs [B]'s mental health assessment.
4. The incident on 5 February and 13 February and the consumer clinical assessment and any indications for further assessment or referral.
5. The care provided on 26 February 2021 and the transition to hospital.
6. The response to sexual abuse allegations and reasonableness of investigation.
7. If the suggestion of dementia for Mrs [B] impacted any differential diagnosis.
8. Any other aspects of care that the advisors consider warrant comment.

Please comment on the interRAI and level of care assessment while Mrs [B] was in the first facility from 22 January 2019 to February 2021 and the appropriateness of the level of care provided.

Mrs [B] was admitted to the first facility on 22 January 2019 at rest home level of care. Due to a change in care home environment and related concerns with her health and wellbeing, Mrs [B] transferred to the rest home community at the second facility on 18 February 2021 for ongoing care. Mrs [B]'s medical history included osteoarthritis, hypertension, diverticulosis, impaired renal function, reactive depression, dementia, anxiety disorder, and cervical carcinoma.

Nursing and medical notes indicate Mrs [B] was well supported by a range of health professionals during her stay at the first facility. Nursing assessments and related nursing documentation reflect specialist involvement in care planning and care evaluation. The reviewed clinical documentation shows that Mrs [B] required minimal assistance from care staff with activities of daily living. It appears she regularly experienced periods of concern and anxiety, which influenced her feelings of safety and daily routines. As outlined in progress note entries and clinical records, she required regular assistance from staff with medication management to support her quality of life.

The submitted copies of Mrs [B]'s electronic care record show her interRAI assessments and nursing care plan were created and reviewed within recommended timeframes according to contractual responsibilities and organisational policies.

As outlined in the Care Home's Clinical Assessment Policy, dated March 2020, the interRAI long-term care facilities assessment (LTCF) is required to be completed within 20 days of admission and the wellness plan, or long-term care plan, within 21 days of admission. These documents were reviewed six monthly: 29 August 2019, 18 February 2020, 27 August 2020. InterRAI scores appear consistent over time, and identified priority areas are reflected in the care plan. It appears additional nursing assessments were completed as clinically indicated during Mrs [B]'s admission at the first facility.

The Care Planning Policy, dated March 2020, provides guidance for staff regarding commencing and evaluating short and long-term care plans within a combined electronic

record. It provides discussion about identified resident strengths, needs and preferences, and agreed support. There is evidence of registered nurse (RN) evaluation on 7 June 2019, 16 August 2019, 31 August 2020, 2 September 2020, 11 November 2020, and 24 February 2021, which appears to meet the agreed contractual timeframes. InterRAI assessment scores are supported by a record of additional admission assessments, which recognise areas of actual and potential risk and level of function. There is evidence of personalised strategies to support Mrs [B] with her activities of daily living.

The New Zealand Health and Disability Service Standards and Age-Related Residential Care (ARRC) Services Agreement require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. Progress note entries, email communication and allied health documentation provide evidence of open communication and consultation with Mrs [B] and her daughter, Ms [A], which supports the principles of care partnership in decision-making. Interventions in Mrs [B]'s care plan provide an individualised approach, which reflects delivery of person-centred care. Evaluation of care appears to follow a multidisciplinary approach, with evidence of input from Mrs [B], her daughter Ms [A], the general practitioner (GP), the nurse practitioner (NP), and qualified care and activity staff in case conference records. There is evidence of referral to, and involvement of, allied health professionals in the care record, including a comprehensive gerontology assessment, which supports Mrs [B]'s assessed level of rest home care.

From the evidence reviewed to answer this question, it appears the care provided to Mrs [B] met accepted practice standards under the circumstances.

Please comment on the care provided by the first facility and assessment for dementia diagnosis and the process of cognition assessment in an elderly consumer.
The clinical documentation clearly evidences a person-centred relationship between Mrs [B], her daughter and EPOA (not activated) Ms [A], and the nursing and medical teams involved in her care. Preadmission clinical records identify that Mrs [B] had a chronic history of anxiety and depression and required regular, close support from her daughter. Mrs [B] was known to Older People's Mental Health services and had previously received support as a community-based consumer before moving to aged residential care.

The clinical file documentation includes comprehensive reports completed by highly experienced professional clinicians that outline Mrs [B]'s medical history, presenting symptoms, related clinical decisions, and agreed care interventions. Health information discusses identified cognitive impairment and a proposed diagnosis of dementia dating back to 2017. The clinical records evidence collaboration between health professionals during her stay at the first facility, which aligns to best practice standards. There is frequent reference to Mrs [B]'s daughter Ms [A] as her advocate, which evidences care partnership and informed decision-making.

Mrs [B]'s electronic care records provide evidence of regular communication with Ms [A] with statements from qualified and care staff recording content from telephone calls and email messages. There is evidence of a weekly review by a registered nurse. There is evidence of escalation of concern from wellness partners (care staff) to the RN and from the

RN to the clinical manager, GP, and NP. There is evidence of referral to specialist older person's services for further assessment regarding Mrs [B]'s mood and behaviour, and involvement of a Gerontology Nurse Specialist, which follows accepted practice standards.

Cognition assessment

As outlined in the care home clinical assessment and care planning policies, the interRAI LTCF assessment tool is used to comprehensively assess a resident's level of ability, to inform a personalised care plan. The review process allows the assessor to compare data across a timeline to determine changes in need that may indicate criteria for wider involvement by specialist healthcare professionals or transition to a higher level of care. There is discussion of interRAI scores in Mrs [B]'s care planning with reference to supportive strategies to manage triggers and symptoms of anxiety. There is regular discussion of assessment scores, such as the Geriatric Depression Assessment and Montreal Cognitive Assessments (MoCA) in reports by specialist clinical services, who also state in clinical records that Mrs [B]'s deteriorating cognition with anxiety may have influenced assessment score outcomes.

From the evidence reviewed to answer this question, it appears the care provided to Mrs [B] met accepted practice standards under the circumstances.

Please comment on the care provided by the first facility in regards to Mrs [B]'s mental health assessment.

The clinical records provide evidence of comprehensive assessment and care by a range of health professionals during Mrs [B]'s stay at the first facility. There is evidence of consultation prior to any changes in care with Ms [A] as EPOA (not activated) and respect shown in written form for Ms [A]'s perspectives and wishes for Mrs [B]'s care. In addition to prescribed medication management, Mrs [B]'s care plan provides guidance for staff on supportive, non-pharmacological strategies to manage episodes of anxiety. It appears from progress note entries there were multiple triggers influencing mood, behaviour, and decision-making, which were appropriately communicated to the medical team by nursing staff.

From the evidence reviewed to answer this question, it appears the care provided to Mrs [B] met accepted practice standards under the circumstances.

Comment:

There was no identified specific plan of support evidenced in the care record outlining strategies to assist Mrs [B] to orientate to her new environment given her history of anxiety, and the potential impact to her health and wellbeing.

The Clinical Assessment Policy states that an interim care plan will be completed within 24 hours of admission '*to direct immediate care interventions and support the resident through their settling in phase'*.

The response letter from the provider acknowledges the oversight in recognising and supporting Mrs [B]'s response to environmental changes when relocating to the new multi-level building. This presents an improvement opportunity for providers to consider when

relocating residents within the care home or to new and unfamiliar environments and to consider individualised care and safety needs.

Please comment on the incident on 5 February and 13 February 2021 and the consumer clinical assessment, and any indications for further assessment or referral.
Progress note entries in the week prior indicate Mrs [B] experienced regular episodes of anxiety, which were relieved with prescribed medication, reassurance, and support from staff. The weekly RN review reports that her weight and blood pressure monitoring was stable and that she was eating and drinking well.

Mrs [B] was seen by the NP on 3 February 2021 following a call from Ms [A] regarding reports of worsening anxiety, depression, and fatigue. Clinical notes indicate that a proposed treatment plan was discussed with Ms [A], as Mrs [B]'s nominated representative. Medications were reviewed and reduced, and a low-dose antidepressant commenced. The clinical record refers to the use of behaviour monitoring charts and regular RN review with NP evaluation, which is an accepted approach to practice.

As outlined in behaviour charts and progress note entries on 1 February 2021, Mrs [B] verbalised to staff that she felt 'trapped', with prior entries stating she was missing her daughter, friends, and previous room. On 4 and 5 February 2021, Mrs [B] reportedly verbalised to staff that she wanted to die and would 'jump of[f] the balcony'. There is evidence of increased visual checks by staff in the behaviour monitoring records and progress notes, with discussion of personal care and meal refusal, and displays of unusual behaviour with aggression. According to nursing notes, the RN requested that staff encourage activities, monitor and report any suicidal tendencies; however, there is no evidence that a nursing risk management plan was commenced at this time to enable staff to consistently meet care and safety needs across all shifts.

On 9 February 2021, Mrs [B] was seen by the NP regarding the behavioural concerns. Clinical notes state that Mrs [B] denied suicidal ideation and referred to the event as being 'just a bad day'. On 10 February 2021, Mrs B reportedly expressed a desire to 'throw herself off the balcony' if she was unable to go out. The behaviour chart refers to an intervention of 'TLC' with no effect, and clinical records show Mrs [B] was given PRN lorazepam to help reduce feelings of distress.

It is unclear what nursing assessment occurred at this time or what risk mitigation steps and safety measures were formally commenced given the ongoing concerns with her wellbeing. There is no evidence of additional nursing assessment or clinical guidance by the clinical manager or a delegated senior RN during this timeframe. While there is evidenced consultation with the NP, which is accepted practice, there does not appear to be a referral to, or consultation with, mental health services.

*I note the care home had public health precautionary measures in place due to the COVID-19 pandemic alert system, which may have impacted staffing and clinical practice priorities for all health service providers at this time.

From the evidence reviewed to answer this question, it appears the care provided to Mrs [B] met the minimum standard for accepted practice under the circumstances. There is an

opportunity for improvement regarding the management of safety needs, particularly in a multilevel building with identified at-risk behaviour. Lack of a specific, documented risk-management plan for potential intent to self-harm would be considered a moderate to significant departure from accepted practice standards; however, I acknowledge evidence of documented holistic support from the care team, with appropriate care escalation to the NP at this time. It appears the care team were regularly observing and offering support to Mrs [B] and were responsive to her needs. There is evidence of monitoring occurring and regular communication with the NP and EPOA amid the competing priorities with COVID-19 at this time.

Please comment on the care provided on 26 February 2021 and the transition to hospital.

Background

Mrs [B] transferred from from the first facility to the second facility on 18 February 2021. As outlined in the provider response letter and file evidence, a verbal handover was completed by the first facility RN to the receiving RN at the second facility prior to resident transfer. Transfer notes evidenced in the clinical file are comprehensive and discuss Mrs [B]'s daily care requirements, including priority care concerns of anxiety and weight management. Records indicate Mrs [B] had lost further weight since transfer to the new building at the first facility, with anxiety identified as a likely contributing factor. The clinical record shows Mrs [B] received care in line with the organisation's Nutritional Policy which outlines accepted strategies for unintentional weight loss — refer Frailty Care guidelines for weight management (HQSC, 2019).

The Clinical Assessment Policy dated March 2020 states that an interim care plan will be completed within 24 hours of admission '*to direct immediate care interventions and support the resident through their settling-in phase'*. The RN review dated 19 February 2021 evidences that a meeting was held between the duty RN, Mrs [B], and her daughter, in line with the organisation's Admissions Policy. The entry discusses nursing assessment, care requirements, specific goals for care, and resident orientation to the new care home.

Progress note entries between 20 and 25 February 2021 describe a reduced oral intake with reluctance to accept assistance with personal care needs. The nutritional record form indicates Mrs [B] tolerated small servings of offered food or fluids, and entries from care staff discuss meal refusal. Nursing progress notes describe unsettled behaviour with episodes of urinary incontinence. It is unclear what nursing assessment occurred at this time. The interRAI assessment and nursing care plan indicates Mrs [B] was continent of bowel and able to self-toilet. There is unclear reporting in bowel records, with no entry 22 and 23 February 2021. Records indicate a medium bowel result on 24 and 26 February 2021. There are no references in the bowel record to episodes of incontinence, nor identified concern regarding reports of abdominal pain or signs of constipation within the nursing care record.

Progress note entries on 26 February 2021 report that Mrs [B] experienced three episodes of vomiting during the AM shift. There is no reference to vomiting episodes in earlier entries in the clinical record. There is evidence of escalation to an RN for assessment, communication with the NP for clinical guidance and support, and communication with Mrs [B]'s daughter and EPOA. The progress note entries discuss precautionary isolation

measures as part of infection prevention and control processes, which is in line with accepted practice. The care record indicates Mrs [B] experienced a further episode of vomiting at 1830hrs, and care staff informed the duty RN. The duty RN reportedly assessed Mrs [B] at 1900hrs, who presented as weak and dehydrated, was refusing to eat and drink, and had not settled with prescribed antiemetic medication. Following discussion with Ms [A] and the NP, a decision was made to transfer Mrs [B] to hospital for further assessment, and a non-urgent ambulance was called at 1935hrs. This approach is in line with management of acute deterioration as outlined in the Frailty Care Guides (HQSC, 2019).

At 2015hrs on 26 February 2021, Mrs [B] vomited 100mls of light brownish liquid. The RN requested Mrs [B] remain nil per mouth until assessed by paramedics, which is in line with first aid measures. At 2045hrs, Mrs [B] vomited a further 50ml of brown liquid and reported abdominal pain to staff. At 2330hrs, Mrs [B] was assessed by paramedics. The RN entry describes her as frail in presentation following six vomiting episodes; three on the AM shift and three on the PM shift. At 0010hrs, Mrs [B] vomited a further three times with approximately 200mls of vomitus. Mrs [B] was reportedly distressed and unwilling to consent to ambulance transfer. Following discussion between paramedics and Ms [A] as EPOA, Mrs [B] was sedated and transferred to hospital for further care. The care record reflects that Mrs [B] was transferred to hospital at 0025hrs 27 February 2021 accompanied by a comprehensive nursing transfer summary.

Mrs [B] was seen by acute care clinicians and diagnosed with a small bowel obstruction. A decision was made for supportive, comfort care, and Mrs [B] passed away in early March 2021. I extend my condolences to Mrs [B]'s family at this time.

From the evidence reviewed to answer this question, it appears the care provided to Mrs [B] met accepted practice standards under the circumstances.

Comment

The care record reflects that Ms [A] contacted the care home on 3 March 2021 to inform them of Mrs [B]'s health status. There does not appear to be a record of communication evidencing interaction between the care home nursing team and ward staff to enquire about Mrs [B]'s wellbeing following hospital transfer. This would be an accepted approach when a care home resident has been acutely transferred for further assessment as part of professional care collaboration.

Please comment on the response to sexual abuse allegations and reasonableness of investigation.

The clinical record reflects that at 1750hrs on 16 February 2021 the duty RN received a phone call from Ms [A] who expressed concern about Mrs [B]'s safety and an observed change in her mother's mood and behaviour. The record reflects Mrs [B] reportedly voiced to her daughter, Ms [A], accounts of inappropriate physical contact that she received from a person between 14 and 15 February 2021. Nursing records show the duty RN commenced hourly visual checks to ensure Mrs [B]'s safety needs were maintained, escalated concerns to the NP and handed over care responsibilities to the incoming shift. It is unclear if the on-call clinical lead or village manager was informed, or if the duty RN received any guidance from another senior leader regarding management of the alleged incident, the potential

health and safety risk to other residents residing in the same care home community, or professional documentation responsibilities. While actions are in line with safe approaches to practice by a duty team, there is no evidence of senior leadership, nursing assessment, commencement of a wellness behaviour care plan with rationale for any additional monitoring, or that an incident report was completed at this time.

Progress note entries between the event notification date 16 February 2021 and discharge date 18 February 2021 discuss completion of hourly monitoring, daily activities, and support with personal care. There is discussion regarding episodes of anxiety and low mood, supportive interventions and administration of PRN medications. The behaviour monitoring form only reflects two entries on 16 February (1200hrs, 2000hrs) and one entry on 17 February (1300hrs).

The evidence bundle reflects a statement from the NP who, following discussion with Mrs [B]'s daughter, contacted the clinical and facility management teams on 17 February 2021 regarding the allegations of abuse and recommended they conduct a thorough investigation.

The organisation's Incident Management policy, March 2020, (20), states 'an investigation is commenced to understand the contributing factors, put in place appropriate corrective actions and ensure proactive management to prevent or minimise the risk of recurrence'. Point (21) discusses criteria for escalation and external reporting regarding health and safety risks to residents, in line with statutory, regulatory or contractual requirements. As outlined by the Health and Disability Services (Safety) Act 2004: Section 31 Reporting Guidelines, any event that identifies risk to an older person's health and safety needs, such as an assault of any kind, is required to be reported to HealthCERT.

The provider response letter dated 10 September 2021 includes a brief investigation report, which comprises an event background and timeline with a summary of findings and outcomes. The report states that clinical and care staff working within the identified timeframe were interviewed regarding the allegations of inappropriate conduct, with inconclusive findings. There is no discussion of involvement with the organisation's internal quality and risk team nor reference to an incident management process or complaint framework within the submitted evidence. There is no discussion noted or evidence provided regarding corrective actions or quality improvement opportunities.

The incident management policy (19) refers to open disclosure, stating 'residents and their family/whānau/EPOA are notified and provided with clear information about what happened, what the outcome was, what steps were taken immediately to minimise or manage the situation, what changes will be needed for the resident, and how recurrence will be minimised or eliminated. Support should be offered as appropriate'.

There is evidence of communication with Mrs [B]'s daughter, Ms [A], by qualified and care staff during the timeframe in question; however, there is no entry from the care home manager or clinical manager within file evidence acknowledging the complaint or a statement providing event follow-up, which would be accepted practice. There is no evidence that a meeting was held between the care home management team, Mrs [B] or,

Ms [A] to formally acknowledge the event, communicate the investigation process or share the investigation findings, which would be accepted practice.

Additionally, there is no evidence regarding an event debrief with staff or a clinical case review. There is no evidence of additional education offered to clinical and care staff regarding resident care and safety needs, contributing factors or strategies to manage similar events in future, incident management, communication, and documentation responsibilities, which would be accepted practice.

From the evidence reviewed to answer this question, it appears the management and investigation process of the alleged assault did not meet accepted practice standards under the circumstances. This presents as a moderate to serious departure from professional standards of care and would be viewed similarly by my peers.

Please comment if the suggestion of dementia for Mrs [B] impacted any differential diagnosis.
I am unable to provide comment on this question as the criteria of diagnosis sits outside the practice scope of a Registered Nurse.

Please comment on any additional findings or other aspects of care that warrant noting.
I note that at 0245hrs on 24 February 2021, Mrs [B] reportedly required assistance from staff with toileting and personal care needs. Care staff described her as feeling anxious and she accompanied a carer to the lounge area. At 0330hrs, Mrs [B] was identified as missing from the lounge. According to file evidence, she was located in an inner courtyard garden area a short time later and returned to the care home. It is unclear if she had sustained any injury or if her health, care, or safety needs were at risk. According to the clinical file evidence and provider response, it appears that Mrs [B] was not assessed by an RN, an incident report was not completed, and Mrs [B]'s daughter was not informed of the event until two days later on 26 February 2021. There is no evidence of submission of a corrective action plan to address the departures from accepted practice standards for incident management.

The ARRC Services Agreement and Health and Disability Service Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in resident's health condition or of any adverse event. Evidence of communication with a resident's nominated representative is a significant part of service provider responsibilities and a fundamental part of the nursing process. This is a moderate to serious departure from professional standards of care and would be viewed similarly by my peers.

Clinical advice
I note that the events occurred during the COVID-19 pandemic period 2020–2022 and would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams, and health service providers during this time.

Based on this review, I recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately

communicated to minimise the risk of a similar occurrence in the future. To support this approach, I recommend that care home teams complete the new online modules for further learning — https://www.hdc.org.nz/education/online-learning/

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

References

Health and Disability Commissioner. (2022). Online Learning. https://www.hdc.org.nz/education/online-learning/

Te Tāhū Hauora Health Quality & Safety Commission. (2019). Frailty Care Guides. http://www.hqsc.govt.nz/

Further in-house clinical advice by RN Ferreria

CONSUMER : [Mrs B]

PROVIDER : Arvida

FILE NUMBER : C21HDC01380

DATE : 30 April 2024

Request for additional advice: 30 April 2024

Thank you for the opportunity to review the provider's responses and supporting information and consider changes to my initial advice. I have been asked to provide further advice/comment on the following questions:

Further Advice Needed — first facility

1. The adequacy of communications with Ms [A] regarding the allegations of sexual assault, specifically whether the following amount to acknowledgement of the complaint by staff:
   - phone communication with Ms [A] regarding the allegations and
   - providing the investigation report, with covering letter, to Ms [A]
2. Appropriateness of improvements to incident reporting made since the complaint was lodged including:
   - training material provided to staff and clinical leads
   - annual training requirements
   - improved oversight measures, and
   - any comments on other appropriate training measures available.
3. Whether Mrs [B]'s care and safety needs were adequately met during Mrs [B]'s transition to and settling in period to a new room within the first facility.

4. Any other comments you wish to make.

Further Advice Needed — second facility

1. Whether the 'incident' where Mrs [B] was found in the internal courtyard by staff on the morning of 25 February 2021 would be considered an adverse event given […] explanation and further context provided by staff
2. Whether waiting to notify Ms [A] of the incident until 26 February 2021 still constitutes a departure from the expected standard of care.
3. Adequacy of training Arvida provided for Wellness Partners regarding incident reporting at the time based on the evidence provided.
4. Any other comments you wish to make.

First facility

The adequacy of communications with Ms [A] regarding the allegations of sexual assault, specifically whether the following amount to acknowledgement of the complaint by staff:

- phone communication with Ms [A] regarding the allegations and
- providing the investigation report, with covering letter, to Ms [A]

The Adverse Event policy (2022) and Incident Management policy (2019) state that the policy purpose is to provide staff with clear guidelines, procedures and processes for documentation and management of all adverse/incidents/accidents/near-miss events, noting that the standard is met when events are reported and documented in the correct electronic system (resident's progress notes and incident record) within 24 hours. Event investigations steps are discussed, which includes communication with whānau/family. The Concerns and Complaints Policy outlines organisational processes and role responsibilities regarding managing consumer feedback. The policy states that the standard is met when complaints are addressed, acknowledged, investigated, and resolved promptly, and the complainant informed of the outcome.

As outlined in my initial advice, there is an apparent oversight by managers at the time regarding adverse event documentation in the care record and escalation of the alleged events, which was not in line with organisational standards. The provider has advised that despite the lack of information provided by senior leaders in the care record, the Village Manager did communicate with Mrs [B]'s daughter, Ms [A], and commence an investigation, per adverse event management steps. The investigation report (not dated/signed) was reportedly shared with Ms [A], accompanied by a letter dated 20 April 2021, which included an apology, and both documents acknowledged areas for future improvement. This appears to align with the organisation's policy on Open Disclosure.

Entries in Mrs [B]'s care record reflect that communication routinely occurred between Mrs [B]'s daughter, Ms [A], and the care home's clinical team while she was resident at the care home. I note that Mrs [B] had transferred from the first facility to the second facility at the time of the investigation, which may have influenced the timeliness of post-event communication and reporting timeframes, as outlined in the Complaint Management policy. Given the nature of the allegations, the related delay in sharing event updates and

investigation information with whānau/family would be considered a deviation from accepted practice.

In summary, to respond to this question, file information indicates that verbal and written communication occurred between the parties involved while Mrs [B] was resident at the care home. There are deviations relating to timely completion and sharing of event investigation findings, which would be viewed similarly by my peers.

* Departure from accepted practice: Moderate.

Appropriateness of improvements to incident reporting made since the complaint was lodged including:

- training material provided to staff and clinical leads.
- annual training requirements
- improved oversight measures, and
- any comments on other appropriate training measures available.

While a corrective action plan was not referenced, the provider has discussed improvements made to clinical systems and processes in response to learnings from the complaint, which appear to be appropriate in the circumstances.

Whether Mrs [B]'s care and safety needs were adequately met during Mrs [B]'s transition to and settling in period to a new room within the first facility.

As outlined in my initial advice, it does not appear that a specific support plan was in place to guide Mrs [B]'s care and safety requirements during the settling-in phase, as indicated in organisational policies. The provider response, 20 November 2023, has discussed supportive interventions provided by the care team, noting that COVID-19 restrictions were in place at the time and possible influences on Mrs [B]'s wellbeing. I acknowledge the clarifications in the provider response, but this does not change my advice in the circumstances.

Second facility

Whether the 'incident' where Mrs [B] was found in the internal courtyard by staff on the morning of 25 February 2021 would be considered an adverse event given […] explanation and further context provided by staff

As outlined in the provider's response 10 September 2021, Mrs [B] had been experiencing worsening delusions/hallucinations and paranoid ideation, with anxiety and episodes of wandering prior to her admission from the first facility on 18 February 2021.

The provider has stated that, while a nursing handover occurred between the care home teams, usual admission nursing assessments and care planning processes were not completed in line with Care Planning policy guidelines. The provider has discussed the resident orientation process, acknowledging that Mrs [B] may have experienced increased anxiety with behavioural changes while settling into her new home. The provider has acknowledged that revised nursing assessments and an interim care plan should have been developed to manage any identified risks, despite the internal transfer process, in line with accepted practice standards.

The Adverse Event policy (2022) and the revised Resident Incident Escalation Matrix provide useful guidance regarding resident event classifications and related actions. The Incident Management policy (2019) outlines interventions, documentation, and communication responsibilities following resident (or others) events. The policy states that events are required to be reported and documented in the resident's progress notes and incident record within 24 hours. Point (13) of the policy refers to communication with nominated representatives and related documentation responsibilities.

The provider response 10 September 2021 acknowledged that an incident report should have been completed for the episode of wandering on 24–25 February 2021, which would have triggered relevant resident event processes, including a requirement to communicate with Mrs [B]'s whānau/family, and apologised.

The provider has queried the requirement for event reporting in the circumstances and submitted additional evidence 18 October 2023, which has included photos of the lounge area and internal courtyard with a site plan showing Mrs [B]'s room location. I acknowledge the discussion points raised in the manager's response; however, given Mrs [B]'s history, documented concerns with her wellbeing, and identified risk factors I concur with the previous response that an incident report was required, in line with service provider responsibilities and policy requirements.

As outlined in my initial advice, given the scenario, lack of communication, further assessment, and incident reporting, this would be considered a deviation from accepted practice and viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

Whether waiting to notify Ms [A] of the incident until 26 February 2021 still constitutes a departure from the expected standard of care.
The provider response 10 September 2021 has acknowledged that delayed communication was outside of accepted organisational processes. No change to my initial advice.

- Departure from accepted practice: Moderate to serious

Adequacy of training the second facility provided for Wellness Partners regarding incident reporting at the time based on the evidence provided.
The provider has discussed delivery of additional training on incident management and reporting, as evidenced in submitted content including Wellness Partner learning records Feb 2020–2021, which appears appropriate.

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

Further clarification received from RN Ferreira on 29 May 2025:

Event management and reporting requirements are discussed in policy information that was current at the time of Mrs [B]'s admission. Approaches to harm and safety have since

changed, and serious event reporting processes are now managed by Te Tāhū Hauora Health Quality & Safety Commission rather than HealthCERT. Responsibilities to report serious events (SAC1/SAC2) remain. As outlined in guidance (pg6), once care and safety actions have been implemented, leaders review the event to determine a risk rating and manage accordingly per local policy guidelines. It appears from the evidence supplied that the provider considered these steps and responded accordingly.

It would be considered best practice that following a resident-reported event, the care home team follow their local policy, consult with their clinical and operational leaders, and seek guidance/support from a health professional (GP/NP) about reporting criteria.

If there was evidence of confirmed assault following case review then, yes, providers have a responsibility to complete external reporting per guiding docs.

It appears the provider determined there was no evidence of an alleged assault nor risk to resident health and safety and therefore did not meet serious event reporting criteria, which would be considered reasonable.

The incident management process would still be expected to reflect rationale for any actions/inactions in the circumstances.