Oceania Healthcare Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC01304)

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 3
Opinion: Oceania Healthcare Limited — breach 15
Opinion: RN C — adverse comment 21
Opinion: RN E 23
Recommendations 25
Follow-up actions 26
Appendix A: Independent advice to the Commissioner 27

Executive summary

1. Mrs A was a resident of a rest home then owned and operated by Oceania Healthcare Limited (Oceania).

2. Mrs A had five falls at the rest home between 10 May 2017 and 20 June 2017. Her Tinetti Risk Assessment falls risk rating was not reviewed, and no multi-disciplinary review (MDR) was organised, following any of the five falls, which was inconsistent with Oceania's policy. The falls risk assessment and care plan for Mrs A, as at 20 June 2017, categorised her as a low risk for falls. Meanwhile, a new interRAI assessment completed for Mrs A on 12 June 2017 categorised her as a high risk for falls.

3. On 27 June 2017, Mrs A had an unwitnessed fall. She remained at the rest home, where she received pain relief and nursing care, for three days. On 30 June 2017, Mrs A was no longer able to bear weight and was taken to hospital, where it was discovered that she had a left pubic ramus fracture.

Findings

Oceania

4. The Deputy Commissioner found that Oceania failed to provide services to Mrs A with reasonable care and skill in the following areas:

   a) Oceania's staff failed to adhere to its policy and procedure relating to residents' falls;
   b) There was a lack of cohesion in Mrs A's assessments and care planning;
   c) Administration of pain relief following Mrs A's fall on 27 June 2017 was delayed and sporadic; and
   d) The delay in GP assessment following the 27 June fall was too long.

5. Accordingly, the Deputy Commissioner found that Oceania breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

Clinical Manager RN C

6. The Deputy Commissioner was critical that RN C did not ensure that Mrs A's care planning and assessments were cohesive and coordinated. The Deputy Commissioner was also critical that following Mrs A's fall on 27 June, RN C was not more closely involved in the assessments, documentation, and follow-up care.

Registered Nurse (RN) E

7. The Deputy Commissioner was critical that RN E did not undertake more thorough assessments on the day after Mrs A's fall on 27 June, and that he did not act on the suggestion of Mrs A's GP and the GP's practice nurse to send Mrs A for an X-ray on 29 June. The Deputy Commissioner acknowledged that RN E did not adhere to Oceania's moving and handling policy when he decided to assist Mrs A to stand without a hoist after her 27 June fall. However, the Deputy Commissioner considered that this was not unreasonable, as Mrs A declined the use of a hoist and was insistent on standing.

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

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Recommendations

8. It was recommended that Oceania develop an assessment tool for follow-up reassessment of a resident who has had a fall; amend its falls policy to clarify who is responsible for assessing a resident after a fall; review its moving and handling policy and consider amending it to cover situations when a resident declines the use of a hoist; provide evidence to HDC that it has implemented the changes to policy that Oceania had already identified; and provide HDC with evidence of further training and education for staff on falls prevention and post-falls care.

9. The Deputy Commissioner also recommended that Oceania provide Mrs A and her family with a written apology.

10. The new owner of the rest home will be asked to share the anonymised report with its staff and consider whether any learning can be taken from this case, and report back to HDC.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her mother, Mrs A, by Oceania Healthcare Limited. The following issue was identified for investigation:

- *Whether Oceania Healthcare Limited provided Mrs A with an appropriate standard of care between October 2016 and July 2017.*

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

13. The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Complainant/consumer's daughter
Oceania Healthcare Limited	Provider

Also mentioned in this report:

Dr J	General practitioner
Mrs K	Daughter
RN L	Registered nurse
Ms M	Staff member

14. Further information was received from:

RN C	Clinical Manager
Ms D	Business and Care Manager

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RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
Ms I	Healthcare assistant (HCA)
District health board	
Medical centre	

15. Independent expert advice was obtained from a registered nurse, Dr Karole Hogarth, and is included as Appendix A.

Information gathered during investigation

Introduction

Mrs A

16. On 5 October 2016, Mrs A, aged 89 years at the time, was admitted as a permanent private resident for rest-home care as she was no longer able to live on her own and required a higher level of care.

17. On admission, Mrs A had a number of serious medical conditions, including Parkinson's disease,[2] atrial fibrillation,[3] cerebral atrophy,[4] cerebrovascular disease,[5] a cataract[6] in her right eye, and osteoarthritis[7] in her knees. Her admission record also notes that she had very poor mobility and was generally off-balance. Mrs A had been admitted to the rest home previously on five separate occasions for respite care.

The rest home

18. At the time of the events to which this investigation relates, the rest home was owned and operated by Oceania.[8] The rest home's four-year certification from the Ministry of Health at the time was due to expire.[9]

Clinical Manager RN C

19. The Clinical Manager at the time was RN C.[10] RN C told HDC that she was employed as a registered nurse at the rest home before being appointed as the Clinical Manager. The Clinical Manager job description listed one of the job purposes as:

[2] A progressive degenerative disorder of the brain. Symptoms include tremors, stiffness or rigidity, and slowness of movement.
[3] An irregular, rapid heart rate.
[4] The loss of neurons and connections between neurons in the brain.
[5] A group of conditions that affect blood vessels of the brain and can lead to a cerebrovascular event, such as a stroke.
[6] A clouding of the lens in the eye.
[7] The most common form of arthritis causing cartilage breakdown in the joints.
[8] The rest home has since been sold.
[9] After the rest home was sold, the Ministry of Health certified the rest home for a 12-month period.

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"To ensure the provision of high level of quality delivery by providing clinical leadership to clinical and care staff, ensuring Oceania Healthcare policies, procedures, contractual and audit requirements are met and maintained."

20. Key responsibilities included:

"Provides an environment that promotes resident safety, independence, quality of life and good health and ensures the Oceania Healthcare Model of Care — Connect model of care is incorporated and delivered promptly and effectively addresses any clinical issues raised and discusses these with residents family members medical personnel and Business and Care Manager."

5 October 2016 to 27 June 2017

Tinetti Assessment review — 5 October 2016

21. On 5 October 2016, the Tinetti Risk Assessment (Tinetti Assessment) for Mrs A was reviewed[11] by RN C. A Tinetti Assessment measures a person's gait and balance, and is used to assess a person's risk for falls. The outcome of this review was that Mrs A's initial Tinetti score of four and classification as a low risk for falls were unchanged.

Care Plan — 27 October 2016

22. A Person Centred Care Plan (the Care Plan) was completed for Mrs A on 27 October 2016 by RN C. The Care Plan recorded:

"[Mrs A] is lucid most of the time, when [Mrs A] becomes muddled it can indicate an underlying urinary tract infection — staff to report incidence of [increased] confusion to RN & document."

23. The Care Plan also noted that Mrs A mobilised with a walking frame, and that she required "supervision when turning herself to sit on bed, chair, commode as she can sometimes misjudge distance which increases risk of slip to floor or near miss", and that she required assistance when using the toilet or commode. Mrs A's Tinetti score of four and classification as a low risk for falls were reflected in the Care Plan.

Fall — 11 November 2016

24. At 1am on 11 November 2016, a nurse found Mrs A sitting on the floor beside her bed. Mrs A told the nurse that she had slipped off the side of the bed. An incident report recorded that the nurse had not found any injuries on Mrs A, that neurological observations had been commenced, and that Mrs A's family had been notified. Oceania told HDC that after this fall, Mrs A was given non-slip socks to minimise her risk of slipping.

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[10] RN C is no longer employed by Oceania.

[11] An initial Tinetti Assessment for Mrs A was completed on 10 November 2015, when Mrs A was first admitted for respite care. RN C gave Mrs A a Tinetti score of four and, accordingly, documented her as a low risk for falls. The four risk factors identified in the Tinetti Assessment were that Mrs A was over 80 years of age, had poor hearing, walked with a walking frame, and had a neurological condition (Parkinson's disease).

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25. On 25 November 2016, RN C updated the Care Plan to record that Mrs A's commode had been removed from her room during the day, and that a sensor mat[12] was to be used during the night. Oceania told HDC that the sensor mat was put in place after a discussion with Mrs A's family as an intervention to reduce Mrs A's falls.

Tinetti Assessment review — 24 April 2017

26. The Tinetti Assessment for Mrs A was reviewed again on 24 April 2017 by RN F. In this review, Mrs A's Tinetti score of four and classification as a low risk for falls remained unchanged from the previous review. RN F told HDC that when she updated the Tinetti Assessment, she was unaware of Mrs A's fall in November 2016, and that had she known about this, she would have increased Mrs A's falls risk to medium, and also updated Mrs A's family and GP, and organised a multi-disciplinary review (MDR)[13] for Mrs A.

27. Oceania advised HDC that RN F was Mrs A's key nurse from around May 2017 onwards, and that RN F reviewed all of Mrs A's assessments around 24 April 2017. RN F told HDC that she updated Mrs A's file in April 2017, which included reviewing the Tinetti Assessment and attending Mrs A's six-monthly review with Mrs A's GP, Dr J.

MDR — 30 April 2017

28. RN C recorded the outcome of an MDR on 30 April 2017. The MDR included comments from RN F and Dr J, as well as Mrs A's pharmacist and other Oceania staff. RN C also recorded in the MDR a discussion with Mrs A's daughter, Mrs K, which included an observation that Mrs A's Parkinson's appeared to be progressing, as Mrs A was slowing down when mobilising. RN C noted in the MDR that a new interRAI assessment[14] of Mrs A was to be completed to determine whether she needed an increased level of care.

Four falls — 10 May 2017 to 29 May 2017

29. On 10 May 2017, Mrs A fell onto her knee while walking back to her room with a healthcare assistant[15] at 6.45pm. An incident report states that the fall occurred because Mrs A was wearing new high-heeled shoes that were too big for her. Mrs A was assessed by RN L as not having any resulting injuries, and her family was notified.

30. On 21 May 2017, Mrs A was found lying on the floor next to her bed at 11.30pm. Mrs A told the healthcare assistant who discovered her that she had rolled out of bed. Mrs A was assessed as not having any resulting injuries. Neurological observations were commenced by RN L, and Mrs A's daughter was informed.

31. At 7.45pm on 22 May 2017, Mrs A was found by another resident after having fallen when her walking frame tipped over. Mrs A sustained a one-centimetre cut above her right eyebrow. Neurological observations from the fall the previous day were continued by RN E

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[12] A sensor mat detects when a person stands on it, and sends out an alert. Frequently sensor mats are used in aged-care facilities as a falls prevention measure.

[13] An MDR is a review of a resident by healthcare professionals from various disciplines to determine goals, evaluate outcomes, and make recommendations.

[14] Resident Assessment Instrument — a standardised instrument for evaluation of the needs, strengths, and preferences of residents in long-term care.

[15] Healthcare assistants are nursing support caregivers who work under the direction of a registered nurse.

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for another 24 hours, and Mrs A's family was notified on 23 May 2017. Oceania told HDC that Mrs A's urine was tested and found normal on 23 May 2017 after staff noted that Mrs A was displaying confusion.

32. On 29 May 2017, Mrs A fell while using her commode at 11pm. No incident form was completed for this fall, although the progress notes record that the registered nurse (unnamed in the notes, but Oceania advised HDC that the nurse on duty at the time was RN H) was aware of the fall.

InterRAI Assessment — 12 June 2017

33. On 12 June 2017, RN G undertook a new interRAI assessment of Mrs A at the request of RN C. RN C told HDC that she requested a new interRAI assessment because she believed that Mrs A required a higher level of care owing to her general decline and progression of her Parkinson's disease. The assessment was reviewed and marked as complete by RN C.

34. The new interRAI assessment recorded that Mrs A was a high falls risk. RN G told HDC that when she undertook the interRAI assessment, there were incident forms in Mrs A's file for three falls in May, and that these three falls automatically triggered a high falls risk rating in the assessment. However, neither the Tinetti Assessment nor the Care Plan for Mrs A were updated at the same time to reflect the new high falls risk rating. The interRAI assessment also recorded that Mrs A's decision-making had declined in the preceding 90 days.

35. RN C told HDC that any issue concerning a resident's safety or risk identified in the interRAI assessment "is addressed through [the] care plan and implementation of policies". RN C added: "[T]he RN or key-worker were required to update the care plan, my responsibility was to ensure that the risks were managed or reduced."

36. Oceania advised HDC that although RN F was responsible for the assessment, planning, and delivery of Mrs A's care at the time of the 12 June 2017 interRAI assessment, RN F was not trained to undertake interRAI assessments. For this reason, RN G, and not RN F, undertook the 12 June 2017 interRAI assessment for Mrs A.

37. One of Oceania's policies states that "[r]esidents who have fallen more than twice in one month must have a thorough reassessment of their health status undertaken". Following this reassessment, the resident's Care Plan is to be evaluated and updated as necessary. This policy is set out in detail at paragraph 74 below.

38. According to Oceania, RN F did not update the Tinetti Assessment to reflect the high falls risk in the interRAI assessment, as she "may have not been aware of the process". RN F told HDC that she was unaware of any change in Mrs A's falls risk, as this "was not handed over" to her and was not recorded in Mrs A's Care Plan. RN F also told HDC that she could not recall whether she was aware that a new interRAI assessment was being completed for Mrs A at the time, but said that she did not have any involvement with interRAI assessments while at the rest home.

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Fall — 20 June 2017

39. At 4am on 20 June 2017, RN F found Mrs A sitting on her bedroom floor. Mrs A told RN F that she had fallen down while trying to go to the toilet. RN F told HDC that she commenced neurological observations immediately, and checked Mrs A for injuries, but did not find any. RN F completed an incident form, but acknowledged to HDC that she did not review Mrs A's falls risk when she completed the form. RN F commented:

> "I cannot fully remember my reasoning behind not updating the falls risk. At around 0400hrs is when the night shift pad round usually starts and so the time restraints and my heavy workload may have been a contributing factor."

Confusion

40. The progress notes for 10 May 2017 to 20 June 2017 record a number of occasions on which Mrs A appeared to be confused. Specifically, Mrs A was found out of bed and wandering multiple times overnight, at times wanting to take a shower, or expressing worry about her children. Other incidents of confusion were also recorded, including Mrs A undressing in the main lounge of the rest home, and ringing her call bell multiple times but being unable to explain what she needed.

Fall on 27 June 2017

41. At approximately 2pm on 27 June 2017, Mrs A fell in the hallway of the rest home. The progress notes record that Mrs A was walking without her walking frame, lost her balance, and was unable to grab the hand rails in the hallway. Healthcare assistant Ms I responded to the emergency bell following Mrs A's fall. Ms I told HDC that she found Mrs A lying on her left-hand side, and noticed a lump above her left eyebrow. Ms I said that she placed a pillow under Mrs A's head but did not move her, because she was waiting for Mrs A to be checked by RN E.

42. RN E told HDC that he completed a head-to-toe assessment of Mrs A, which he said included observing "lengthening of either legs or rotation of the either calf". At this stage, he observed only the bump on the left-hand side of Mrs A's head. When asked about pain, Mrs A indicated to RN E that the lump on her head was the site of her pain. Mrs A was assisted to a sitting position by RN E and Ms I. Both RN E and Ms I told HDC that Mrs A refused the offer of a hoist to lift her up, and that she was becoming frustrated with having to wait to get off the floor.

43. RN E advised HDC that, accordingly, he considered that it was in Mrs A's best interests to get her up and to her room as soon as possible, and that the use of a hoist was unnecessary. In explaining his decision not to use a hoist, RN E told HDC that he believes that he assessed Mrs A thoroughly in accordance with Oceania's policy (set out below), and considered that she required only minimal assistance to stand.

44. RN E said that he asked Mrs A whether she could try to pull herself up using the walking frame, while he and Ms I supported her back and held the walking frame. Ms I told HDC that Mrs A was concerned that her pants were falling down, so she and RN E reassured her that they would hold up her pants for her. Ms I said that she and RN E stood on either side

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of Mrs A and helped her to stand, after which Ms I retrieved Mrs A's walking frame from the main lounge.

45. Once standing, Mrs A was assisted by RN E and Ms I to walk to her room using her walking frame. Both RN E and Ms I told HDC that Mrs A denied any pain while walking. RN E added that he observed her gait, and that Mrs A seemed "to be walking as usual which is equal small steps".

46. Ms I and RN E completed an incident report for the fall, which records that when Mrs A was asked about pain, she pointed to her head. The report also notes that neurological observations were commenced, and that Mrs A's daughter was advised of the fall on the same day.

47. RN C told HDC that she did not hear the emergency bell that day, and thinks that she may have been out of the building. RN C said that later she was informed about the fall by RN E, who told her that he had assessed Mrs A and had no concerns. RN C was also called into the office of Business and Care Manager Ms D, where Oceania staff member Ms M[16] reported that she had observed RN E and Ms I "getting [Mrs A] to her feet".

48. A staff incident report was completed by Ms D in respect of RN E and Ms I lifting Mrs A to stand, and listed Ms M as a witness. The incident was classified as a near miss,[17] owing to the risk of injury or harm to staff. Ms D identified that one of the causes of the incident was that staff did not adhere to Oceania's "Moving and Handling Policy".[18]

49. The incident report documented that RN E checked Mrs A over and decided to get her up with the assistance of Ms I. The report also noted that Mrs A was impatient and insisting on getting up, so RN E and Ms I "assisted her to stand up by holding her pants on each side and 'dragging' her up to a standing position". A different section of the report recorded that Mrs A was "lifted", as opposed to dragged, to her feet, while another staff member went to get the walking frame. The report further provided:

> "Any resident found on the floor, who cannot get up themselves or on own with minimum help, is not to be lifted physically, a hoist is used."

50. Ms I told HDC:

> "[Mrs A] was able to help herself up with little guidance from [RN E] and myself with minimal assistance … I felt that I was respecting [Mrs A's] wish to not use the hoist as she was getting frustrated. I did not lift or drag her off the floor as indicated although it may have seemed like we did."

51. RN C told HDC that after the fall she spoke to RN E and noted that he "was following usual procedure guidelines following a fall". RN C said that RN E advised her that Mrs A had a

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[16] Oceania told HDC that Ms M was visiting the rest home that day to provide training to staff, and that she is no longer employed by Oceania.
[17] An unplanned event that did not result in injury, illness or damage but had the potential to do so.
[18] The relevant part of this policy is set out at paragraph 76 below.

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headache, and that he had assessed her for injuries and commenced neurological observations, which were within the normal range.

52. At 3.30pm, RN E recorded in Mrs A's progress notes that she was reporting pain on her head, and she had been given a cold compress for her head. RN E also recorded a handover note that Mrs A was to be given paracetamol as required for her pain. At 9pm that evening, Mrs A was given paracetamol by the healthcare assistant on duty, for "pain in the hip. Pain: 9".

53. On 27 June 2017, RN E updated Mrs A's Tinetti Assessment and recorded a new score of seven, and the corresponding falls risk rating of medium.

28 June 2017

54. On the morning of 28 June 2017, RN H documented in the progress notes that neurological observations were being continued. The progress notes also show that Mrs A was complaining of a sore left hip. RN C told HDC that she was given conflicting reports about Mrs A's pain levels that morning, so she "went to [Mrs A's] room and asked the HCA who was attending to her cares, if [Mrs A] was mobilising and if there were any concerns". RN C said that the healthcare assistant told her that Mrs A had mobilised from her bed to her chair with no apparent problems. RN C said that she observed Mrs A walking to her bed without limping, and considered that Mrs A "didn't appear to have any difficulty mobilising". RN C also said that Mrs A "denied any pain".

55. Mrs A's progress notes record that she remained in her room all day and spent most of the day in bed. RN E recorded that Mrs A was given paracetamol at 11am "for pain related to fall". He also documented that neurological observations had finished and she appeared stable, and that Mrs A's daughter had visited. RN E told HDC that he discussed the incident with Mrs K, and advised her that Mrs A was in pain and required further rest, and that they would continue to monitor her. RN E said that Mrs K agreed with this plan.

56. Mrs A was given paracetamol three times that day, at 10.47am and 1.33pm by RN E, and at 11.02pm by RN G. The medical administration record for Mrs A shows that at 10.47am, she was reporting head and hip pain but was not able to rate the level of her pain. At 1.33pm, Mrs A was again unable to rate her pain but complained of a sore shoulder, head, and hip. At 11.02pm, Mrs A reported a "very sore" hip. RN G recorded in the progress notes at 11.25pm that Mrs A had a sore left hip and that her mobility was to be monitored. Overnight, Mrs A was reported to be unsettled and confused.

29 June 2017

57. Mrs A's progress notes show that she was reporting pain again on the morning of 29 June 2017, but she was still able to walk and bear weight from her bed to the commode. The progress notes also record that Mrs A was "a bit confused and talking about [her] children". RN E told HDC that he faxed Dr J to advise him about Mrs A's condition and to request stronger pain medication and a review of Mrs A's Parkinson's medication.

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58. RN E spoke with Dr J's practice nurse, who advised that Dr J had charted Panadeine[19] as required and an increase of Madopar,[20] and that Dr J would visit Mrs A the following day. RN E told HDC that Dr J and the practice nurse were concerned about Mrs A's welfare, and were wondering whether she needed an X-ray. RN E considered that as Mrs A had been charted stronger pain medication, they could continue to monitor her until Dr J's visit the next day.

59. RN C told HDC that RN E informed her that day that he had contacted Dr J for advice regarding Mrs A's 27 June fall and her ongoing pain, and that Dr J had charted further analgesia.[21] Although RN C did not document in the progress notes that day that she had spoken to Mrs A, RN C told HDC that every day she would speak to each resident, but did not necessarily document these daily interactions.

60. On the afternoon of 29 June 2017, Mrs A's granddaughter visited and was concerned about Mrs A's left hip pain. Mrs A's granddaughter called members of her family, and one of Mrs A's daughters and one of her sons arrived at the rest home. RN G told HDC that she and RN E met with Mrs A's daughter to discuss Mrs A's condition. RN G said that she and RN E advised the daughter that RN E had spoken with Dr J earlier that day, and that Dr J had prescribed paracetamol and codeine, and an increase in Madopar. According to RN G and RN E, Mrs A's daughter agreed to wait until Dr J's visit to Mrs A the following morning. This was reflected in the progress notes, which documented that the daughter was happy to wait for Dr J's visit before deciding whether to transfer Mrs A to hospital.

61. Mrs A was given paracetamol and codeine at 6.01pm that evening by RN G, who recorded in the medical administration record: "Given 2 tablets for sore left hip. Pain: 9." According to the progress notes, the pain medication had "some effect". RN G told HDC that Mrs A reported to her that evening that her pain was getting better. RN G also told HDC that Mrs A was able to walk a short distance with her walking frame at this time.

30 June 2017

62. On 30 June 2017, Mrs A's progress notes document that she was no longer able to bear weight. Mrs A's daughter, Mrs B, was visiting Mrs A that day, and told HDC that she asked staff whether a doctor had been called to see if Mrs A had injuries other than the bruise on her face. RN H told HDC that she assessed Mrs A at around 11am, and Mrs A told her that her left hip was very sore. RN C told HDC that RN H advised her that she was concerned about Mrs A, as she appeared to be in pain. RN C said that she instructed RN H to contact Dr J by telephone for advice.

63. RN H informed Dr J's practice nurse that Mrs A was not weight bearing. Dr J's practice nurse telephoned RN H at approximately 12.30pm and advised her to send Mrs A to

[19] Panadeine is a brand name for a pain medication that combines paracetamol and codeine.
[20] Madopar is a brand for a medication that treats Parkinson's disease.
[21] Pain medication.

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hospital. RN H rang for an ambulance, which arrived at 1.36pm. On admission to hospital, an X-ray revealed that Mrs A had a left pubic ramus fracture.[22]

64. Mrs A remained in hospital until 11 July 2017. Following discharge from hospital, Mrs A moved out of the rest home and into another facility for hospital-level care.

Further information

Oceania

65. Oceania acknowledged to HDC that there were shortfalls in some areas of Mrs A's assessment and monitoring, which caused a significant injury, but maintained that Mrs A's care was reasonably well provided by all care staff. Oceania said that given Mrs A's pain levels and decreased mobility following her fall on 27 June 2017, an X-ray and GP review should have been arranged earlier. Oceania stated:

> "[T]he delay in seeking Medical treatment and the pain management following [Mrs A's] fall was unacceptable and did not meet Oceania Healthcare's own expectation of acceptable levels of care for our residents."

66. Oceania further stated that it "has robust procedures in place for falls and Pain Management. If they were adhered to, [Mrs A's] fall would have been adequately assessed and managed." HDC was provided with copies of Oceania's orientation and checklist manual for new registered nurses, which includes a checklist requiring nurses to confirm that they have read Oceania's policies, including its Falls Policy and Moving Policy. Oceania also provided a copy of its education log, which evidenced that staff had attended regular training on various matters, including medication management. However, Oceania did not provide HDC with evidence that specific training on care planning, head-to-toe assessments, and pain assessment had been provided to staff prior to 27 June 2017.

RN C

67. RN C told HDC that it was accepted practice that the registered nurse on duty was the most senior person on duty. She added:

> "As clinical leader I was not expected to attend to every fall within the facility to complete assessments of the patients as this was the responsibility of the registered nurse on duty. It would be difficult to attend each fall within the facility & still meet the expectations of the role considering we had [approximately 50] patients …
>
> It was my understanding that the RN on duty was expected to assess the patient, and complete an accident/incident form including preventative measures. The RN was expected to inform the family & update the care plan and/or a short term care plan as required."

68. RN C also stated: "[At the rest home] staff ratios were kept at a minimum; we had high staff sickness rates as well as a high staff turnover due to the stressful environment & high expectations." She added:

[22] A broken pelvic bone.

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"[W]orking in residential care in NZ is an extremely high pressure & stressful area due to limited staffing along with unrealistic expectations of the staff. The stress in my experience was indescribable …

I strongly believe that the staff involved in this incident had the best interest of the patient at the forefront but with the management team at the time, myself included there were no clear processes & the whole incident became confusing & complex due to inconsistencies between staff."

RN E

69. RN E told HDC:

"With regards to why [Mrs A] was not sent to the hospital for xray and further test, I strongly believe that the decision was a collective effort by the entire team as I [had] not received any strong message that it [was] necessary at that time and I rel[ied] as well on the HCA's observation that she was mobilizing and weight bearing."

Changes made

Oceania

70. Oceania provided HDC with evidence of its corrective action plan put in place following these events, which included education for its nurses on falls management and assessment. Oceania said that it also provided the following training:

- Pain management training, including assessment and medication, for the rest home registered nurses; and
- Progress notes training for all rest home staff.

71. Other changes introduced by Oceania following these events include:

- All resident injuries are now photographed, especially facial injuries;
- All resident falls are now notified to GPs, regardless of whether or not there is any resulting injury; and
- Oceania's Care Plan document has been updated to reflect triggers that may be identified in the interRAI assessment.

RN C

72. RN C told HDC:

"On reflection of this incident as a whole there [are] many things I would do differently, mainly accurate, cohesive documentation supporting the actions/ interventions by staff members providing care to [Mrs A]. This incident highlighted my challenges as a new Clinical Manager and was instrumental in my resignation from that post … I would like to add that working in residential care in NZ is an extremely high pressure & stressful area due to limited staffing along with unrealistic expectations of the staff."

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RN E

73. RN E told HDC:

"I should've been more vigilant in assessing a fall, I should've been more thorough when it comes to my notes …

This incident became an eye opener to me … I am confident to say that I have become a better nurse coming out of this incident and have improved in so many ways. I [now] write my notes more thoroughly, on which terms are acceptable to the NZ practice. … I have become more assertive in assessing my key-residents, ensuring that all their assessments are up-to-date."

Relevant policies and training

Falls Management Policy and Falls Prevention Flow Chart

74. Oceania's Falls Management Policy (the Falls Policy) provides:

"**5.3** Resident falls

All residents who fall must be assessed for injury by the most senior staff member on duty prior to moving their position.

The senior staff member notifies the family/EPOA (adhering to the Oceania Care Company Open Disclosure Policy) and the doctor if necessary.

An Unwanted Event Form is completed and given to the Business and Care Manager/Clinical Manager.

A Post Falls Assessment is completed to identify contributing factors for the fall and further Corrective Actions to be taken.

Any unwitnessed fall or a fall that involves injury to the [resident's] head must have neurological observations taken. (refer to the neurological observation guidelines)

5.4 Residents who Fall Frequently

Residents who have fallen more than twice in one month must have a thorough reassessment of their health status undertaken. This will include but not in entirety:

- A medical review to exclude physiological causes, i.e. Delirium
- A medication review
- A Nursing review
- A physiotherapy review

Following the review the [resident's] Person Centred Care Plan will be evaluated and updated accordingly.

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The resident will be entered on the Frequent Fallers Register by the Clinical Manager. The residents on the register will be reviewed after each fall as per policy and will be removed from the register if falls decrease below 2 falls per month."

75. Oceania also provided HDC with a copy of its Falls Prevention Flow Chart (the Falls Flowchart), which required staff to complete a Tinetti Assessment following a resident fall, and enter or change the resulting Tinetti score in the resident's Care Plan. If the resident's falls risk is assessed as medium or high, then the staff member must take further steps, including analysing the resident's falls history for trends, identifying possible causes and prevention measures, and writing an appropriate falls prevention goal in the resident's Care Plan. If a resident experiences more than two falls in one month, the Falls Flowchart requires the staff member to arrange for an MDR.

Moving and Handling Policy

76. Oceania's Moving and Handling Policy (the Moving Policy) provides (emphasis in the original document):

"**4.1 RESIDENTS**

…

- A hoist is used if the transfer requires the manual lifting [of] the whole or a large part of the resident's weight. **Two people must be present for the transfer**.
- Any resident found on the floor, who cannot get up on his/her own or with only minimal assistance, is not lifted manually — a hoist is used.
- Handling residents manually occurs only if it does not involve lifting most or all of a resident's weight or in exceptional or life threatening situations."

77. In response to the provisional opinion, Oceania told HDC that it also provides mandatory annual training days for nursing and HCA staff. The training for HCA staff in 2017 included training on moving and handling, and falls. The nursing training in 2017 included training on falls prevention.

Responses to provisional opinion

78. Mrs B, Oceania, RN C, and RN E were provided with relevant parts of my provisional opinion, and their responses have been incorporated into the report where appropriate. In addition, I note the following:

Mrs B

79. Mrs B told HDC that her mother is doing well at the new facility.

Oceania

80. In response to the proposed recommendations in the provisional opinion, Oceania provided HDC with evidence that its Falls Policy has been amended to clarify that the most senior health professional on duty is responsible for assessing a resident who has fallen,

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before the resident is moved from his or her position. Oceania stated that it would meet all of the other proposed recommendations.

RN C

81. RN C told HDC that she had no further comment to make in response to the provisional opinion.

RN E

82. RN E told HDC that on the afternoon of Mrs A's fall on 27 June 2017, he and a single caregiver were left to look after approximately 50 residents when he was supposed to be working on his notes and finishing his shift, as everyone else was attending training. He questioned whether this staffing was adequate. RN E also told HDC:

> "[The staffing level] doesn't change the fact that the resident wasn't sen[t] to the hospital in a timeframe but this is an appeal to hear me out that maybe there is something wrong with our staffing. I am glad that the facility that I have work[ed] in the last 3 years is now under new management for they have acknowledge[d] the issue and rectif[ied] it by placing a 2nd RN working from 9am until 6pm on a daily basis and … a new Facility Manager that understand[s] it[s] staff and their welfare."

Opinion: Oceania Healthcare Limited — breach

Introduction

83. In accordance with the Code, Oceania had a responsibility to operate the rest home in a manner that provided its residents with services of an appropriate standard. My expert advisor, RN Karole Hogarth, advised that overall Oceania's policies are succinct and easily understood (although she was mildly critical of some wording in the Falls Policy, as discussed at paragraph 116 below).

84. Nonetheless, multiple staff failed to follow appropriate procedures in light of Mrs A's increasing number of falls. As a result, Mrs A was put at risk of harm, and ultimately sustained a significant injury when she fell on 27 June 2017. Further, following this fall, there was a delay in providing Mrs A with pain medication, and it was administered sporadically, and the effectiveness of the dose administered was not monitored consistently. In addition, Mrs A was not assessed by a doctor until three days after her fall.

85. As this Office has stated previously,[23] inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not support and assist staff sufficiently to do what is required of them and ensure that its residents receive optimal support, and Oceania must bear overall responsibility for this.

[23] 16HDC01380.

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86. I note RN C's comments that the rest home was a stressful working environment with high expectations on staff, which led to high rates of staff sickness and staff turnover. I also note that in response to the provisional opinion, RN E raised concerns about the staffing levels at the time. However, RN Hogarth advised that the staffing levels indicated on the roster (one registered nurse) are what would be accepted as normal practice for this number of residents in a facility.

Falls between 10 May 2017 and 20 June 2017

87. Mrs A had five falls between 10 May 2017 and 20 June 2017, on the following dates:

- 10 May 2017 (after which RN L assessed Mrs A for injuries and completed an incident report);
- 21 May 2017 (after which RN L assessed Mrs A for injuries and completed an incident report);
- 22 May 2017 (after which RN E assessed Mrs A for injuries and completed an incident report);
- 29 May 2017 (for which no incident report was completed, but the progress notes document that RN H was aware of the fall); and
- 20 June 2017 (after which RN F assessed Mrs A for injuries and completed an incident report).

88. During this same period, Mrs A was recorded as experiencing multiple episodes of confusion. The progress notes show that Mrs A's urine was tested once during this period (on 23 May 2017) and was found to be normal.

89. Mrs A's Tinetti Assessment was not reviewed, and no MDR was organised, after any of the five falls between 10 May 2017 and 20 June 2017. Although a new interRAI assessment was carried out by RN G, and reviewed and marked as complete by RN C on 12 June 2017, the new falls risk rating identified in this assessment was not carried through to Mrs A's Care Plan.

90. RN C told HDC that the registered nurse or key-worker was responsible for updating the Care Plan to reflect the risks identified in a resident's interRAI assessment. Oceania told HDC that RN F was responsible for the assessment and planning of Mrs A's care, but RN F told HDC that she was not aware of the change in Mrs A's falls risk. Neither RN F nor RN G nor RN C updated Mrs A's Care Plan with the new falls risk rating. As a result, at the time of Mrs A's 27 June fall, her Tinetti Assessment and Care Plan categorised her as a low falls risk, while her interRAI categorised her as a high falls risk.

91. Together Oceania's Falls Policy and Falls Flowchart required staff members to take certain actions following a resident's fall. Specifically, the most senior staff member on duty was to assess the resident for injury before the resident was moved, and then a new Tinetti Assessment was to be undertaken. Following the Tinetti Assessment, any change in the resident's Tinetti score was to be documented in the Care Plan. A score of medium to high required further action to be taken, including analysis of the resident's falls history,

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identification of causes, and implementation of appropriate falls risk prevention measures. Any resident who had more than two falls in one month required a thorough health status review and an MDR.

92. RN Hogarth advised:

> "The falls policy and the falls flowchart provided by [the rest home] are straightforward and easily implemented if the appropriate assessments are completed for the client. In this instance the lack of procedural adherence resulted in a significant injury to [Mrs A]."

93. I accept RN Hogarth's advice.

94. RN Hogarth was also critical that Mrs A's frequent falls and changing falls risk were not documented consistently across the Tinetti Assessment, the interRAI, and the Care Plan. Specifically, RN Hogarth advised: "[T]hat the falls documentation does not fit with the pattern seen in [Mrs A's] daily notes indicates a lack of cohesiveness in the care of this client."

95. A number of registered nurses cared for Mrs A following her falls between 10 May 2017 and 20 June 2017. I am critical that not one of the nurses completed a new Tinetti Assessment for Mrs A after her falls, as required by the Falls Flowchart. Further, Mrs A was no longer a low risk for falls, having fallen three times in May and having exhibited increasing confusion. However, none of the nurses who provided care for Mrs A completely followed the Falls Policy or Falls Flowchart requirements for residents who fall frequently, or appeared to identify that Mrs A was falling more frequently and therefore warranted a reassessment of her falls risk.

96. If the Falls Policy and Falls Flowchart had been followed, a thorough reassessment of Mrs A's health status would have been undertaken after her third fall in May 2017, and an MDR would have been organised. Further, as Mrs A was no longer a low falls risk, an analysis of her falls history, including identification of the causes of her falls and implementation of prevention measures, should have been undertaken. Although some preventative measures were already in place, such as the use of an alert mat and non-slip socks, further measures could have been implemented, including the use of hip protectors, an assessment of Mrs A's walking frame, closer supervision while Mrs A mobilised, and an MDR to identify and analyse Mrs A's changing needs. I am critical that these strategies were not implemented, as they may have prevented Mrs A's fall on 27 June 2017, or reduced the seriousness of her resulting injuries.

97. In my opinion, these recurrent failures by multiple staff to adhere to policy demonstrate a concerning lack of compliance with policy and procedure by Oceania staff. I am also critical of the inconsistent documentation of Mrs A's falls risk and the lack of coordination of assessments and care planning, which failed to reflect and respond to her changing needs.

98. I acknowledge that Oceania's induction materials required new nurses to confirm that they had read Oceania's policies, including its Falls Policy and Moving Policy. However, HDC was

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not provided with evidence that Oceania had provided regular training to nurses and other Oceania staff about managing residents' falls risks and care planning. Therefore, I consider that the training provided by Oceania did not address this area adequately, which is concerning. In response to the provisional opinion, however, Oceania said that it had in place mandatory annual training for its nursing and HCA staff at the rest home, and in 2017 this training covered falls prevention.

Fall on 27 June 2017

99. Immediately following Mrs A's fall on 27 June 2017, RN E completed a head-to-toe assessment and commenced neurological observations. At 3.30pm, RN E recorded that Mrs A was reporting pain on her head. However, Mrs A was not given paracetamol until 9 o'clock that evening. RN C did not review Mrs A personally on 27 June 2017. Instead, RN C spoke to RN E, who told her that Mrs A had been assessed for injuries and was complaining of a headache, but that neurological observations were within the normal range.

100. On 28 June 2017, RN H recorded that Mrs A's neurological observations were ongoing. RN C visited Mrs A that morning and observed her walking to her bed. RN C said that Mrs A was not limping, and denied any pain.

101. Mrs A received a further three doses of paracetamol on 28 June 2017, when she was reporting pain in her left hip, as well as her head and shoulder. RN E gave Mrs A two doses of paracetamol, and RN G gave her one dose. RN G also documented that Mrs A's mobility was to be monitored in light of her sore hip. Mrs A spent the day in her room and was observed to be mobilising from her bed to the commode.

102. On 29 June 2017, Mrs A continued to report pain, but was able to walk from her bed to the commode. She received paracetamol and codeine from RN G in the evening, after RN E had telephoned Dr J. During the telephone conversation, Dr J's practice nurse queried with RN E the need for an X-ray, but RN E considered that with the stronger medication, Mrs A could be monitored until she was seen by Dr J the following day. RN C said that RN E told her about his conversation with Dr J's practice nurse, and that Dr J had charted stronger pain medication for Mrs A. RN C said that she visited Mrs A that day but did not document this interaction.

103. In the afternoon of 29 June 2017, Mrs A's granddaughter visited and was concerned about Mrs A's hip pain. She called members of Mrs A's family to the rest home, and RN E and RN G met with Mrs K to discuss Mrs A's condition. Following this discussion, Mrs K agreed to wait until Dr J's visit the following day before sending Mrs A to hospital for an X-ray.

104. On 30 June 2017, Mrs A was no longer able to weight bear. RN H told RN C that she was concerned about Mrs A, and RN C advised RN H to telephone Dr J. RN H was advised by Dr J's practice nurse to call for an ambulance to take Mrs A to hospital. Mrs A was admitted and diagnosed with a left pubic ramus fracture.

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Initial assessment

105. RN Hogarth considers that the initial head-to-toe assessment and neurological observations following Mrs A's fall were completed adequately. However, RN Hogarth also commented that "further secondary survey may have shown an anomaly in her pelvis i.e. increased pain with controlled movements". She added that this "further examination and follow-up may have indicated the extent of her injury sooner", but noted that "pelvic fractures … can be quite stable and weight bearing is not uncommon". I accept RN Hogarth's advice that the initial assessment of Mrs A was adequate.

Pain relief

106. RN Hogarth was critical of the initially delayed pain relief and the "sporadic" pain medication given to Mrs A over the three days after her fall. RN Hogarth advised:

> "It is noted that [Mrs A] was unable to rate pain. This would indicate a verbalisation issue but does not preclude the regular dispensing of pain relief to this client. She was very under dosed and was consequently most likely very uncomfortable."

107. RN Hogarth considers that the manner in which pain relief was dispensed to Mrs A was "a moderate degree of departure from standard care and accepted practice". I accept this advice. I am critical that Mrs A was not given pain relief until about seven hours after her fall, even though she had reported pain immediately following the fall. In the days following the fall, when Mrs A was able to rate her pain, either she rated it as 9, or said that her hip was very sore. At least three nurses (RN E, RN H, and RN G), as well as RN C and multiple healthcare assistants, were involved in caring for Mrs A following her fall. In my view, Mrs A was reporting significant pain, and staff should have been alert to the need to dispense pain relief regularly. I am critical that they did not do so.

Timeliness of assessment by a doctor

108. RN Hogarth advised that "the delay of three days for an assessment by a physician in this instance was too long". She considers that when Mrs A reported hip pain on the day after the fall, further assessment and a discussion with her GP should have taken place, especially considering that Mrs A had sustained an injury to her face. Specifically, RN Hogarth highlighted the "failure of staff on shifts following the fall … to reassess [Mrs A] to determine the cause of her ongoing pain".

109. RN Hogarth advised that any fall that results in an injury, and particularly a facial injury, to a person prone to confusion, and especially UTI-related confusion, would warrant an assessment by a physician within 24 hours of the fall. RN Hogarth also noted that according to the Care Plan, Mrs A should have been assessed for an underlying UTI. The reason given for Mrs A's 27 June 2017 fall was that she had been walking without her walking frame, which could indicate that Mrs A was experiencing confusion.

110. In RN Hogarth's view, the delay of three days before Mrs A was assessed by a doctor is a high degree of departure from the accepted standards. I accept this advice.

111. I am concerned that there were multiple opportunities over the three days following Mrs A's fall for staff to escalate concerns about Mrs A's condition and request a GP review.

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Although RN E did contact Dr J on 29 June 2017, Dr J did not visit Mrs A that day. RN E, RN H, RN G, RN C, and several healthcare assistants were involved in Mrs A's care following her fall, yet none appeared to consider that Mrs A's condition warranted more urgent treatment until 30 June 2017. In my opinion, this demonstrates a lack of critical thinking by Oceania staff and, as a result, Mrs A faced an unacceptable delay in receiving the appropriate treatment for her fracture.

Conclusion

112. Mrs A has a number of serious medical conditions, including Parkinson's disease — a degenerative disorder of the central nervous system that mainly affects the motor system. Mrs A also experienced a significant increase in falls and increasing confusion over the six-week period leading up to 27 June 2017. In my view, these circumstances made Mrs A particularly vulnerable, and warranted a heightened level of care and careful consideration of her changing needs. Oceania has accepted that the delay in seeking medical treatment, and the pain management following Mrs A's fall by multiple staff members, was unacceptable and did not meet Oceania's own expectations.

113. As I have stated previously, aged-care facilities are responsible for the operation of the clinical services they provide, and can be held responsible for any service failures.[24] Whilst I accept that the relevant policies and procedures were comprehensive, and the training provided to staff did cover falls prevention, in my view it was Oceania's responsibility to ensure that its policies were adhered to, and that care planning was cohesive and capable of responding effectively to events that indicated that a resident's needs were changing. Oceania is also responsible for the actions of its staff, and must provide its staff with the appropriate support and working environment to ensure that they can do what is required of them.

114. I consider that the failures by Oceania staff, summarised below, demonstrate a pattern of poor care, poor compliance with policy, and a lack of critical thinking by numerous Oceania staff members. In my view, Oceania failed to provide services to Mrs A with reasonable care and skill in the following areas:

- Staff failed to adhere to the Falls Policy and Falls Flowchart;
- There was a lack of cohesion of assessments and care planning;
- Pain relief administration was delayed and sporadic; and
- The delay in GP assessment was too long.

115. Accordingly, I find that Oceania breached Right 4(1) of the Code.[25]

Falls Policy — adverse comment

116. Oceania's Falls Policy provides that "[a]ll residents who fall must be assessed for injury by the most senior staff member on duty prior to moving their position". RN Hogarth

[24] 16HDC01148 (issued 9 April 2018).
[25] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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commented that this wording "is not specific enough", and noted that the most senior staff member on duty would, in many places, "be the manager who may or may not be a health professional". RN Hogarth advised that the ambiguous wording in the Falls Policy would be a "mild departure from the accepted standard and is really only because it needs to be specific". I accept RN Hogarth's advice and agree that the Falls Policy should have clarified that the most senior health professional on duty should assess a resident following a fall.

117. However, it is pleasing to see that Oceania has amended its Falls Policy to clarify that the most senior health professional on duty is required to assess a resident after a fall.

Opinion: RN C — adverse comment

118. As the Clinical Manager, ultimately RN C was accountable for the delivery of Mrs A's care. RN C was responsible for providing clinical leadership to nursing and care staff, and ensuring that clinical issues were addressed effectively.

119. RN C completed a review of Mrs A's Tinetti Assessment on 5 October 2016. She also completed Mrs A's Care Plan on 27 October 2016. She undertook an MDR on 30 April 2017, in which she recorded that a new interRAI assessment was to be undertaken to determine whether Mrs A required an increased level of care, in light of the apparent progression in her Parkinson's disease.

120. Mrs A had five falls between 10 May 2017 and 20 June 2017, on the following dates:

- 10 May 2017;
- 21 May 2017;
- 22 May 2017;
- 29 May 2017; and
- 20 June 2017.

121. The Falls Policy required RN C to enter Mrs A into the Frequent Fallers Register. As Oceania was unable to provide to HDC the Frequent Fallers Register in place while Mrs A was a resident of the rest home, I am unable to determine whether RN C added Mrs A to the register.

122. RN G undertook the new interRAI assessment on 12 June 2017, and RN C reviewed it and marked it as complete. The interRAI assessment recorded Mrs A as having a high falls risk. However, this change in falls risk was not recorded in Mrs A's Tinetti Assessment or Care Plan. RN C told HDC that the nurse or key-worker was responsible for updating the Care Plan to reflect the risks identified in a resident's interRAI assessment. Oceania told HDC that RN F was responsible for the assessment and planning of Mrs A's care, but RN F told

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HDC that she was not aware of the change in Mrs A's falls risk. Neither RN G nor RN C updated Mrs A's Care Plan with the new falls risk rating.

123. RN C said that she did not hear the emergency bell when Mrs A fell on 27 June 2017, as she may have been outside the building at the time. I accept that she may not have been in a position to attend to Mrs A immediately following her fall. RN C was later informed of the fall by RN E, who told her that he had assessed Mrs A and did not have any concerns. RN C saw Mrs A on 28 June 2017, and enquired about her pain and saw her mobilising, but did not document this.

124. RN C told HDC that she spoke to Mrs A again on 29 June 2017, but as a matter of course did not document her daily interactions with every rest home resident. RN C stated that RN E advised her that day that he had contacted Dr J for advice regarding Mrs A's fall on 27 June and her ongoing pain, and that Dr J had charted further analgesia.

125. On 30 June 2017, Mrs A was no longer bearing weight. When RN H reported to RN C her concerns about Mrs A's pain, RN C advised RN H to contact Dr J. Dr J's practice nurse advised RN H to send Mrs A to hospital. RN H rang for an ambulance, and Mrs A was transferred to the public hospital, where an X-ray revealed a left pubic ramus fracture.

126. RN Hogarth commented that RN C should "have picked up that [Mrs A] had had multiple falls prior to this [27 June 2017] incident and initiated strategies to minimise the risk to this client". I accept RN Hogarth's advice. RN C was closely involved in planning for Mrs A's care, having either completed or signed off on all of the assessments and plans. Therefore, RN C had a great deal of oversight of the care planning and assessments, and was in a good position to ensure that they were cohesive and coordinated, and that appropriate strategies were implemented in response to Mrs A's increasing number of falls. I am critical that RN C failed to do this.

127. RN C did request a review of Mrs A's interRAI assessment, which indicates that she appreciated that Mrs A's needs were changing. However, I am critical that she apparently did not appreciate the need for more immediate measures to reduce the risk of harm to Mrs A, in light of her increasing falls between 10 May 2017 and 20 June 2017. In my view, these falls should have alerted RN C that Mrs A was at risk of serious injury, and that immediate preventative measures were called for.

128. RN Hogarth advised that the Clinical Manager is the "most senior staff member" in accordance with the Falls Policy, and therefore "should have attended the fall and ensured that a full assessment was completed", which would have "ensured that the documentation was complete". RN Hogarth also advised that RN C "should have been involved in [a] reassessment in a follow up to [Mrs A's] fall the previous day" in order to "determine the cause of her continuing pain and [to implement] a call to the physician". RN Hogarth noted that RN C said that she spoke to Mrs A daily following her fall. In RN Hogarth's view, RN C must have noted the injury to Mrs A's head, which "should have triggered a more in depth conversation and assessment (by herself or as instructed to the RN on duty) and then documented".

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129. I accept RN Hogarth's advice. Although RN C was not able to attend Mrs A's fall immediately, in my view she should have been more closely involved in the assessments, documentation, and follow-up care after the fall. I acknowledge RN C's comments that she considered that it was the registered nurse's duty to undertake these actions following a fall, and that it would have been difficult for her to attend to every fall and carry out her other duties. I also acknowledge RN C's comments about the stress and pressure on staff at the rest home. Nonetheless, I consider that in light of Mrs A's visible facial injury and ongoing pain after her fall, RN C should have appreciated the need for her close clinical leadership and oversight of Mrs A's care. I am critical that she failed to do so.

Opinion: RN E

Conversation with Dr J on 29 June 2017 — adverse comment

130. On 27 June 2017, Mrs A fell in the hallway of the rest home. Ms I responded to the emergency bell following Mrs A's fall, and was followed by RN E. RN E then completed a head-to-toe assessment of Mrs A, and the only injury he noted was the lump on the left-hand side of Mrs A's head. When asked about pain, Mrs A indicated to RN E that the lump on her head was the site of her pain.

131. With the help of Ms I, RN E assisted Mrs A to stand (discussed further below). They walked back to Mrs A's room. RN E commenced neurological observations following the fall, and documented the fall in Mrs A's progress notes. At the end of his shift, RN E noted that Mrs A was reporting pain on her head, and that she had been given a cold compress for the pain. He also noted that Mrs A was to be given paracetamol as required for the pain.

132. On the morning of 28 June 2017, Mrs A reported a sore left hip. RN E gave Mrs A paracetamol at 10.47am, when she was reporting head and hip pain but was not able to rate the level of her pain. RN E gave Mrs A more paracetamol at 1.33pm, when Mrs A was again unable to rate her pain but complained of a sore shoulder, head, and hip.

133. That day, RN E also documented that Mrs A's neurological observations had finished and she appeared stable. RN E discussed Mrs A's fall with Mrs K, who was visiting Mrs A, and advised Mrs K that Mrs A was in pain and required further rest, and that they would continue to monitor her. RN E said that Mrs K agreed with this plan.

134. At 11.02pm, Mrs A reported a "very sore" hip and was given paracetamol by RN G. Overnight, Mrs A was reported to be unsettled and confused.

135. On 29 June 2017, RN E faxed Mrs A's GP, Dr J, to advise him about Mrs A's condition and to request stronger pain medication and a review of Mrs A's Parkinson's medication. RN E was advised by Dr J's practice nurse that Dr J had charted Panadeine and an increase in Madopar, and that Dr J would visit Mrs A the following day. During the conversation, the practice nurse advised RN E that she and Dr J were concerned about Mrs A's welfare. The

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practice nurse raised the possibility of an X-ray for Mrs A. However, RN E considered that because Mrs A had been charted stronger pain medication, staff could continue to monitor her until Dr J's visit the next day.

136. RN E and RN G later met with Mrs K, who came to the rest home after Mrs A's granddaughter raised concerns about Mrs A's hip pain. RN E and RN G advised Mrs K that RN E had spoken with Dr J, who had charted stronger pain medication and would visit Mrs A the following day. Mrs K was reported to be happy to wait until Dr J's visit before deciding whether to take Mrs A to hospital.

137. On 30 June 2017, Mrs A was no longer bearing weight. RN H rang for an ambulance after speaking with Dr J's practice nurse. Mrs A was transferred to the public hospital, where an X-ray revealed a left pubic ramus fracture.

138. RN Hogarth noted that according to the progress notes, 28 June 2017 was the first time Mrs A reported hip pain. RN Hogarth advised that "further assessment should have been undertaken at this time by the RN including a conversation with the physician". In respect of RN E's conversation with Dr J on 29 June 2017, RN Hogarth commented that if a further nursing assessment had been undertaken on 28 June 2017, this "would have perhaps provided more in depth background for the decision making of the physician". RN Hogarth said that "[d]iscussions with the Practice Nurse and the physician in the days following the fall may not have fully captured the extent of [Mrs A's] discomfort".

139. I note RN E's comment that he strongly believes that the decision not to send Mrs A to hospital for an X-ray earlier was a collective decision by staff. I also note that several different staff members provided care to Mrs A following her fall. Nonetheless, I accept RN Hogarth's advice that RN E should have undertaken further, more thorough assessments of Mrs A the day after her fall, to determine the source of her hip pain. I am critical that he did not do so.

140. I am also critical that RN E did not act on the suggestion of Dr J and his practice nurse to send Mrs A for an X-ray on 29 June 2017. In my opinion, this was a missed opportunity to ensure that Mrs A received the appropriate care and treatment for her fracture, which had already been delayed by two days at this point. Instead, Mrs A had to wait for another day before being seen at the public hospital.

Adherence to Moving Policy — other comment

141. HDC received inconsistent accounts from RN E and Ms I about whether or not Mrs A's walking frame was used to help her to stand up following her fall on 27 June 2017. According to RN E, Mrs A used the walking frame to pull herself up with the assistance of RN E and Ms I. Conversely, Ms I said that she retrieved Mrs A's walking frame from the lounge after she and RN E had assisted Mrs A to stand. The staff incident report completed at the time recorded that a staff member recovered Mrs A's walking frame while she was being assisted to stand. Accordingly, I find it more likely than not that Mrs A's walking frame was not used to help her to stand.

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142. However, both RN E and Ms I state that Mrs A was offered and declined the hoist to lift her up, and that Mrs A was frustrated by having to wait to get up. The incident report is consistent with these statements, as it recorded that Mrs A was insisting on getting up. RN E also told HDC that he considered that it was in Mrs A's best interests to get her up and back to her room as quickly as possible. Ms I said that she considered that she was respecting Mrs A's wishes not to use the hoist.

143. RN Hogarth considers that RN E's decision to assist Mrs A off the floor manually with the help of Ms I, rather than use a hoist, was a failure to adhere to the Moving Policy, which "put both the client and the staff involved in manually lifting her at risk of injury".

144. I note RN Hogarth's advice. However, in my view, it is relevant that Mrs A declined the use of a hoist, and became frustrated and insisted on getting up. I also acknowledge that both RN E and Ms I considered that helping Mrs A to stand, rather than using a hoist, was in her best interests and in line with her wishes.

145. While it is important that staff adhere to policies designed to reduce the risk of accidents and injuries occurring, there will be situations where strict adherence to policy may not be the only reasonable response. In my view, it was not unreasonable for RN E to decide that Mrs A could be assisted to stand without a hoist, as she declined the use of a hoist and was insistent on standing.

Recommendations

146. I recommend that Oceania provide a written apology to Mrs A and her family for its breach of the Code. Oceania is to send the apology to HDC within three weeks of the date of this report, for forwarding to Mrs A and her family.

147. I also recommend that, if not already done in the intervening period since these events occurred, Oceania:

    a) Develop an assessment tool to be used by the most senior health professional on duty, for the follow-up reassessment of a resident who has had a fall. Oceania is to provide HDC with evidence of the assessment tool and complementary training for staff, within three months of the date of this report;

    b) Review its Moving Policy, with particular consideration as to whether amendments are required to cover situations where residents decline the use of a hoist. Oceania is to report back to HDC with the results of this review, within three months of the date of this report;

    c) Provide HDC with evidence that the changes it has implemented (see paragraphs 70–71 of this report) have been reflected in the relevant policies, within three months of the date of this report; and

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d) Provide HDC with evidence of plans for further training and education for its entire staff on falls prevention and post-falls care, within six months of the date of this report.

148. If Oceania considers that measures have been introduced that satisfy any or all of the above recommendations, Oceania should provide HDC with evidence of these measures, within three months of the date of this report.

149. The new owners of the rest home will be asked to:

a) Share the anonymised report with staff who previously were employed by Oceania, and consider whether any learning can be taken from this case and translated to improvements to its own policies and procedures; and

b) Provide HDC with a report on its consideration of this investigation, within three months of the date of receiving the anonymised report.

Follow-up actions

150. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania, will be sent to the new owner of the rest home.

151. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania, will be sent to the DHB, the Health Quality & Safety Commission, and the Ministry of Health (HealthCERT), and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Dr Karole Hogarth:

"HDC REPORT

REFERENCE: C17HDC01304

1. Thank you for the request to provide clinical advice regarding the complaint from [Mrs B] in relation to the care of [Mrs A] at [the rest home].

   In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1989. Upon registration I was appointed to a new graduate position at Waikato Hospital and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Waikato hospital. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract I moved to England and worked as an RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as the weekend nurse and casual as a RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enrol in a PhD which I did following a further year of travel where I worked as an RN for the Australia blood service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role 2 days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Midwifery and Nursing students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full time position in the School of Nursing at Otago Polytechnic where I am still currently employed as a Principal Lecturer, Curriculum Leader and Programme Leader Year 2. I am also a Justice of the Peace for New Zealand having completed the requirements for this role in 2016.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by [the rest home] was reasonable in the circumstances and why.

   With particular comment on:

   a. the timeliness of GP review following [Mrs A's] fall on 27th [June] 2017.

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b. the reasonableness and adequacy of the assessments and monitoring of [Mrs A] following her fall on 27th June 2017.

c. the overall standard of care provided to [Mrs A] by [the rest home].

d. any other matters in this case that you consider warrant comment.

For each question I am asked to advise:

a. what is the standard of care/accepted practice?

b. if there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

c. how would it be viewed by peers?

d. recommendations for improvement that may help to prevent a similar occurrence in future.

4. In preparing this report I have reviewed the documentation on file:

   1. Letter of complaint dated […]

   2. Response from Oceania Healthcare with letters dated 21st August 2017.

   3. Clinical records from Oceania Healthcare covering 26th June 2017 to 11th July 2017.

5. Background

[Mrs A's] daughter, [Mrs B] raised concerns about the care her mother received at [the rest home]. [Mrs A] was admitted to [the rest home] as a permanent resident on 5th October 2016. On 27th June 2017, she had a fall leaving a bruise on the side of her face. On 30th June 2017, [Mrs B] visited her mother and inquired as to whether [Mrs A] had been reviewed by a doctor since the fall. [Mrs A's] GP was contacted. Upon the advice of the GP she was taken to Accident and Emergency by the ambulance that afternoon. An x-ray indicated that [Mrs A's] pelvis was fractured.

[Mrs B] also had concerns regarding the cleaning of [Mrs A's] room, namely the carpet and insects in her locker.

My comments are confined to the care provided by [the rest home].

6. Timeliness of GP review following fall on 27th June 2017

a. What is the standard of care/accepted practice?

In my opinion the delay of three days for an assessment by a physician in this instance was too long. The client, [Mrs A] is 90 years old and slight of frame (57.4 kg) assessment by a physician would have been advisable. Even if no injury was found (other than that to her head) an assessment for UTI would have been warranted as per her nursing care plan (NCP) (goal 2). This states that when [Mrs A] is muddled i.e. getting up without her walker; this can indicate underlying UTI. [Mrs A] had also suffered numerous falls in the preceding weeks and at any stage she should have been

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reassessed as to her safety and falls risk (as per goal 12 NCP). On the day after her fall the 28th June; [Mrs A] complained of hip pain (first time it was documented in notes) further assessment should have been undertaken at this time by the RN including a conversation with the physician.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

Correspondence indicates that conversations were held with a physician regarding [Mrs A's] welfare — increase and changes of pain medication. A further RN assessment the following day would have perhaps provided more in depth background for the decision making of the physician. [Mrs A] had last been seen by her physician in May 2017 as per the MDT report. Discussions with the Practice Nurse and the physician in the days following the fall may not have fully captured the extent of [Mrs A's] discomfort.

I would consider that this is a high degree of departure from accepted practice and care of [Mrs A].

c. How would it be viewed by your peers?

I believe my peers would concur that waiting 3 days for physician assessment is too long given the increasing levels of pain and decreased mobility exhibited by [Mrs A].

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

It can be very difficult to assess the extent of injury in an elderly person but I would suggest that any fall that has an injury especially to the face in someone prone to confusion especially related to UTI would warrant checking by a physician within 24 hours of a fall.

7. The reasonableness and adequacy of the assessments and monitoring of [Mrs A] following her fall on 27th June 2017

a. What is the standard of care/accepted practice?

A head to toe assessment was completed by the attending RN and I assume that this would have included a musculoskeletal assessment looking for internal rotation and limb shortening plus other more central injuries. There was no specific mention of pain assessment but this is part of the top to toe. Neurological assessment was commenced with observation started at 1415 following the injury and continued over a 17 hour period and charted, no change was seen in neurological status during this time. Pain relief was given (paracetamol) at 2100 hours on the 27th June. There was no mention of neuro observations in her notes on either PM or night shift of the 27th June though these were documented on the neuro observation chart.

In the letter of [RN E] it is stated that 'since enough time was given to regain consciousness'. If in fact [Mrs A] had been unconscious then she should have been

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seen as soon as possible by a physician. Given that this RN seems to be an IQN (assumption from the way the letter is written) with possibly English as a second language this needed to be clarified as unconsciousness was not mentioned in [Mrs A's] notes.

These would be the minimum expected with further observation of the client for the next few hours including pain assessment regularly.

The following were also completed as required:

- Incident form completed
- Documented in her patient notes
- Family notified
- Post fall assessment

Head to toe is adequate but further secondary survey may have shown an anomaly in her pelvis i.e. increased pain with controlled movements. It states in notes that she was able to stand and escorted back to room but there was no mention of her pain; was she able to weight bear normally? [Mrs A] was complaining of pain (as noted at 1500 27th June) but no pain relief was given until 2100 hours.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

Most assessment was adequately completed. Pain relief was delayed; the Medimap chart shows that paracetamol was not dispensed until 2100 hours. Pain relief over the next three days was sporadic. It is noted [that Mrs A] was unable to rate pain. This would indicate a verbalisation issue but does not preclude the regular dispensing of pain relief to this client. She was very under dosed and was consequently most likely very uncomfortable.

I would consider this a moderate degree of departure from standard care and accepted practice.

c. How would it be viewed by your peers?

I believe that my colleagues in practice and education would find the assessment of [Mrs A] as adequate but further examination and follow-up may have indicated the extent of her injury sooner. Her pain relief was inadequate as it was not dispensed regularly and would have resulted in significant discomfort.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

A head to toe assessment was completed by the RN at the time of the incident this however was not enough to determine the underlying fracture. Pelvic fractures (no information regarding the type, location or displacement if any provided in notes) can be quite stable and weight bearing is not uncommon. Further assessment for fractures

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could be built into the head to toe given the advanced age of the clients in care and the risks of bony injury with minimal force. Regular pain relief is essential especially in those clients that find it difficult to verbalise their pain.

Photographs could be taken of the injuries also (face) for notes and to send through to a physician to provide a more detailed picture of the client's injuries and for wound care assessment should the area break down and require further treatment.

8. The overall standard of care provided to [Mrs A] by [the rest home]

a. What is the standard of care/accepted practice?

[Mrs A] had documented falls on the following dates in May/June 2017:

- 10/5/17 — onto knee ?family notified
- 21/5/17 — fall not well documented in notes, neuro observations commenced, family notified
- 22/5/17 — fall in toilet not documented in notes until 23/5/17, ?family notified
- 29/5/17 — fall not well documented in notes, ?family notified
- 20/6/17 — fall not well documented in notes, neuro observations commenced, family notified
- 27/6/17 — fall documented in notes well, neuro observations commenced, family notified

[Mrs A's] InterRAI assessment states that she is a high falls [risk] but this does not correspond with the score of 4 on her Falls Risk Assessment at the date of this incident. Given the number of falls [Mrs A] had in the previous weeks a full reassessment, as per the falls flowchart needed to have been undertaken. The fact this was not done and that the falls documentation does not fit with the pattern seen in her daily notes indicates a lack of cohesiveness in the care of this client.

Following on from the falls in May if the falls policy had been adhered to [Mrs A] may well have had her falls risk reassessed at this time and some of the strategies from the falls flow chart implemented. The fact that a review was not implemented or at the time of any of the other falls prior to the 27th June 2017 means that [Mrs A] was put at risk.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

The falls policy and the falls flowchart provided by [the rest home] are straightforward and easily implemented if the appropriate assessments are completed for the client. In this instance the lack of procedural adherence resulted in a significant injury to [Mrs A] and given her age her recovery is likely to be prolonged. Adherence to the policy would have initiated any of the following.

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- Review by MDT would have been initiated (21–28 April last review)
- Use of hip protectors
- Test treat infection — increasing periods of confusion (goal 2 in NCP)
- Last assessment of walker safety

I would consider this a high degree of departure from accepted practice and standard of care as the failure of follow-up regarding [Mrs A's] falls and the poor documentation of some of the falls noted above resulted in significant injury.

c. How would it be viewed by your peers?

I believe my peers in practice and education would agree that there are significant gaps in the management of [Mrs A's] safety. Her increasing age and decreasing mobility have not been fully reassessed following the increasing number of falls in the preceding months of May/June 2017.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

All falls need to be well documented in the client's notes with some way of highlighting this so that action is taken within a prescribed period of time. Several of the falls noted above were not well documented in [Mrs A's] notes with any degree of detail.

There is a need to have more cohesion between the documentation to ensure that assessments that are completed are actioned. For example in this instance the InterRAI assessment, falls assessment and notes would have alerted a reassessment. A falls database would be useful if not already in place (is the Falls Register digital?). This could trigger alerts when a fall is entered and ensure follow-up as per the falls flow chart provided. This fits with 5.5 Falls Analysis in the falls policy of [the rest home].

9. Any other matters in this case that warrant comment

a. What is the standard of care/accepted practice?

In regards to the cleanliness of [Mrs A's] room there is evidence that her carpet was regularly cleaned and when requested. The 'ant infestations' usually occur over the colder months such as indicated in this case. Ant treatment had been undertaken in the previous 12 months. They do seek out a food source once inside with open packaging etc. a prime target. Keeping food in closed containers and wiping surfaces along with the ant treatment may mitigate the issue.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

[The rest home] have undertaken cleaning and pest control in response to requests from staff and family. Regular wiping down of room surfaces and insect spray if there are any localised pests should be adequate.

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I would consider this a minor departure from accepted standards if any.

c. How would it be viewed by your peers?

I would expect that my peers in practice would agree that these steps are adequate.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

Overall recommendations:

- It is advisable not to shorten, abbreviate or use other similar 'text' language in notes. This minimises the risk of misinterpretation and potential for error e.g. p'mol for paracetamol
- It was noted that there was use of imperial measures in the patient notes. Again this can be confusing and lead to error. Metric measures should be used in all clinical notes in New Zealand to avoid confusion.
- Routine photographs of wounds and/or injuries is very helpful and easily managed with digital devices. This would be useful if further treatment is needed and gives a baseline for management. It also fits with the use of the recommended wound care policy and standards.

References

Ministry of Health. 2016. Designated Auditing Agency Handbook: Ministry of Health Auditor Handbook (revised 2017). Wellington: Ministry of Health.

Wound Care Association. 2008. Skin care guidelines. NSW Australia."

The following further advice was obtained from RN Hogarth:

"HDC REPORT

REFERENCE: C17HDC01304

1. Thank you for the request to provide additional clinical advice regarding the care provided by Oceania Healthcare NZ Ltd and its employees to [Mrs A] between October 2016 and July 2017.

   In preparing this further advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1989. Upon registration I was appointed to a new graduate position at Waikato Hospital and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Waikato hospital. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract I moved to England and worked as an

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RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as the weekend nurse and casual as a RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enrol in a PhD which I did following a further year of travel where I worked as an RN for the Australia blood service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role 2 days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Midwifery and Nursing students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full time position in the School of Nursing at Otago Polytechnic where I am still currently employed as a Principal Lecturer, Curriculum Leader and Programme Leader Year 2. I am also a Justice of the Peace for New Zealand having completed the requirements for this role in 2016.

3. The Commissioner has requested that I review the documentation and provide further expert advice on whether I consider the care provided to [Mrs A] by Oceania Healthcare NZ Ltd and its employees was reasonable in the circumstances and why.

   With particular comment on:

   a. changes to my initial advice in any way in regard to the care provided by Oceania Healthcare NZ Ltd.
   b. identify individuals (if any), responsible for the departures identified in my advice received on 29th November 2017
   c. comment on the appropriateness and adequacy of the policies listed above
   d. whether I have any advice about the manner in which the staff adhered to the policies
   e. comment on the adequacy of the staffing arrangements as detailed in the staffing rosters in relation to monitoring [Mrs A] when she was mobilising.
   f. comment on any other matters in this case that you consider relevant.

For each question I am asked to advise:

a. what is the standard of care/accepted practice?
b. if there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?
c. how would it be viewed by peers?

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d. recommendations for improvement that may help to prevent a similar occurrence in future.

4. In preparing this report I have reviewed the documentation on file:

   1. Letter of complaint dated […]
   2. Response from Oceania Healthcare dated 21st August 2017.
   3. Oceania Healthcare's response dated 31st August 2018, including

      a. Response letter
      b. Roster
      c. Position descriptions
      d. Key nurses and signatures
      e. RN statements
      f. Falls/incident reports
      g. InterRAI LTCF form
      h. Person centred care plan
      i. Multi-disciplinary review form
      j. Faxes from GP
      k. Moving and handling policy
      l. Care progress notes 10th November 2015 to 12th July 2017
      m. Education log
      n. RN orientation
      o. manual

5. Background

[Mrs A] became a permanent private paying resident of [the rest home] on the 5th October 2016. At the time of her admission [Mrs A] had several serious health conditions; Parkinson's disease, cerebral atrophy, cerebrovascular disease, osteoarthritis (knees), cataract and atrial fibrillation.

[Mrs A's] mobility was very poor and she used a walking frame to mobilise. Prior to this event, during the period of the 10th May–20th June 2017, [Mrs A] had five falls on separate days (more than two falls in one month). An InterRai assessment completed on 12th June 2017 stated that [Mrs A] had three or more falls during the last thirty days and assessed her as 'high falls' risk. In [Mrs A's] care plan the falls assessment score was 4 and she was assessed as 'medium risk'.

[Mrs A's] daughter, [Mrs B] complains that her mother fractured her pelvis following a fall inside [the rest home] on 27th June 2017. After the fall, her mother was not taken to [hospital] until the 30th June 2017 despite a recommendation from the doctor to do so. Following admission to [hospital] an x-ray indicated that [Mrs A] had a fractured pelvis.

6. Changes to my initial advice in any way in regard to the care provided by Oceania Healthcare NZ Ltd.

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On review of the additional information provided there are some areas that I would like to highlight.

The incident form of 27th June 2017 states that client was 'dragged' to her feet by holding her pants. The Oceania Healthcare Moving and Handling policy states that a hoist must be used if a client is unable to get to their feet themselves or with minimal assistance.

The Oceania Healthcare Falls Management policy states that when a resident falls they must be assessed by the most senior staff member (assume this means health professional as this is not clear in the policy) on duty which in this instance was the Clinical Leader as per the roster.

The clinical leader (as per the job description) should have overall knowledge of the residents and therefore ensure that the information is entered into the falls register and also ensure that the InterRAI assessment is updated for the client. The main failing in this instance is the fact that the frequent falls by [Mrs A] were not documented cohesively with differences in the falls risk assessment and InterRai which meant that the care plan was not updated and therefore no further interventions such as hip protectors, or closer supervision when mobilising, were put in place this means that [Mrs A] was put at risk.

The HCAs that witnessed the incident are not named in either of the reports by [RN E] though on the incident form this states that it was [Ms I] however on the roster she was not due on shift until 1500hrs whereas the incident occurred at 1400hrs, did she begin shift early? The 2nd witness [Ms M] is not on the roster, assuming he/she staff.

The Staff Incident Reporting and Investigation form completed by [Ms D] states the body part involved was to the back and shoulder (is this of a staff member, potential injury?), this report is more thorough than the incident report related to this event for [Mrs A]. This is also where the witnesses are named as above.

a. What is the standard of care/accepted practice?

All falls should be documented accurately including the description of the incident, and the injuries sustained by the client need to be accurate (ACC). All staff must adhere to the Moving and Handling policy of the facility to ensure they are not injured during the care of a client.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

From the information provided, two policies were not adhered to in this instance

- Oceania Healthcare Falls Management Policy
- Oceania Healthcare Moving and Handling policy

This is a significant departure from the accepted standard of care.

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As the Falls Management policy was not followed with the documentation of the increasing number of falls and more than 2 in one month by [Mrs A], this resulted in a significant injury to her.

Failure to adhere to the Moving and Handling policy meant that staff were put at risk of injury and that [Mrs A] was moved in a way that was not acceptable i.e. 'dragging' her to her feet.

c. How would it be viewed by your peers?

I believe that my colleagues in practice and education would find the failure of staff and the facility to meet the requirements of their own policies is not acceptable practice. Even more so when it results in an injury to a client.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

Regular policy updates and staff training need to be undertaken to ensure currency. As the training roster does indicate that staff have participated in training there may need to be some accountability if policies are not adhered to following intervention such as training.

Review of the policies regularly by a third party may be useful to pick up anomalies e.g. specific language in the policy would clarify the roles of the staff members.

7. Identify individuals (if any), responsible for the departures identified in my advice received on 29th November 2017

Staff identified

- [RN E]
- [Ms I]
- [Ms M]

The three staff above as they did not adhere to the Moving and Handling policy requiring a client to be lifted by a hoist if the client is unable to get to their feet unassisted or with minimal assistance.

- Clinical Leader [RN C]

The Clinical Leader as the senior health professional on duty should have attended the fall and ensured that a full assessment was completed this would then have ensured that the documentation was complete. This RN should also have picked up that this client had had multiple falls prior to this incident and initiated strategies to minimise the risk to this client.

a. What is the standard of care/accepted practice?

Adherence to policies and procedures as per Oceania Healthcare.

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b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

Overall the failure of staff to adhere to policies resulted in a significant injury to a client therefore I would consider this a significant departure from the accepted standard of care. However I do not wish this to be punitive, rather an opportunity to learn and to put in place strategies to ensure that this does not happen to another client.

c. How would it be viewed by your peers?

I believe that my colleagues in practice and education would find the failure of staff and the facility to meet the requirements of their own policies is not acceptable practice.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

As in 6d above. There are further training opportunities and clarification about the role of senior staff when a fall occurs in the facility. This will ensure that complete assessment is completed and that the appropriate documentation is completed with the tracking for clients highlighting where action needs to be taken.

8. Comment on the appropriateness and adequacy of the policies listed above

Overall the policies are succinct and easily understood, some more specific language would strengthen this.

a. What is the standard of care/accepted practice?

The Falls Management policy is not specific enough. For example 5.3 states that:

> 'All residents that fall must be assessed for injury by the most senior staff member on duty …'

In many places this would be the manager who may or may not be a health professional.

This would be more specific if it read:

> 'most senior health professional or carer on duty'

In this facility there is a Clinical Leader who is a registered nurse so according to this policy they should have attended this fall and made an assessment of [Mrs A] prior to moving her.

The Moving and Handling policy is concise, easy to follow and fits with other similar policies in other facilities.

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b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

The wording in the Falls Management policy is a mild departure from the accepted standard and is really only because it needs to be specific.

c. How would it be viewed by your peers?

I believe that my colleagues in practice and education would find the wording of the policy is ambiguous and needs clarification.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

As in 6d and 7d above.

9. Whether I have any advice about the manner in which the staff adhered to the policies

As in section 6 and 7 above.

Staff did not adhere to the policies mentioned above.

Falls Policy

The failure to adhere to the Falls Management policy in relation to the care of [Mrs A] over the weeks prior to the 27th June 2017 meant that [Mrs A] was placed at risk.

The Falls Risk Assessment, InterRAI and care plan were not cohesive and therefore her falls risk from the Falls Prevention Flow Chart was not accurately documented.

Moving and Handling policy

The staff directly involved in the incident of the 27th June 2017 did not adhere to the above policy in regards to the moving of [Mrs A] off the floor following her fall. This put both the client and the staff involved in manually lifting her at risk of injury.

a. What is the standard of care/accepted practice?

Staff should adhere to the policies of the facility, this is a minimum standard to ensure the safety and care of the clients in the facility and to ensure the safety of the staff especially around falls and manual handling.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

As above the failure of staff to adhere to policies resulted in a significant injury to a client therefore I would consider this a significant departure from the accepted standard of care.

c. How would it be viewed by your peers?

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I believe that my colleagues in practice and education would find the failure of staff and the facility to adhere to the policies is not acceptable practice.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

As in 6d and 7d above.

Staff need to regularly read the Health and Safety training manuals.

10. Comment on the adequacy of the staffing arrangements as detailed in the staffing rosters in relation to monitoring [Mrs A] when she was mobilising

The staffing levels indicated on the roster are what would be accepted as normal practice for this number of clients in a facility. It is unclear however if there was a 2nd RN on in the AM shift during the week beginning 26th June 2017. Alternatively the Clinical Leader may have been counted as the 2nd RN.

The roster shows:

RN-AM 0645–1400 Monday–Friday there is no name or tick next to this on any day that week.

RN-AM 0645–1515 Monday–Thursday [RN E]

If there is only one RN on shift this means that they were potentially short staffed on this week. It is noted that there is an on call staff member but not their role.

a. What is the standard of care/accepted practice?

The staffing levels indicated on the roster are what would be accepted as normal practice for this number of clients in a facility. An example of like facility staffing:

Residential — minimum

- 1 RN — best practice
- 1 HCA per 8–10 residents — depending on the residents' needs

Hospital — minimum

- 1 RN
- 1 HCA per 5 residents — depending on the residents' needs

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

The roster shows adequate numbers of staff have been rostered on for the shift in question though there are my queries as above regarding the 2nd RN and the timing of the shift of [Ms I] and [Ms M].

I do not see any departure from the accepted standard of care.

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c. How would it be viewed by your peers?

I believe that my colleagues in practice and education would find this acceptable practice.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

Accuracy of roster records could be strengthened also from a health and safety perspective to know who is in the facility e.g. if there is an emergency.

11. Comment on any other matters in this case that you consider relevant

a. My main comments from my first review of this case are still to be reiterated. The delay of three days for a physician assessment is too long.

Failure of the staff on shifts following the fall on the 27th June 2017, to reassess [Mrs A] to determine the cause of her continuing pain and implementing a call to the physician by the morning of the 28th June 2017. Also the inadequate pain relief that was provided to her. The Clinical Leader should have been involved in this reassessment in a follow up to [Mrs A's] fall the previous day. It can be difficult to immediately assess the extent of injury in an elderly person but I would suggest that any fall that has an injury especially to the face in someone prone to confusion would warrant checking by a physician within 24 hours of a fall.

b. Recommendations for improvement that may help to prevent a similar occurrence in the future.

I would recommend that follow up reassessment of any client that has had a fall should be completed by the most senior health professional on duty within 12–24 hours of the incident. This would allow a more streamlined approach to post fall reassessment and ensure that all the appropriate documentation is cohesive. A simple assessment tool may assist with this. This then needs to be communicated to the staff caring for the resident to ensure that any changes are actioned in a timely manner."

The following further advice was obtained from RN Hogarth:

"HDC REPORT — ADDENDUM

REFERENCE: C17HDC01304

Review of a statement submitted by [RN C], Clinical Manager, Oceania Healthcare NZ Ltd regarding the care of [Mrs A] around the time of her fall on the 27th June 2017.

On review of this letter I do not have any changes to my previous advice regarding the care of [Mrs A]. [RN C] does not offer any further information that would alter this advice. There is no specific information about [Mrs A] in her letter relating to the incident of 27th June 2017. This case is about one patient; [Mrs A], a 90 year old slight

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woman weighing ~57kg with a history of recurrent falls. In this instance her fall resulted in an injury to her head and her pelvis.

I absolutely agree that from staff accounts that there was no intent to cause further pain and suffering to [Mrs A] and the care provided was considered though not adequate as far as assessment and pain relief are concerned.

As [RN C] states she would greet all residents as part of her daily routine. I would expect that any concerns from the previous day would be addressed at this time in the conversations with the clients and the RN especially incidents that resulted in injury. If [RN C] had spoken to [Mrs A] she must have noticed the injury to her head and this should have triggered a more in depth conversation and assessment (by herself or as instructed to the RN on duty) and then documented as it would have been an alteration to [RN C's] 'daily routine'. I agree that there is no need to document every normal interaction but what is the point of this daily routine if there is no further action for clients that have had incidents?

Staffing is a perpetual issue in residential care but should not be used as an excuse for non-provision of care to clients. Counting incontinence products would in my opinion not be a priority for a senior staff member when there are staffing issues, as indicated by [RN C], around the days of this incident.

As stated by [RN C] the documentation of falls and the follow up and management of patients with recurrent falls needed to be strengthened as does the language of the Falls Policy. This includes clarification about who the senior staff member is and the roles of the senior leadership in the management of falls rather than solely relying on the 'overworked' RNs on the floor. The Falls Management policy 5.3 states that: 'All residents that fall must be assessed for injury by the most senior staff member on duty …'.

Also the review of clients who have recurrent falls and the warning scores this should trigger meaning that if properly implemented [Mrs A] should have had hip protectors in situ due to her increased risk.

Therefore I reiterate my advice from my review of this case as submitted on the 13th December 2018.

Dr KJ Hogarth
KJ Hogarth
11th April 2019"

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