Decision 21HDC01292
25 June 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care of vulnerable older resident following fall

Introduction

1. At the outset, I express my sympathy and heartfelt condolences to the family and friends of Mrs A for their loss. I hope this report brings some closure for Mrs A's family.

Complaint background

2. In 2021 this Office received a complaint from Mrs B about the care provided to her mother, Mrs A (aged 92 years at the time of the events), at Graceful Home Orewa Limited (operating as Pinehaven Cottage). The complaint concerns the care provided to the late Mrs A when she had an unwitnessed fall on Day 2[1] 2021. Mrs B has concerns about the fall and the investigation of the fall and believes that conflicting information was provided.

3. Mrs A had a background of Alzheimer's dementia, which was complicated by behavioural and psychological symptoms she experienced following a previous fall and head injury. She had been a resident in Pinehaven's dementia unit since the previous year. Mrs B held an activated Enduring Power of Attorney (EPOA)[2] for Mrs A's personal care and welfare.

4. Mrs B's main concern is **how** Mrs A sustained her injuries. Mrs B is concerned that the injuries to Mrs A's nose, gums, mouth, and back of head were not consistent with a fall out of bed. Mrs B wondered whether Mrs A's injuries could have been sustained by being shut in her room and being accidently knocked to the floor by someone opening the door. Mrs B considered that the police should be involved. HDC suggested that Mrs B raise these concerns directly with the police, as HDC's focus is to investigate the standard of care provided to her mother. Mrs A's death was not referred to the Coroner.

[1] Relevant dates are referred to as Days 1-4 to protect privacy.

[2] A legal document in which a person (the donor, in this case Mrs A) appoints another person (the attorney — Mrs B) to make decisions on their behalf if the donor becomes incompetent. A doctor is required to provide a medical certificate outlining the consumer's mental capacity in order to invoke or 'activate' the EPOA.

Names (except Graceful Home Orewa Limited (operating as Pinehaven Cottage) and the advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Outcome sought

5. Mrs B told HDC that she wanted this incident to be investigated to ensure that if the cause was negligence or abuse, it does not happen to anyone else.

Scope of investigation

6. The following issue arising from the complaint was investigated by HDC:

- *Whether Graceful Home Orewa Limited (operating as Pinehaven Cottage) provided [Mrs A] with an appropriate standard of care in [Month1][3] 2021.*

Timeline of events Day 1–Day 4 (as supplied by Pinehaven)

- On **Day 1** at **11.00pm** the evening/night shift commenced, and two carers were on duty.
- On **Day 2** at around **2.32am** a carer noticed that Mrs A was positioned close to the edge of her bed. The carer repositioned her towards the wall for safety.
- At **3.00am** on **Day 2** the carers continued their hourly checks on all residents, which included standing at the resident's door and shining a light into the room to check on the resident, ensuring that no alarms were triggered.
- At around **3.15am** one of the carers heard scuffling noises from Mrs A's room and discovered that she had fallen from her bed. Mrs A was on the floor next to her bed, with her legs positioned under the bed and her hand gripping the leg of the bed. The carer left Mrs A in order to seek assistance from another carer. They moved Mrs A to the middle of the room using a slide sheet and checked for injuries. It is documented that Mrs A was awake and responsive. She was bleeding on the front and back of her head and had facial injuries.
- At **3.36am** the on-call registered nurse was telephoned. She instructed the carers to take vital observations and apply pressure to the sources of bleeding, and to call for an ambulance.
- At **3.42am** an ambulance was called.
- At **4.02am** the ambulance arrived, and ambulance staff attended to Mrs A. The on-call registered nurse arrived to assist. Ambulance staff assessed Mrs A and observed obvious lacerations to the back of her head and the bridge of her nose, along with trauma to her lips and mouth, and a bloody nose. Mrs A's vital signs were within normal range, and she had no shortness of breath, no obvious pelvic injury or bone fractures, and no chest or abdominal pain. Ambulance staff observed that Mrs A appeared to be quite distressed and agitated, but she calmed down following the administration of pain-relief medication.
- At **4.23am** the registered nurse called EPOA Mrs B to inform her of the incident.

[3] Relevant months are referred to as Month1 and Month2 to protect privacy.

- At **5.10am** the ambulance arrived at a public hospital, where Mrs A was diagnosed with a left subdural haematoma secondary to a fall. Mrs A was placed on comfort care.
- Subsequently, Mrs A passed away.

HDC investigation findings

7. I acknowledge that Graceful Home Orewa Limited took ownership and operation of Pinehaven approximately one month prior to the sentinel event on Day 2.

8. HDC gathered information from Pinehaven, including clinical records, documents from the internal investigation, and copies of policies. Having reviewed this information, the following conclusions were reached.

Management of Mrs A's falls risk

- Mrs A's care plan was not updated following her interRAI assessment[4] a few months earlier, which meant that any changes to Mrs A's health status (such as her risk of falling) were not reflected in her care plan.
- Mrs A had a history of urinary tract infections and of waking up at night needing to use the toilet. She had a pattern of unsettled behaviour at night, such as walking for long periods overnight or sleeping in a chair in the lounge or on the floor. Her care plan did not provide guidance on how to address these issues and support her to settle safely at night.
- The Sleep and Comfort policy provided that residents were to be checked at least every two hours overnight, or more often depending on their needs. There was no guidance in Mrs A's care plan on the frequency of safety checks to manage her risk of falling.
- Mrs A's care plan noted the use of a sensor beam[5] because of her high risk of falling and wandering overnight; however, there is no evidence of how often the device was checked to ensure that it was operational.
- Mrs A's care plan noted generic fall minimisation strategies (such as keeping the bed low to the ground). However, the plan lacked details on how to maintain her environmental safety — for example, ensuring that her floor was clear of items that could cause her to trip, the use of lighting to guide her to the bathroom, whether she could move herself in the bed independently, or where her meaningful items were situated (such as close to her bed at night) to prevent her from over-reaching and falling out of bed.

[4] A tool used to assess a person's health and wellbeing needs and to help develop a comprehensive plan of care for the individual.
[5] A motion detection system used to alert staff when a resident who is at risk of falling moves from a bed or chair.

- The Ngā Paerewa Health and Disability Services Standard[6] and the Age-Related Residential Care Services Agreement [7] provide that the resident and their nominated representatives (such as next of kin or family) are to be involved in all aspects of their care. Mrs B was the EPOA for Mrs A, and in this capacity had the right to be informed of Mrs A's care and to give informed consent to any changes in her care plan. Pinehaven told HDC that no multidisciplinary review meetings[8] were held with Mrs B.

Sentinel event management — Day 2

- The Falls Management policy states that in the event of an unwitnessed fall, staff activate the emergency bell and stay with the resident. Prior to first aid being given to the resident, or to moving them, the resident needs to be assessed for injury. This is also noted in Pinehaven's Post-fall Protocol, which provides that for serious injuries such as a suspected head injury or bleeding, the resident should not be moved, and the on-call registered nurse is to be contacted. However, it is documented that on finding Mrs A on the floor, the emergency bell was not activated, and the carer who found Mrs A left her to seek help from another staff member. It is also noted that Mrs A was repositioned prior to contacting the on-call registered nurse.
- The Adverse Event Policy provides that an investigation is to be conducted to identify the root cause of an event and identify what corrective actions are needed to ensure that the event does not occur again. Although an event review occurred, it is unclear whether the cause of the fall was identified, whether a meeting with Mrs A's family occurred to discuss the outcome of the investigation, or whether staff were informed of the outcome of the investigation and were able to take learnings from it.

Altercation between Mrs A and a carer

- Progress notes indicate that three days prior to the events, an altercation occurred between Mrs A and a carer. Mrs A was alleged to have experienced feelings of irritation, and she was escorted back to her room. Mrs A's care plan provided guidance on how to manage her behaviour, along with de-escalation interventions, and noted to 'leave [Mrs A] to do what she wants to do as her behaviour is not at risk'. As noted by my in-house nursing advisor, registered nurse (RN) Jane Ferreira, an appropriate approach at that time was to consider any unmet needs (such as hunger, toileting, pain, boredom) and to offer appropriate assistance (such as rest, companionship, an activity). There is no evidence that this event was escalated to a registered nurse for support.

[6] A comprehensive set of guidelines that outline the requirements for safe and high-quality health and disability services in New Zealand.

[7] A contract between Health New Zealand|Te Whatu Ora and aged residential care providers that ensures that a national standard of services is provided to residents in long-term residential care.

[8] Meetings that involve a variety of health disciplines involved in the resident's life, such as physiotherapists, general practitioners, nurses, dietitians, etc.

In-house advice (Appendix A)

9. RN Ferreira identified the following departures from the accepted standard of care provided by Pinehaven:

- Management of Mrs A's falls risk — **mild to moderate departure**
- Sentinel event management Day 2 — **moderate to significant departure**
- An altercation between Mrs A and a carer — **moderate departure**

Response to provisional opinion

Graceful Home Orewa Limited

10. Graceful Home Orewa Limited was given a copy of RN Ferreira's advice and the provisional opinion and was given the opportunity to respond. Graceful Home Orewa Limited stated that it had acquired Pinehaven less than a month before Mrs A's fall on Day 2, and it considers that it cannot be held responsible for any breach that was due to the previous owners. RN Ferreira acknowledged that although Pinehaven was in a transition stage and was implementing new systems and processes, staff would still be expected to practise with competence and to the accepted standard of care.

11. Graceful Home Orewa Limited told HDC that it has provided a comprehensive apology letter to Mrs A's family.

12. Graceful Home Orewa Limited conveyed its 'deep regret that this tragic incident occurred'.

Mrs B

13. Mrs B was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. Some of her concerns have been addressed in separate correspondence.

14. Mrs B stated:

> 'After carefully reading through the report I was surprised and shocked to learn of the severity of Pinehaven's very lax processes, record keeping and lack of staff training as per industry standards.
>
> …
>
> I'm appalled and saddened at Pinehaven's lack of care given to our dear mum, we trusted Pinehaven and their staff to look after her and guide her through her horrendous illness, we thought she was safe and was receiving the very best of care …
>
> I do believe that Pinehaven haven't been honest as to what exactly happened leading up to and just after mum's fall, there were too many conflicting comments between carers and RN's written statements …'

15. Mrs B also told HDC:

> 'I'm pleased to learn that steps have been taken to remedy this so hopefully it doesn't happen to anyone else at Pinehaven and I am hoping that Pinehaven's systems are frequently audited from hereon.
>
> Our mum [Mrs A] was a loving and much loved wife, mother, grandmother, sister, aunty and friend. She was the most gentle, kind, softly spoken, encouraging, devoted, hard working, unbiased, selfless, caring mother anyone could wish for and she didn't deserve this cruel end to her life.'

Mrs C

16. Mrs A's daughter, Mrs C, was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. Some of her concerns have been addressed in separate correspondence.

17. Mrs C told HDC:

> 'The initial care at Pinehaven was wonderful. She was happy and well cared for but in the last month there was a big change in the facility's atmosphere, staff and residents appeared unsettled and tense. This was at the time of new ownership and staff being replaced by the new owners own staff. A few of the old staff resigned during this time.
>
> …
>
> Although I hope with all my heart that Mum was not a victim of an assault, I do feel the circumstances surrounding her "fall" are not clear and I am not convinced that the truth has yet to come out … [There were] contradictory statements by some of the people involved.
>
> …
>
> Our beautiful mum was the kindest soul, always looked for the positives in everyone and everything, never got angry or frustrated and had the patience and forgiveness of a saint. She was a very wise woman who would help anyone and always said "two wrongs don't make a right." We just want to make something "right and good" come out of mum's devastating death in a way that she would want us to.'

Decision

18. The issue in this matter is whether Graceful Home Orewa Limited (operating as Pinehaven Cottage) provided Mrs A with an appropriate standard of care in Month1 2021. RN Ferreira identified issues in three areas of Mrs A's care and advised that in all three areas, the care provided by Pinehaven fell below the accepted standard of care. I accept RN Ferreira's advice.

19. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[9] requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that Graceful Home Orewa Limited (operating as Pinehaven Cottage) did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Changes made since events

20. Pinehaven told HDC that additional education was provided to its staff, and the following changes were made:

- Six-monthly resident review meetings were implemented.
- A new system for updating residents' care plans following both interRAI nursing assessments and the six-monthly resident review plans was implemented.
- A 'Falls Focus Group', which includes an event feedback process for its staff, was created.

Recommendations

21. RN Ferreira noted that the corrective actions taken by Pinehaven were comprehensive. I acknowledge the changes made by Pinehaven and consider these to be appropriate in the circumstances.

22. I therefore recommend that Graceful Home Orewa Limited (operating as Pinehaven Cottage):

a) Provide a written apology to Mrs A's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date this report.

b) Complete the HDC online education modules and provide feedback to HDC within three months of the date of this report.

Follow-up actions

23. A copy of this report with details identifying the parties removed, except Graceful Home Orewa Limited (operating as Pinehaven Cottage) and the advisor on this case, will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

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

Appendix A: In-house clinical advice to Commissioner

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

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

2. Documents reviewed

Consumer letter dated …

Provider response letter dated …

Clinical documentation including nursing and medical progress notes, monitoring forms, incident reports, family communication record, acute care records

Organisational policies including falls management, neurological observations, admission to hospital, sleep and comfort

Call bell reports and audit form

Operational information including staff orientation and education records

Additional information received … including bowel records, monthly observations and behaviour monitoring records, revised organisational policies and evidence of post-event quality improvements

1. Complaint

[Mrs A's] daughter and EPOA, [Mrs B], has expressed concern regarding the care provided to her late mother following a fall event on [Day 2]. Her concerns relate to the timeframe of the fall event, communication and care provided to her mother at this time.

2. 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 nursing management of [Mrs A's] care and if it maintained adequate standards of falls prevention and management.
2. The clinical file records, the fall event timeline and provider response to consider if the provider's investigation was adequate.

Background

[Mrs A] was admitted to the care home at dementia level care in [2020]. Her medical history included severe aortic stenosis, ischaemic heart disease, bradycardia, pulmonary hypertension, hypertension, dyslipidaemia, glaucoma and depression. Prior to admission [Mrs A] was under the care of mental health services at [a public hospital] and had been diagnosed with a moderate to major neurocognitive disorder, mixed type late onset with behavioural and psychological symptoms of dementia (BPSD). She was assessed as requiring ongoing care in a safe environment and met criteria for admission to dementia level care.

1. **Please comment on the nursing management of [Mrs A's] care and if it maintained adequate standards of falls prevention and management.**

Clinical documentation indicates [Mrs A] was independently mobile with a low walking frame and required supervision and support with activities of daily living. Her medical and nursing history included recurrent falls and nursing notes indicate she sustained a number of falls while resident at the care home. File documentation reflects regular input from [Mrs A's] general practitioner (GP) in partnership with mental health services for older people, with regular medication reviews in response to fall events. There is evidence of monthly and as-required monitoring of vital signs, resident weight, and completion of neurological observations where indicated per the organisation's Falls Management and Neurological Observations policies.

InterRAI nursing assessments completed [twice in 2020 and once in 2021] provide discussion of falls risk assessments and the nursing care plan [reviewed in 2020] provides appropriate discussion of generic falls minimisation strategies in line with the organisation's Falls Management policy and supporting information. As outlined in the Health Quality & Safety Commission's (HQSC) Frailty Care Guides recommended practice is to develop a care plan with interventions to address individual risk factors, focussing on prevention strategies within a person-centred model of care (HQSC, 2019). It is unclear if this care plan was evaluated and updated following the InterRAI assessment [in 2021], which would be accepted nursing practice as part of the six-monthly resident review process.

Clinical file documentation including InterRAI assessments, nursing care plan and GP records discuss sleeping difficulties and day/night reversal. [Mrs A] had a history of urinary infections with nocturnal bladder frequency triggering wakefulness to use the toilet. Carer entries in nursing progress notes also reflect that [Mrs A] had a pattern of unsettled behaviour at night, routinely waking for extended periods overnight followed by daytime rests. Nursing assessments discuss wakefulness but the nursing care plan does not provide specific guidance about [Mrs A's] personalised settling routine, strategies to safely support her wakeful periods, or resettling techniques, such as non-pharmacological interventions, given her identified needs. There is no evidence of communication

or education about [Mrs A's] care needs provided by registered nurses (RN) to the care team at this time which would be accepted practice.

There are identified discrepancies regarding [Mrs A's] requirements for safety checks overnight. The organisation's Sleep and Comfort policy states that '*resident checks are generally conducted two hourly, or more often depending on the resident's need,'* and that the registered nurse will establish an agreed schedule and document this in the care plan. The care plan does not provide specific guidance regarding [Mrs A's] overnight care and frequency of safety checks to manage her falls risk, which would be accepted nursing practice. Care entries in progress notes discuss completion of hourly checks, with an entry [the day before Day 1] stating that half-hourly checks were completed. It is unclear what the rationale was for this change in observation.

File information indicates that [Mrs A] preferred to sleep in a chair in the lounge or dining room rather than in her bedroom. There are frequent entries discussing unsuccessful redirection back to bed between 0200–0400hrs, irritability of mood with restlessness, and observations of risk-taking behaviour. An entry [from the previous month] stated [Mrs A] was seen moving herself from her bed to the floor. It is unclear what prompted the position change and what additional safety measures were considered by the clinical team at this time. Usual practice would be to review contributing factors to the observed behaviour, consider unmet needs, review and update falls risk management strategies, including a review of environmental hazards, and request a GP and physiotherapy review.

[Mrs A's] care plan referred to the use of a sensor beam. It is unclear what frequency of maintenance checks occurred to ensure the device was safely operational given her high falls risk status. There is no specific discussion provided of her room configuration, meaningful items, flooring, lighting, call bell access and use, or process for her to seek staff assistance. The care plan discusses generic falls minimisation strategies referring to loose bedding, and having the bed at a low position, however it does not specifically discuss the safe positioning of bed wheels or checks to ensure that bed brakes were applied. The care plan does not discuss [Mrs A's] preferred sleeping position when in bed, if she had independent bed mobility, or if strategies such as a mattress perimeter guard had been considered to support safe positioning. The care plan discusses moving [Mrs A's] bedside table at night as an intervention to reduce harm from a fall, however it is unclear how often she accessed the bedside table, or what items were contained that were important to her that she may require, potentially contributing to over-reaching or falling.

[Mrs A] was seen weekly by her GP in [Month 1 and Month2] 2021. Progress notes discuss care occurring, noting [Mrs A] was refusing meals and appeared tired and sleepy.

There appears to be limited recognition of gradual decline and signs of frailty by the clinical team, given reducing oral intake, day-night reversal, changes to mood and behaviour and the associated risk of weight loss, falls, and triggers to unmet needs. There is limited evidence of involvement from the clinical manager or RNs at this time.

Accepted practice would be to consider a clinical review meeting with the RN team to collaboratively, in consultation with the EPOA, develop a specific care plan to outline how to manage signs of increasing frailty, nutritional, personal care and safety needs at this time.

There is evidence of communication with [Mrs A's] EPOA following GP visits, but as outlined in the provider response, no multidisciplinary resident review meetings were held with the EPOA to discuss ongoing goals for care. The resident review process is an important opportunity to review health, safety and wellbeing data to determine if the documented interventions remain appropriate, as outlined in service provider contractual requirements.

The Ngā Paerewa Health and Disability Services Standard (HDSS) and Age-Related Residential Care (ARRC) Services Agreements require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. As the EPOA for [Mrs A], [Mrs B], as the consumer's decision-maker, has the right to be informed and to give informed consent to proposed changes to an agreed plan of care. Care decisions are made in partnership with the EPOA and registered nurses at the care home, and evidence of these interactions is required to be documented in the resident's family/whānau contact record, care plan, progress notes and meeting minutes.

From the evidence reviewed to respond to this question I consider the falls prevention and management strategies offered to [Mrs A] to be of the minimum standard of practice under the circumstances. There are opportunities for improvement relating to clinical leadership, care oversight and recognition of resident change or decline; and systems and process standards concerning communication and documentation standards. **Departure from accepted practice: Mild to moderate**.

2. **Please review the clinical file records, the fall event timeline and provider response to consider if the provider's investigation was adequate**.

According to the provider response letter, resident progress notes and incident reports, [Mrs A] was found on the floor of her bedroom at 0315hrs on [Day 2]. The documentation states that [Mrs A] had sustained facial and occipital injuries following an unwitnessed fall event. Progress note entries and acute care information reflects that [Mrs A] was promptly assessed by paramedics and transferred via ambulance to hospital with a suspected head injury. Following clinical assessment, [Mrs A] was diagnosed with an acute on chronic left subdural

haemorrhage. A decision was made for palliative care and [Mrs A] passed away on … I extend my condolences to [Mrs A's] family at this time.

Review of the fall event

[Mrs A's] EPOA, [Mrs B], has raised concerns regarding the accuracy of the fall event timeline, which is referenced in acute care information, referring to an unknown length of time between the fall and carers finding [Mrs A] on the floor, and related communication processes.

The provider response letter dated … includes a timeline based on their post-fall investigation process. From an evidence-based lens there appears to be a query regarding the accuracy in documentation of care interventions between 0215hrs and when [Mrs A] was found at 0315hrs, in contemporaneous progress notes, call bell records, incident reports and the investigation response.

As outlined in the provider response it appears that [Mrs A] was assisted to bed between 0215 and 0230hrs on [Day 2]. Nurse Call records show that [Mrs A's] sensor was activated at 02.32.55hrs lasting 42 seconds. It is unclear what interventions occurred at this time as there is no supporting entry in the contemporaneous progress note record. A separate progress note dated [Day 2] (no time entered) states that [Mrs A] woke at 0215hrs from a chair in the lounge. She was asked to return to her bedroom as carers wanted to mop the floor. The provider timeline refers to resettling at 0230hrs, in line with alerts in the nurse call records. The provider response states that is unclear from the post-fall investigation if the nurse call system was reset after it was activated at 02.32.55hrs on [Day 2].

The provider response states that [Mrs A] was checked during hourly rounds at 0300hrs on [Day 2], and was asleep. This is evidenced in the contemporaneous care record which states — (5am) "*Last round was 3am (hrly check) she was asleep. I repositioned her as she was too close to the edge of her bed to the middle of her bed*." There is no evidence of activation of the nurse call system at this time.

A separate, detailed entry in the progress notes [Day 2] (no time entered) states that during resident checks [Mrs A] was found lying close to the edge of her bed.

She was woken, assisted to turn over to face the wall, with a pillow placed behind her. The entry provides discussion of turning off a buzzer, pushing a red light on the wall next to [Mrs A's] bed and reactivation of the call system on exiting the bedroom.

The provider response suggests that [Mrs A] fell sometime between 0300 and 0315hrs on the Day 2. Incident report (GCL.17) records the event time as 0300hrs. Incident report … and a separate progress note (retrospective) entry completed [less than a week after the fall] records the event time as 0315hrs. The Falls Management policy states that for unwitnessed fall events staff will activate the emergency bell to seek assistance as soon as a resident is seen on the floor. Staff

will stay with the resident and that the resident will be assessed immediately for injury prior to being moved or first aid given. This is in line with recommended practice standards as outlined in the Frailty Care Guide's post-fall assessment (HQSC, 2019).

A review of call bell records shows that [Mrs A's] call bell was last activated at 02.32.55hrs on [Day 2]. There is no record of emergency nurse call activation at the time of finding [Mrs A], as recommended in the care home policies. According to file information the carer who found [Mrs A] sought help from a more experienced staff member in a different part of the care home rather than remaining with the resident as outlined in policy guidance.

The organisation's Post-fall protocol (GCL.22) provides a flow sheet to support decision-making and states that for a major/serious injury such as a suspected head injury or bleeding: Do Not Move the Resident, call the on-call RN and emergency services. This is in line with accepted practice standards. I note the event history discusses the use of a slide sheet to reposition [Mrs A] prior to seeking RN guidance. It is unclear if the on-duty care team had received first aid and adverse event training prior to the incident, and what steps have been implemented to support responder actions in future emergency situations.

Progress notes and incident event records show the care team informed the On-Call RN between 0325–0336hrs on [Day 2]. Acute care reports show that the care home requested ambulance support at 0347hrs. Records show paramedics arrived at the care home at 0402hrs, assessed [Mrs A] and transferred her to hospital at 0437hrs, [Day 2].

According to file documentation the on-call RN arrived at the care home while paramedics were assessing [Mrs A]. The RN entry … confirms the carer call time, outlines on-call guidance given and refers the reader to incident reports. There is no evidence of RN documentation on the submitted event reports, or follow up by the [senior staff], which would be accepted practice in the circumstances. The RN progress note entry confirms that [Mrs A's] EPOA was informed of the fall event and transfer to hospital but there is no time recorded of this communication in the progress notes or family/whānau contact record which is a departure from accepted standards of documentation and reporting. It is also unclear from the clinical records when the fall event was escalated to the [senior staff], as outlined in the Adverse Event policy.

The Adverse Event policy provides guidance about the incident investigation process, including a work flow diagram. The policy states that an investigation is focussed on identifying the root cause of the event to inform corrective and preventative actions (page 2). It is unclear from the provider response if a root cause analysis (RCA) was undertaken, or equivalent method of systematic review, to identify contributing factors to [Mrs A's] fall, inform findings and recommendations as part of the critical event investigation process. It is unclear

what causative factors were identified by the provider, such as consideration of resident factors given a previous fall event [three days before the event], or medical needs given [Mrs A] was reportedly unwell on [Day 1], or environmental factors such as the application of call systems or bed brakes as outlined in the carer entry [Day 2]. There is no evidence that a meeting occurred with [Mrs A's] daughters to discuss the outcome of the investigation or share a summary report, nor evidence of event feedback to the care home team, which is accepted practice following a critical event.

The provider response [three months after the event] has acknowledged [Mrs A's] family and provided an apology. The response letter is comprehensive, providing an outline of [Mrs A's] care during her admission and outcome of the fall event investigation, including an apology for any previous miscommunication. The provider response letter … has discussed improvements made since the incident on [Day 2]. The provider has submitted evidence of corrective actions in response to queries with the nurse call system including all-staff training on call system use, safety enhancements including an audible alarm to alert the care team in addition to screen monitoring and pager use, installation of CCTV cameras and implementation of a Falls Prevention committee.

I note the organisation has reviewed systems and processes, and engaged an external provider to support their operational and clinical management responsibilities. There does not appear to be evidence of an organisational call bell policy in use to guide staff about accepted practice standards and responsibilities, which presents an improvement opportunity to support the revised nurse call audit process and staff education plan.

While it appears the care home has provided evidence of improvement initiatives taken to address the complaint relating to nurse call systems, there are further improvement opportunities to be considered relating to incident management systems, processes and documentation standards. From the evidence reviewed to respond to this question there appears to be moderate to significant departures from accepted practice standards regarding accurate reporting and follow up, effective communication and documentation standards which would be viewed similarly by my peers. **Departure from accepted practice: Moderate to significant.**

Additional comment

There is an entry of concern in progress notes [three days before the event], which refers to an altercation between [Mrs A] and a carer, with [Mrs A] being returned to her bedroom. This is not consumer-focussed care, given this is a resident's home, and I consider this intervention to be below acceptable care standards. The care plan states that [Mrs A] was known to experience feelings of irritation with staff and residents and provides guidance under behaviour management and de-escalation interventions to "*leave her to do what she wants to do as her behaviour is not at risk".* An accepted approach at this time would be to recognise that all

behaviour has meaning and consider any unmet needs, such as pain, hunger, thirst, toileting, boredom or loneliness and offer appropriate assistance. This may include strategies to support rest, offer companionship or a meaningful activity to promote safety and wellbeing. I note there is no evidence of escalation to an RN for support, clinical leadership or follow up which would be accepted practice in the circumstances.

Safely supporting residents living with dementia/mate wareware requires care teams to receive appropriate training, to be flexible in their approach to shift routines, to have the necessary skills to recognise and act on resident need and engaged clinical leadership to ensure the care and safety needs of older people, and those providing care, are consistently maintained. **Departure from accepted practice: Moderate.**

1. Clinical advice

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

Based on this review I recommend the care home team complete additional education on communication with and about older people and their family/ whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend the care home team complete additional education on person-centred care and effective communication with health consumers and consider implementing the use of the ISBAR communication tool to better inform clinical assessments, actions and safe, evidence-based decision-making. To support this approach, I recommend that the care home team complete the new HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/.

Jane Ferreira, RN, PGDipHC, MHlth
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Health and Disability Commissioner

References

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

Health Quality & Safety Commission. (2019). Frailty Care Guides. https://www.hqsc.govt.nz/resources/resource-library/frailty-care-guides-nga-aratohu-maimoa-hauwarea-2023-edition/

Additional comment: 28 March 2024

Thank you for the opportunity to review the provider's response … with supporting information and consider changes to my initial advice. The provider's response is comprehensive and reflects a number of improvements made by the care home in response to this event. This has included policy reviews, the introduction of an electronic care record, implementation of resident review meetings, and delivery of education and training as indicated in the recommendations. Based on the improvements made, the provider has asked that I review the submitted information and reconsider my decisions regarding reasonable standards of care.

Discussion points include:

- Approaches to falls prevention and management.
- The standard of incident reporting following [Mrs A's] significant fall event
- My comment regarding carer interactions.

1) Falls prevention and clinical management strategies.

Nursing care plans, Six-monthly resident clinical review meetings.
Improvements are noted, however, at the time of [Mrs A's] admission there were identified departures in nursing assessment, care planning and documentation standards. No changes made to the original advice provided.

2) Incident management strategies and reporting.

I was asked to consider if the provider's investigation into the fall event on [Day 2] was adequate.

Adverse event/emergency protocol and training
Improvements are noted regarding a call bell policy, education and training.

Post-adverse/emergency and RCA reporting.
File evidence reports that [Mrs A] passed away … after the fall with harm event, which met critical incident criteria. The Falls Prevention and Adverse Event policies outline actions and role responsibilities for significant events, in line accepted patient safety processes for SAC 1 and 2 events.

My advice concerning *RN responsibilities to review and complete adverse event documentation* relates to … and … , paper-based records. As discussed in my previous advice, these incident reports and wider clinical records provide no evidence of any post-event review by the RN, clinical or care home manager. The newly submitted electronic event document … completed by the RN … and … has classified the event as "serious". The event follow up [Day 3] comments on corrective actions but provides no discussion of [Mrs A's] health status at the time. Given this was classified as a serious event, it would be considered accepted practice to include a resident update with evidence of senior leader involvement

in the adverse event review process. The event record reflects the investigation was closed [a week after] and corrective actions closed [2 weeks later], which does not appear to align with the new evidence …

(31,56). The provider has shared additional evidence of a Quality Improvement Suggestion (Corrective Action Plan) Form (GCL58) commenced … in response to [Mrs A's] fall event and signed off … I note this process was not referenced in the event report … The quality improvement form offers falls risk reduction strategies however there is no discussion of improvements made to incident management processes, staff training, communication and documentation standards to demonstrate policy requirements.

Post-incident communication with family/EPOA and care team.
(34). It is considered accepted practice that following adverse events, outcomes of an event investigation will be shared with the care team to support the learning process. From the reviewed file information, it does not appear that [care home senior staff] met with the care team to debrief and share investigation findings in line with significant investigation timeframes. The provider has referred to the Quality Improvement Form (GCL58) and Falls Focus Group (GCL53), commenced … , which outlined a process to share falls-related feedback with the care home team using PDSA methodology (1 June 2022). I acknowledge the strengthening of falls prevention and management strategies and feedback processes in response to this event.

3) Care communication

The response and supporting information is noted.

Summary
I acknowledge that the provider had recently acquired the care home and was transitioning to new systems and processes at the time of [Mrs A's] fall event, however as outlined in policies and service provider contractual requirements, duty teams would still be expected to practise with competence and to the accepted standard of care. I have reviewed the provider responses, submitted evidence, my initial advice and the additional information and consider my advice remains appropriate in the circumstances.

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