The Selwyn Foundation

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC00912)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This opinion relates to the services provided to an elderly independent living resident at a retirement village, which is owned and operated by the Selwyn Foundation.

2. The occupation licence between the retirement village and the woman required her to purchase entry-level care services, which included a telephone call from a registered nurse once a month for ten months in each year, and a visit by a registered nurse to her apartment unit once every six months for up to half an hour per visit, to check her wellbeing.

3. The retirement village considers that the services it provided did not meet the interpretation of "health services", and therefore the Code of Health and Disability Services Consumers' Rights (the Code) did not apply.

4. The woman had a fall, and when she was visited by a Resident Services representative, the representative said that the woman did not agree to see a nurse. The representative visited her again later that day and found her slumped down in her chair and confused. She was unable to move and was complaining of pain in her back, so the representative rang for an ambulance.

5. The woman was transported to hospital.

Findings

6. The Deputy Commissioner considered that in these particular circumstances, both the representative and the retirement village were healthcare providers, and therefore the Code applies to the services provided to the woman.

7. The retirement village's care of the woman was found to be inadequate. The processes and procedures for independent living residents were insufficiently clear to staff, and its training and monitoring of practice was insufficient. The system for completion of the floor register meant that staff believed they could sign in on behalf of residents. The initial call to the woman was made by reception staff, who communicated with the representative in an environment that was noisy and not conducive to effective handover of information. There was a lack of policy to guide the representative when he visited the woman.

8. The Deputy Commissioner found that the Selwyn Foundation failed to provide services to the woman with reasonable care and skill, and that it breached Right 4(1) of the Code.

9. Comment is made that during the representative's first visit, he should have recognised the need to seek clinical assistance, or suggested to the woman that she contact her family.

10. The Deputy Commissioner highlighted that this case presents a valuable opportunity for the wider retirement village sector to learn from the events that transpired. The provision of health and disability services to residents who live independently within a retirement village setting is not unique to the retirement village. It is reasonable to assume that such living arrangements will only increase in the future as the population of older people grows, and more demand is placed upon aged residential care services. It is also reasonable to assume

that an increasing number of older people with comorbidities will continue to live independently within retirement villages for longer periods, with prerequisite support services in place. For the system to operate effectively, and for these residents to remain safe and continue to live well, it will require respective roles and the scope of responsibility of all the parties concerned to be defined clearly and followed consistently.

Recommendations

11. It is recommended that the Selwyn Foundation and the representative each apologise in writing to the woman's family for the criticisms in this opinion.

12. It is recommended that the Selwyn Foundation:

- Develop policies that cover falls and head injuries and are applicable to independent living residents, and arrange training for relevant staff on the content of the policies.
- Review the training of staff with regard to the Code, and ensure that all relevant staff have training on Selwyn Foundation policies that apply to independent living residents.
- Ensure that all Resident Services representatives have a current first aid certificate, and consider whether reception staff should also be required to have a first aid certificate.
- Ensure that a copy of the Code is provided to all existing residents, and subsequently include the Code with all entry information.
- Develop a process to record the content of conversations between residents and staff regarding health issues.
- Prepare information for residents explaining the Independent Living Emergency Response policy and, in particular, the circumstances when it will be determined that an emergency situation exists.
- Review the Floor Register Check Procedure to determine whether the procedure should specify that residents must sign or place a tick on the register themselves, and that staff may not do so for them.

Complaint and investigation

13. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his mother, Mrs A (dec), at a retirement village. The following issue was identified for investigation:

- *Whether the Selwyn Foundation provided Mrs A with an appropriate standard of care in 2018.*

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

15. The parties directly involved in the investigation were:

Mr B	Consumer's son
The Selwyn Foundation	Provider
Provider/retirement village	

16. Further information was received from:

Ms C	Resident hospitality staff member
Ms D	Provider/receptionist
Ms E	Provider/receptionist
Mr F	Provider/Resident Services representative
District health board	

17. Independent expert advice was obtained from Registered Nurse (RN) Julia Russell (Appendix A).

Information gathered during investigation

Introduction

18. This opinion relates to the services provided to Mrs A at a retirement village operated by the Selwyn Foundation. At the time of these events, Mrs A was aged in her eighties and was living independently in an apartment. She was taking a number of medications, including dabigatran (a blood-thinning medication that slows down the body's ability to clot blood).

19. In response to the provisional opinion, the Selwyn Foundation said that the staff involved were not aware that Mrs A was taking dabigatran, as she was residing in independent living accommodation and managed her own medication. The Selwyn Foundation stated:

> "Even if the staff involved were aware that [Mrs A] was taking dabigatran it is very unlikely that they would have been aware of the significance of that medication, [as] knowledge of the effect of such medications is beyond what would be expected of staff in these roles."

20. The Selwyn Foundation told HDC that independent living consumers are reviewed at the time they move in, to check their fitness to live independently — as would be done in any private home — and to check whether there are health-related issues that would place them at undue risk. The Selwyn Foundation stated:

> "The residents do not require ongoing medical or clinical support, are able to come and go as they want and they purchase other services, such as cleaning, meals and laundry services, from the Village as required. The resident is able to continue using their own General Practice Doctor, clinics of their choice and other medical and support services as they need."

21. The occupation licence between the retirement village and Mrs A required her to purchase entry-level care services, which included a telephone call from a registered nurse once a month for ten months in each year, and a visit by a registered nurse to her apartment unit once every six months for up to half an hour per visit, to check her wellbeing.

22. In response to the provisional opinion, the retirement village accepted that it is a health service provider when providing aged residential care services in its care homes and when providing certain services to independent living residents. The retirement village acknowledged that the routine calls and visits from a registered nurse included in the lifestyle services package offered to Mrs A were health services.

23. However, the retirement village did not agree that the services provided to Mrs A at the time under investigation were health services, or that if they were considered to be health services, they fell below the standard of being provided with reasonable care and skill, having regard to the services that were promised in Mrs A's occupation licence and disclosure statement.

24. The retirement village told HDC that its view is that the services it provided, and the checks conducted (discussed below), did not meet the interpretation of "health services", and therefore the Code of Health and Disability Services Consumers' Rights (the Code) did not apply.

25. The retirement village said that retirement village residents were not provided with copies of, or information about, the Code as part of their information package (provided before entering into the occupation licence). The retirement village accepts that Mrs A should have been provided with a copy of the Code at the time of entry.

Resident Services representatives

26. The job description for Resident Services representatives provides the following:

> "The person in this position is responsible for providing professional care services to residents living independently. Resident service representatives provide support and help for residents in different ways throughout the day, liaising with families as well as welcoming visitors to the village."

27. The job description provides that Resident Services representatives work closely with the village managers and with the Wellness/Medical Centre staff on behalf of the residents, in order to ensure that residents are offered the support and care provided by the village. The job description states that Resident Services representatives undertake welfare visits as scheduled, complete any documentation required, and update the resident database, including making notes of observations. The job description does not state what a welfare visit entails.

28. Resident Services representatives are required to have a first aid certificate. They undertake first response duties, which include answering emergency calls and system alerts then going to the resident's apartment, meeting and assisting emergency services such as ambulance staff, responding to the resident's needs while seeking help, and completing incident

documentation. The retirement village said that each independent living unit is fitted with emergency call points with buttons to push in an emergency, and the residents also receive a call pendant for use in an emergency. When triggered by the resident, the alarm is relayed to a third-party provider. After hours, the on-duty village registered nurse or the senior registered nurse on duty at the hospital/rest home is contacted by the third party provider, and will act as the first responder.

Sign-in process

29. The retirement village told HDC that some of the units and residents have a daily sign-in check. The process was not documented, but the practice was that the Resident Services team checked the floor register book each morning and followed up with any resident who had not signed in for the day. In general, this was done after 11am each day. The following occurred when a resident did not sign in:

- The Resident Services team checked the floor register book after 11am and contacted the resident if the resident had not signed the book.
- If the resident was unwell or had had a fall, the Resident Services team member enquired whether any assistance was required and assisted with any arrangements.
- If an emergency had occurred, the Resident Services team member would make an assessment of the situation, call for an ambulance (either through activation of the emergency call point or through a 111 call), and either call for the village registered nurse to assist if required or stay with the resident until the emergency services arrived. The Resident Services team member would also advise reception or another team member of the emergency, so that the emergency services could be provided access into the relevant building and unit.
- Following the incident, the family would be contacted if the resident requested it or if the resident had experienced an emergency and was hospitalised.

Emergency alarm process

30. The retirement village said that if a resident activates their alarm, their unit/apartment is called and, if the resident answers, the staff member determines the nature of the emergency. Based on the nature of the emergency, the staff member may then call for an ambulance to attend to the resident, and also alert the relevant village staff members. The Resident Services team will dispatch a first responder with first aid training to attend to the resident. On arrival, the Resident Services team member makes an assessment of the emergency and may decide to call the village registered nurse to assist with more advanced care until the emergency services arrive, or proceed to apply basic first aid if required until the emergency services arrive.

31. If the resident does not answer the call from the third-party provider of the alarm-monitoring services, the relevant village staff members are alerted through the arranged channels, and the Resident Services team will dispatch a first responder with first aid training to attend to the resident. The first responder will assess the emergency and may then call the emergency services, request the village registered nurse to attend the resident, or take

other action as appropriate. An example of other action is arranging for an ill resident to attend the village medical centre and calling family if requested.

Events

Concerns raised about Mrs A

32. One morning, Mrs A did not sign the floor register book, or come down from her apartment to go on a shopping trip as usual. The retirement village receptionist Ms E stated that the shuttle driver noticed Mrs A's absence from the scheduled shopping trip and told the reception staff.

33. The receptionist, Ms D, stated that she rang Mrs A to ask her whether she would be going shopping, and Mrs A replied that she was not going as she had hit her head the previous day and was not feeling well. Ms E said that Ms D told the driver that Mrs A would not be going as she had fallen and did not feel well.

34. The retirement village stated that Ms D and Mr F are not registered health providers or caregivers. It said that both are employed within the independent living operations and do not provide clinical services.

35. The retirement village told HDC that the reception staff had no documented process to follow in this situation. The retirement village advised that all of its Resident Services team hold up-to-date first aid certificates. HDC asked the retirement village to provide evidence that the staff involved held current first aid certificates in 2018, whether they were aware that Mrs A was on dabigatran and the significance of that, and whether the staff involved had received training on unwitnessed falls or head injuries. However, the retirement village did not respond to these questions. Subsequently, in response to the provisional opinion, the retirement village provided a first aid certificate showing that Mr F underwent basic first aid training in late 2016, which meant that the certificate was current until late 2018. The retirement village said that its reception staff are not required to be trained in first aid.

36. Ms E stated that she and Ms D discussed Ms D's conversation with Mrs A at the time, and then asked Resident Services representative Mr F to check on Mrs A.

37. Ms D stated that she explained to Mr F that Mrs A did not sound her normal self, and that Ms D had told her that Mrs A had hit her head the previous day.

38. Mr F told HDC that at around 10.30am Ms D told him that Mrs A had had a fall. He stated:

> "[Ms D] was standing at the door, and I was sitting on my desk. Didn't hear [Ms D] saying '[Mrs A] hit her head', she saying the message in the doorway, lots of noise and I was attending another resident's concern."

39. Resident Hospitality staff member Ms C stated that she shared an office with Resident Services staff. She said that on that morning, Ms D came in and stood by the filing cabinet facing Mr F. Ms C said that she was concentrating on her work at the time, so she was unable to relate the full conversation that Ms D had with Mr F, but she did hear Ms D say that she

had called Mrs A when she had not shown up, and that Mrs A had told her that she had had a fall during the night. Ms D asked Mr F to check on Mrs A.

First visit

40. Mr F said that he went to see Mrs A at around 11.10am. He stated that Mrs A did not open the door when he knocked, so he opened the door and found her sleeping on her chair. He said that he called her name when he was inside and said, "It's me [Mr F]," and she replied, "It's you [Mr F]." He said that he asked her about the fall, and she replied, "I can't remember, but I am okay, I just feel tired and want to sleep."

41. Mr F said that Mrs A did not mention having hit her head, or having a sore back. He said that he saw a spot of dry blood on her neck and asked her what had happened, and she replied that she was all right. He stated that he tried to check her neck, but she gestured him away and said, "I am OK … I'm tired and just want to sleep."

42. Mr F said that he asked Mrs A if she wanted a nurse, and she replied that she was "OK", so he advised her to activate her alarm if she needed help. He said that he did not stay long, and made a note to himself to check her later. He stated that she was smiling when he left. Mr F then filled in the floor register book with "OK" on behalf of Mrs A. The retirement village said that at the time of these events, some staff thought it was an acceptable practice to sign the floor register book on behalf of independent living residents, and the retirement village had no policy to the contrary. The retirement village stated:

> "As [Mrs A] appeared to respond to [Mr F's] questions in a coherent manner and refused assistance, [Mr F] signed the register as was the practice at the time."

43. The retirement village stated that Mr F said that during this visit he was standing diagonally across from Mrs A and did notice some dry blood, but when he enquired as to the cause of it and whether any assistance was needed, she refused his offer. The retirement village stated that Mr F did not physically force Mrs A to undergo a more thorough check, and to have done so would have been in breach of her rights, as she was "deemed to be coherent enough at the time", and was not in a clinical environment.

44. Mr B told HDC that his mother had sustained "a significant head injury and was suffering from a head concussion caused by an impact to the head". He stated: "[She] was in shock, disorientated, confused and amnesic caused by the impact to her head and consequently was not able to activate the Emergency Call Response." He considers that his mother's autonomy should have been overridden, because she had suffered a head trauma.

Second visit

45. Mrs A did not come down for lunch, so Mr F went back to her apartment at around 2.00pm. He stated that she was sitting in the same chair but she was slumped down with her head leaning back onto the back of the chair. He said that she was looking at him and he did not see any blood on her clothes. He stated that he asked her, "Do you know where you are?" and she replied, "I don't know."

46. Mr F said that Mrs A was unable to move and was complaining of pain in her back, so he rang for an ambulance (see para 49 below for the information he gave to the ambulance service) and informed Ms D that the ambulance was coming. He stated that Mrs A started to improve after the ambulance arrived. He said that the paramedics were with Mrs A for about 30 minutes and, at first, he thought they would not take her to hospital, but they did take her.

47. After the ambulance left with Mrs A, Mr F informed Mr B of the events that had occurred.

48. The retirement village stated that based on Mr F's statement, it considers that he acted appropriately during the second visit to Mrs A, and took the actions that it would expect a Resident Services staff member to take when observing a resident to be in need of emergency assistance.

Ambulance service

49. The ambulance service provided HDC with its clinical records, audio transcript, and information regarding Mrs A's presentation. The ambulance service stated that a 111 call was received at 2.08pm, and the ambulance arrived at the retirement village at 2.20pm and departed at 2.37pm, arriving at the public hospital at 2.55pm.

50. The audio transcript of the 111 call states that the caller said that there had been a report that Mrs A had had a fall the previous day, and when he visited her, she did not know where she was, and he saw blood on her neck and a stain going down to her chest. The caller said that the blood was already dry and there was some tissue paper there also with blood on it. He said that she looked pale and could not move.

51. The ambulance service stated that on arrival, the ambulance officers found Mrs A alert and sitting in her chair. She told the officers that she had fallen the previous day, but could not remember whether she had been feeling unwell, or had tripped and fallen. She told them that she was experiencing lumbar back pain. The record states that retirement village staff informed the officers that they had checked on her in the morning and again in the afternoon when she did not arrive for lunch, and decided to call an ambulance.

52. When the ambulance officers assessed Mrs A they found that she had a small laceration to the back of her head, and no other obvious or abnormal systems or injuries. There is no mention in the ambulance service record of her having hit her head.

53. Mrs A's initial vital signs were a heart rate of 89 beats per minute, a respiratory rate of 12 breaths per minute, blood pressure of 115/88mmHg, temperature of 36.6°C, and a blood glucose reading of 11mmol/litre (normal is less than 7.8mmol/L). The ambulance care summary lists Mrs A's current medications, including dabigatran (a blood thinner).

54. The Ambulance Care Summary states under the section for notes that Mrs A's last recollection was having lunch the previous day. The notes state: "Rest home staff checked [patient] this [morning], saw her sitting in chair, thought she was asleep, then rechecked [patient] at 2.00pm when [patient] didn't arrive for lunch."

55. The ambulance service stated: "The officers administered paracetamol, and Mrs A was transported to [the public hospital], travelling comfortably with no changes in her presentation."

Admission to hospital

56. Mrs A was assessed by an Emergency Department registered nurse at 3.05pm. A blood test conducted at 3.25pm showed signs of infection.[1]

57. Mrs A underwent a CT scan of her head at 7.03pm. The notes refer to an investigation to ascertain whether she had experienced a brain bleed or stroke. The results showed no brain bleed, but a likely new stroke when the scan was compared to a scan from 2014. Two staples were applied to close the cut on her head. Mrs A had an initial pH of 6.93.[2]

58. The hospital records state that Mr B said that three days previously his mother had told him that she felt as if she had the flu, and she had a cough and was a "bit chesty".

59. An X-ray conducted at 11.00pm showed that Mrs A had a broken bone in her upper arm and fluid in her lungs, with no evidence of consolidation (lung tissue filled with fluid rather than air). The working diagnosis was pneumonia, and Mrs A was administered antibiotics.

60. Sadly, Mrs A died at around 11.50pm. It is documented that the most likely terminal diagnosis was overwhelming sepsis, although no obvious skin, respiratory, or urinary source of the infection was identified. The cause of death on the death certificate is stated as "community acquired pneumonia".

Documented processes

Emergency Call Response Independent Living policy (2013)

61. The Emergency Call Response Independent Living policy in force at the time of these events set out the process to be followed if an independent living resident activated an emergency call point. The policy does not refer to the process to be followed in other circumstances.

Suspected Serious Injury guidelines (2017)

62. The Suspected Serious Injuries guidelines state that in the event of a resident accident where a serious injury may have occurred, and in a situation where pain and distress to the resident is obvious immediately after the incident, staff should not hesitate to arrange for the resident to be transferred to hospital.

[1] Including a significant leucocytosis (a sign of an inflammatory response) and "left shift", where young or immature white blood cells are present, most commonly the result of infection.
[2] The pH of the blood should be around 7.4. A lower pH means that the blood is more acidic. A pH of less than 6.8 or greater than 7.8 is considered to be incompatible with life.

Head Injury management procedure (2013)

63. The Head Injury management procedure states that the procedure applies to all residents following a head trauma (for example, a fall), especially for an unwitnessed fall, whether injury is obvious or not.[3] If the resident is conscious, the steps to be taken are:

- Summon help — call the registered nurse on duty
- Reassure the resident
- Transfer the resident to bed if able — otherwise place in the recovery position
- Make the resident comfortable and keep the resident warm

64. The criteria for the registered nurse to refer the resident to hospital following a head injury include any of the following:

- A Glasgow Coma Scale (GCS) score of less than 15 on initial assessment
- Any loss of consciousness as a result of the injury
- Any focal neurological deficit since the injury
- Any suspicion of skull fracture since the injury
- Amnesia for events before or after the injury
- Persistent headache since the injury
- Any vomiting episodes since the injury
- Any seizure since the injury
- Any previous cranial neurosurgical interventions
- A high-energy head injury, such as a pedestrian being struck by a vehicle, or a fall greater than one metre or more than five stairs
- A history of a bleeding or clotting disorder
- Current anticoagulant therapy such as warfarin
- Suspicion of a non-accidental injury

65. While the documented processes for serious injuries and head injuries state that they apply to all residents, it is unclear whether staff at the retirement village were aware of the processes, or followed them. The retirement village did not have in place a policy or procedure relating to the management of falls.

66. In response to the provisional opinion, the Selwyn Foundation said that the policies relating to unwitnessed falls and head injuries were written for, and applicable to, the care homes it operates and were not intended to be applied in the case of independent living residents. As independent living residents are required to be able to live in their unit with only limited supports available through lifestyle packages, the expectation was that where an

[3] As stated, the retirement village considers that this policy did not apply to independent living residents.

independent living resident had a fall this would be handled in the same way as a person living independently in the community. The resident would make their own decision about the level of assistance required following a fall or head injury, and would contact their own GP or make use of the emergency call system as required. Staff who worked solely with independent living residents therefore did not receive training on unwitnessed falls or head injuries.

67. The Selwyn Foundation said that following these events its Independent Living staff were made aware of the clinical head injury management procedure.

Further information

68. The Selwyn Foundation told HDC the following:

- The Resident Services team have first aid training in order for them to act as first responders during emergency evacuations and assist independent living residents in the event of activating their emergency call button or pendant.
- Any medication required may be ordered through the onsite medical services, but residents are responsible for their own daily dispensing and self-monitoring of related conditions.

Resident Incident Report

69. That day, Mr F completed a Resident Incident Report, which sets out the events from his perspective, including that Ms D told him that Mrs A had had a fall. The Incident Report form does not mention that Mr F was aware that Mrs A had hit her head.

70. The retirement village told HDC that the Resident Incident Report form was not completed to the standard it would normally expect. The retirement village noted that at that time, the same form was used for both independent living and residential care residents, and not all fields were relevant to independent living residents.

71. The retirement village stated that the completion of forms by Resident Services staff is covered as part of on-the-job training. It said that it operates a buddy system to support new Residential Services staff and, where necessary, further coaching is given at the time the incident form is reviewed and signed off by the Assistant Village Manager and Village Manager.

Photograph of chair

72. Mr B provided HDC with a photograph of the chair on which his mother was sitting at the time of these events. The photograph was taken after his mother's death. It appears to show a stain on the top of the back of the chair. The photograph also shows a tissue on a side table that appears to have blood on it.

Responses to provisional opinion

73. A response was received from the Selwyn Foundation, and has been incorporated into this report where appropriate. Further submissions made by the retirement village are outlined below.

74. The retirement village sees a clear distinction between the monthly monitoring by a registered nurse as included in the lifestyle services package, and the actions taken by Mr F and Ms D, which were not part of the services promised in the occupation licence and were more akin to a Good Samaritan noticing that a person was not participating in their usual activities and first calling, then visiting her to see if she required any assistance.

75. The retirement village does not agree that the provision of monthly monitoring by a registered nurse means that all contact between retirement village staff and residents ought to be treated as a health service. It said that residents who move into the apartments are required to be capable of living independently, and are at liberty to continue to see their own health service providers outside of the village. In the retirement village's view, the services provided by receptionists and the Resident Services team are similar to a concierge, focussed on resident experience rather than care and wellbeing. It stated that the occupation licence and disclosure statement provided to residents at the time Mrs A moved into the village did not promise or create an expectation from residents that they would be closely monitored by qualified health professionals.

76. The retirement village said that its staff responded as they considered appropriate in the circumstances, respecting Mrs A's autonomy initially and then obtaining appropriate medical attention when that was deemed necessary. Mrs A was presumed to be competent to make her own decisions about the care that she required, consistent with the Code. Mr F is not a health practitioner, and his assessment of capacity could not be as nuanced as might be expected of a medical practitioner. The retirement village submitted: "The actions of staff went above and beyond the services promised in the occupation licence and were appropriate given the staff members' knowledge of the circumstances."

77. The retirement village stated that Mr B's assessment of his mother's condition does not appear consistent with the assessments of the ambulance staff or public hospital staff. The ambulance officers found Mrs A alert and sitting in her chair, with a small laceration to the back of her head, and no other obvious abnormal signs of injuries. There is no mention in the ambulance service report of Mrs A having hit her head. The notes from the hospital refer to an investigation to ascertain whether Mrs A had experienced a brain bleed or stroke. The results showed no brain bleed, but a likely stroke at some time between her previous scan in 2014 and her admission to hospital in 2018, and there is no record of a head injury in the public hospital records.

78. The retirement village considers that there is no evidence that the fall reported by Mrs A was causative or contributory in her death.

79. The retirement village does not agree that there was confusion over the management procedure for a head injury. It stated that the procedure was written for a care home environment, not for independent living, and the application of the procedure was clear to staff. The retirement village acknowledged that the policy did not specifically state that it was intended only for use in the care home setting, but stated that this was because it was not contemplated that any staff member might be confused about its application. The

retirement village further stated that there was clear distinction in the application of policies depending on whether the policy was for independent living or residential care.

80. The Selwyn Foundation disagreed that staff completing the floor register defeated the purpose of the floor register process and was inappropriate. It said that the purpose of the floor register process was to identify if a resident had not left their apartment on a particular day, and ensure that a staff member made contact with them. Where a resident had not signed because they were feeling too unwell, as was the case with Mrs A, staff understood that their role was to discuss with the resident what, if any, further assistance they might want or need. Completion of the floor register by staff therefore served as an indication that this contact had occurred. The retirement village said that Mr F's comment of "ok" in the floor register meant that he was simply noting how Mrs A reported her condition at that time, and indicating that contact had been made. The retirement village stated:

> "This was particularly important on this occasion given his visit to [Mrs A] came about from the contact with [Ms D] and not as part of the floor register checks that would be carried out a little later in the morning."

81. Mr B was also given the opportunity to comment on the provisional opinion. He explained that Mrs A's medications were supplied by the on-site medical team, and therefore the retirement village was aware of, and had a record of, all medications Mrs A was taking.

82. Mr B stated that Mrs A was fit and well prior to this accident, and he is of the view that if the retirement village had had in place the correct policies that covered falls and head injuries, and had had in place training policies for relevant staff, she would have survived the accident.

Opinion: The Selwyn Foundation — breach

Introduction

83. At the outset I would like to express my condolences to Mrs A's family. It is clear that they were deeply distressed by her sudden death and believe that she did not receive adequate care at the retirement village, and that had the retirement village responded differently to events, the outcome for their mother may have been different. Despite this, it is not the role of HDC to determine causation. This opinion focuses on whether the retirement village provided services to Mrs A that were of an appropriate standard, and does not suggest that there was a causative link between the actions of staff and Mrs A's death.

84. Mrs A was an independent living resident in a retirement village. The initial issue to consider is whether the services provided to her fell within the jurisdiction of this Office. The retirement village stated that Ms D and Mr F are not registered health providers or caregivers, and do not provide clinical services, and its view is that the actions of its staff, including Mr F's checks of Mrs A, do not meet the definition of "health services". In response

to the provisional opinion, the retirement village accepted that the monthly monitoring by a registered nurse is a health service, but submitted that the actions taken by Mr F and Ms D were not part of the services promised in the occupation licence, and were more akin to a "Good Samaritan" checking whether Mrs A required any assistance.

85. The retirement village does not agree that the provision of monthly monitoring by a registered nurse means that all contact between staff and residents ought to be treated as health services. It said that the services provided by the receptionists and the Resident Services team were similar to a "concierge", focussed on resident experience rather than care and wellbeing. I disagree, and remain of the view that the services provided were health services.

86. The Commissioner's jurisdiction to consider a complaint under the Health and Disability Commissioner Act 1994 (the Act) requires:

- A health or disability service;
- A health care or disability service provider; and
- A health or disability service consumer.

87. Health services are defined in section 2 of the Act as services to promote and protect health; prevent disease or ill health; and treatment, nursing, rehabilitative, diagnostic, and counselling services. In my view, Ms D's response to the shuttle driver's concerns about Mrs A, and the actions taken by Mr F on the two occasions on which he visited Mrs A were health services, as the steps taken were to promote and protect her health, pursuant to section 2 of the Act.

88. Mr F's job description as a Residential Services representative included a number of duties, such as making notes of observations of residents and updating the resident database, first response duties, answering emergency calls, and responding to residents' needs while seeking help. To the extent that his duties encompassed services to promote and protect the health of residents, I consider that he was a healthcare provider.

89. Mrs A's occupation licence required her to purchase entry-level care services that included personal care services and health services, including a telephone call from a registered nurse once a month for ten months in each year, and a visit to her residential unit from a registered nurse once every six months for up to half an hour per visit to check on her wellbeing. There were also additional lifestyle packages available that included assistance with dressing, medication dispensing, and the like. In light of this, and to the extent that it provided services to promote and protect the health of residents, I consider that the retirement village is also a healthcare provider, pursuant to section 3(k) of the Act. Consequently, residents at the retirement village who are living independently under an occupation licence are entitled to services that comply with the rights set out in the Code.

90. At the time of these events, the retirement village did not provide new independent living residents with information about the Code. Clause 1(3) of the Code provides that every provider must take action to inform consumers of their rights, and enable consumers to

exercise their rights. My expert advisor, RN Julia Russell, advised that the Code leaflet should be provided with all entry information. I agree, and consider that all existing residents should also be reminded of their rights under the Code regularly.

Compliance with processes

91. Ms D became aware that Mrs A had not arrived to go on a shopping trip. She contacted Mrs A, who said that she had fallen and hit her head the day before and was not feeling well. The head injury management procedure states that the procedure applies to all residents following a head trauma, including an unwitnessed fall, whether injury is obvious or not. If the resident is conscious, the staff member should "Summon help — call RN on duty". In response to the provisional opinion, the Selwyn Foundation said that the policies relating to unwitnessed falls and head injuries were written for, and applicable to, the care homes operated by the retirement village, and were not intended to be applied to independent living residents. It said that staff who worked solely with independent living residents therefore did not receive training on unwitnessed falls or head injuries.

92. Ms D knew that Mrs A had fallen and hit her head, but she did not contact the registered nurse. Ms D and Ms E discussed what to do and decided that Ms D should ask Mr F to check on Mrs A.

93. Ms D then asked Mr F, who was trained in first aid, to check Mrs A. I am concerned that the noisy environment meant that although Mr F knew that Mrs A had fallen, by his account he was not aware that she had hit her head.

94. Mr F went to see Mrs A at around 11.10am. He stated that she did not open the door when he knocked, so he opened the door and found her asleep on her chair. He said that once he was inside, he called her name and said, "It's me [Mr F]," and she replied, "It's you [Mr F]." He said that he asked her about the fall, and she replied, "I can't remember, but I am okay, I just feel tired and want to sleep."

95. Mr F said that Mrs A did not mention having hit her head, or having a sore back. He said that he saw a spot of dry blood on her neck and asked her what had happened, and she replied that she was all right. Mr F said that he tried to check her neck, but she gestured him away and said, "I am OK … I'm tired and just want to sleep."

96. Mr F said that he asked Mrs A if she wanted a nurse, and she replied that she was "OK", so he advised her to activate her alarm if she needed help. He said that Mrs A was smiling when he left. The retirement village stated that during this visit to Mrs A, Mr F acted in line with the process as understood at that time, by asking her about the fall, offering to check the dried blood that he saw on her neck, asking her if she would like the nurse to visit, and advising her to activate her alarm if she needed assistance. The retirement village stated:

> "As [Mrs A] appeared to respond to [Mr F's] questions in a coherent manner and refused assistance, [Mr F] signed the register as was the practice at the time."

97. The retirement village did not expect Mr F to follow the head injury management procedure because it did not apply to independent living residents. However, he was aware that Mrs A

had had an unwitnessed fall and could not remember the events surrounding the fall. In response to the provisional opinion, the Selwyn Foundation said that its expectation was that residents would make their own decisions about the level of assistance required following a fall or head injury, and would contact their own GP or make use of the emergency call system as required.

98. The Emergency Call Response Independent Living policy that was in force at the time of these events set out the process to be followed if an independent living resident activated an emergency call point. The policy does not refer to the process to be followed in other circumstances. My nursing advisor, RN Julia Russell, said that the Emergency Call Response for Independent Living policy had not been updated since 2013, as would have been expected.

99. RN Russell advised that the retirement village needed to have policies covering matters such as falls. She said that there should be a suite of policies and procedures, including emergency management, and also adequate training of staff. She also advised that not having adequate policies and procedures, and associated training, to cover such events as Mrs A's fall was a severe departure from the standards expected.

Was this an emergency?

100. In contrast to Mr F's account of events, Mr B believes that his mother had sustained "a significant head injury and was suffering from a head concussion caused by an impact to the head". He stated: "[She] was in shock, disorientated, confused and amnesic caused by the impact to her head and consequently was not able to activate the Emergency Call Response." He considers that his mother's autonomy should have been overridden, because she had suffered a head trauma.

101. In response to the provisional opinion, the Selwyn Foundation submitted that Mr B's assessment of his mother's condition does not appear consistent with the assessments of ambulance or public hospital staff.

102. I note that neither the paramedics nor the ED staff found that Mrs A had a significant head injury or concussion. The Ambulance Care summary states that on arrival the paramedics found Mrs A conscious and alert, and a secondary survey showed a small laceration to the back of her head with "nil other obvious injuries". However, they also reported that she was unable to recall whether she was feeling unwell the previous day, or whether she had felt dizzy or tripped prior to the fall. The hospital found that Mrs A was alert with a small cut on the back of her head. She underwent a CT scan, which showed no brain bleed, although there was evidence of her having had a stroke at some time since her earlier scan in 2014.

103. Mrs A told Ms D that she had hit her head the previous day. As stated above, Mr F said that Mrs A did not mention to him having hit her head, or having a sore back. He said that she had a spot of dry blood on her neck, and she said that she was all right. He stated that when he tried to check her neck, she gestured him away and said, "I am OK … I'm tired and just want to sleep." The retirement village told HDC that Mrs A was presumed to be competent to make her own decisions about the care that she required, consistent with the Code, despite also arguing that the Code did not apply in that situation.

104. Mr F said that he offered to arrange for the nurse to visit Mrs A, but she refused. Right 7(7) of the Code provides that every consumer has the right to refuse services. However, if this was an emergency, Mr F could have overridden her refusal.

105. As stated by RN Russell, if Mr F had not spoken to Mrs A at the first visit, that would have been a matter of serious concern. However, I am unable to make that finding. There is no evidence that Mr F failed to speak to Mrs A, and the only witness to the visit was Mr F.

106. I note that there is no documentation that Mrs A had declined further assessment, but if, as Mr F said, Mrs A declined a visit by the nurse, I accept that he had to respect her decision if she was able to make an informed choice and it was not an emergency situation. A medical emergency is an acute injury or illness that poses an immediate risk to a person's life or long-term health. If Mr F had known that Mrs A had hit her head, and that she was on dabigatran (and he was aware that this could increase the chance of a brain bleed), then he could have been expected to call in the nurse despite Mrs A's refusal. However, I am not able to make those factual findings. I note that the retirement village submitted that Mr F did not know about Mrs A's medication, and even if he had known, he would not have been aware of the significance of it. In my view, as Mrs A had declined the offer to examine her or to contact the registered nurse, it would have been appropriate for him to suggest that she call her GP or her family, or for him to offer to do so for her. It would also have been appropriate for him to have contacted the nurse himself to discuss the situation and seek advice.

Signing floor register book

107. After his first visit to Mrs A, Mr F wrote "OK" in the floor register book on her behalf. The retirement village stated that at the time of these events, the process for carrying out checks in the independent living apartment buildings was not documented, but it was well understood by the Residential Services staff. It stated that some Residential Services staff believed that they could sign the floor register book on behalf of a resident once they had made contact with the resident.

108. RN Russell noted that at the time, no staff or senior management appeared concerned that Mr F had filled in "OK" in the floor register book, and she considers it likely that it had become a practice that staff would sign for residents, and it was therefore a systems issue. RN Russell advised that staff should not have been signing for residents, and she considers that this practice was a serious departure from the expected standards. In response to the provisional opinion, the Selwyn Foundation disagreed that staff completing the floor register defeated the purpose of the floor register process and was inappropriate. It said that the purpose of the floor register process was to identify whether a resident had not left their apartment on a particular day, and to ensure that a staff member made contact with them. Where a resident had not signed because of feeling unwell, as was the case with Mrs A, staff understood that their role was to discuss with the resident what, if any, further assistance they might want or need, and completion of the floor register by staff was an indication that this contact had occurred.

109. The Selwyn Foundation said that Mr F's comment of "OK" in the floor register simply meant that he was noting how Mrs A had reported her condition at that time, and indicating that contact had been made.

110. I acknowledge these comments, but I remain concerned that the notation in the register was unclear, and it did not identify the reason why Mrs A had not left her apartment that day or whether a further visit was planned. The notation "OK" suggests that there was no health concern, and does not identify who made the entry and the circumstances at the time. I remain of the view that this practice was inappropriate.

Conclusions

111. In my view, the retirement village's care of Mrs A was inadequate. The processes and procedures for independent living residents were insufficiently clear to staff, and its training and monitoring of practice was insufficient.

112. The system for completion of the floor register meant that staff could sign in on behalf of residents. The initial call to Mrs A was made by reception staff, who communicated with Mr F in an environment that was noisy and not conducive to effective handover of information. There was a lack of policy to guide Mr F when he visited Mrs A and discovered that she had fallen and did not recall the events that had occurred, and that she had a spot of blood on her neck. I consider that primarily the retirement village's systems were at fault. Accordingly, I find that the Selwyn Foundation failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

113. This case is important, and presents a valuable opportunity for the wider retirement village sector to learn from the events that transpired. The provision of health and disability services to residents who live independently within a retirement village setting is not unique to the retirement village. It is reasonable to assume that such living arrangements will only increase and become more complex in the future as the population of older people grows, and more demand is placed upon aged residential care services. It is also reasonable to assume that an increasing number of older people with comorbidities will continue to live independently within retirement villages for longer periods, with prerequisite support services in place. For the system to operate effectively and for these residents to remain safe and continue to live well, it will require respective roles and the scope of responsibility of all the parties concerned to be defined clearly and followed consistently.

Mr F — other comment

114. Ms D knew that Mrs A had fallen and hit her head, but Mr F said that he was not aware of this, or of her blood-thinning medication. The retirement village stated that it did not expect Mr F to follow the head injury management procedure because it did not apply to independent living residents.

115. When Mr F asked Mrs A about the fall, she replied: "I can't remember, but I am okay, I just feel tired and want to sleep." He saw dry blood on her neck and asked her what had happened, and she replied that she was all right. He said that he tried to check her neck, but she gestured him away and said: "I am OK … I'm tired and just want to sleep."

116. I consider that Mr F did not think critically. There were a number of concerning factors — Mrs A had blood on her neck, she could not recall the fall, and she was sleepy. Mr F had received first aid training and, during the first visit, he should have recognised the need to seek clinical assistance or to suggest that Mrs A contact her family.

117. After his first visit to Mrs A, Mr F wrote "OK" in the floor register on her behalf. The retirement village stated that Residential Services staff could sign the floor register book on behalf of a resident once they had made contact with the resident. It is apparent that this was accepted practice and, as such, I am not critical of Mr F for having written in the floor register.

The Selwyn Foundation — changes made

118. Since these events, the retirement village has outsourced the services provided by the on-site medical centre to a contracted service provider that supplies the nurses and GPs. Residents may use that service or their own GP.

119. The retirement village's independent living Residential Services staff have been trained in the updated procedures, and the staff have confirmed that if a resident advises them that they have suffered a medical incident, they follow the requirements in the procedure. The retirement village said that its staff understand that if a resident declines assistance and the staff are not in agreement with that, the staff can contact the Village registered nurse or the emergency services, if required.

120. The Selwyn Foundation stated that since these events it has documented the process for the floor register checks, and updated its processes so that residents must sign the floor register book themselves, or place a tick after their name. However, the updated Floor Register Check Procedure (January 2020) does not require residents to sign or place a tick themselves.

121. The Selwyn Foundation has also developed a Resident Incident Report form specifically for independent living residents, and has reviewed and updated its emergency response flow chart for independent living residents.

122. The Selwyn Foundation has also reviewed the independent living emergency call response procedure to be followed if a resident has made an emergency call by activating an emergency call button, or activating a pendant alarm. In February 2020, it updated the Independent Living Emergency Response policy, and now has a section setting out the process for when a staff member suspects that an independent living resident has suffered an urgent medical event but has not activated an emergency call (by activating their call button/emergency pendant), including where a resident has advised a staff member of an urgent medical event. The Policy states that examples of an urgent medical event include:

a) An unwitnessed fall with or without visible injuries;

b) A stroke with or without overt symptoms, such as facial drooping;

c) A serious health event such as pneumonia; and

d) The resident appears to be confused or disorientated.

123. The Selwyn Foundation said that it has reviewed and updated its standard occupation licence and disclosure statement for the retirement village to ensure that the documents clearly describe the services that it provides to independent living residents. The retirement village stated that the provisions of the occupation licence that Mrs A had entered into relating to entry-level care services have been removed from its standard occupation licence. It has reviewed and updated its marketing material for independent living residents to ensure that the services that the Selwyn Foundation offers are described clearly.

Recommendations

124. I recommend that within six weeks of the date of this opinion, the Selwyn Foundation apologise in writing to Mrs A's family for the criticisms in this opinion. The apology is to be sent to HDC for forwarding.

125. I recommend that within six weeks of the date of this opinion, Mr F apologise in writing to Mrs A's family for the criticisms in this opinion. The apology is to be sent to HDC for forwarding.

126. I recommend that within three months of the date of this opinion, the Selwyn Foundation undertake the following and report back to HDC:

a) Develop policies that deal with falls and head injuries applicable to independent living residents, and arrange training for relevant staff on the content of the policies.

b) Review the training of staff with regard to the Code, and ensure that all relevant staff have training on the Selwyn Foundation's policies that apply to independent living residents.

c) Ensure that all Resident Services representatives have current first aid certificates, and consider whether reception staff should also be required to have first aid certificates.

d) Ensure that the Code is provided to all existing residents, and subsequently include the Code with all entry information.

e) Develop a process to record the content of conversations between residents and staff regarding health issues.

f) Prepare information for residents explaining the Independent Living Emergency Response policy and, in particular, the circumstances when it will be determined that an emergency situation exists.

g) Review the Floor Register Check Procedure to determine whether the procedure should specify that residents must sign or place a tick on the register themselves, and that staff may not do so for them.

Follow-up actions

127. A copy of this report with details identifying the parties removed, except the expert who advised on this case and the Selwyn Foundation, will be sent to the Ministry of Housing and Urban Development, Te Ara Ahunga Ora Retirement Commission, the Retirement Villages Association of New Zealand, the Ministry of Health (HealthCERT), and the Health Quality & Safety Commission, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from RN Julia Russell:

"10 June 2019

Re: [Mrs A] — 21HDC00912

Introduction

[Mrs A] was a well [woman in her eighties] living independently in a serviced apartment … run by the Selwyn Foundation. [One afternoon], [Mrs A] sustained a head injury in an unwitnessed fall. Further to this and as reported by [the ambulance service] (at the time of her transfer to hospital) she had sustained a laceration on her head and had pain in her lumbar spine. [Mrs A] was transferred to the hospital [the following day] and died [that evening] at [the public hospital].

The documentation reviewed in the preparation of this report included the:

- Letter of complaint dated [2018] made by [the] children of [Mrs A]
- [The retirement village's] response letters dated [2018] — [retirement village manager] and [2018] by the Selwyn Foundation
- [The] Occupational Right Services Agreement
- Copy of the job description for Resident Services Representatives
- Copy of [the retirement village's] Emergency Call Response Independent Living Procedure
- [Mr B's] comments on [the retirement village's] response
- A decision by the HDC legal team that considers that the care [Mrs A] received from [the] Independent Living Facility is covered by the Code.

Further information was requested about whether new residents were provided with the Code of Health and Disability Services Consumers' Rights 1996. Information from [the Selwyn Foundation] is that this Code is not provided to [retirement village] residents. The HDC legal team has determined that [the] Independent Living Facility is covered by the Code which means the Code should be provided with all entry information.

This report has focused on the following questions:

1. Adequacy of the care provided, and the assessments undertaken by [the retirement village].
   a. What policies and procedures govern the care and responsibility to independent living people?
2. Adequacy of the Emergency Response Policy for Independent living residents

3. The timeliness of the contacting [Mrs A's] family

For each question the following points are considered

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

b. If there is a departure from the standard of care or accepted practice how significant is this considered to be?

c. How would it be it be viewed by peers?

d. Any recommendation for improvement that may help prevent a similar occurrence in the future.

1. Adequacy of the care provided, and the assessments undertaken by [the retirement village]. [Mrs A's] [son and daughter] complained to the Health and Disability Commissioner in [2018] regarding the lack of care provided by staff who were involved with [Mrs A] [at the time of these events]. This complaint centres around the family's expectations of the services that were provided to [Mrs A] in the event of an emergency. At [the apartments] support for independent living is provided by the Resident Services Representative. The position description for this role includes undertaking welfare visits as scheduled, there is no description of what a welfare visit is. [The retirement village] has an emergency call response for independent living policy which was implemented in Dec 2013 — there is no date indicating there has been an update of the policy. The policy describes that during the day the On-Site responders from 0700–2100 are the Independent Living Staff, during the other hours this role is undertaken by the Village Nurse. When the receptionist — [Ms D] — became aware [Mrs A] had had a fall she asked her if she required assistance — [Mrs A] declined. [Ms D] did ask her colleague [Mr F] to check in on her, this was the correct action. [Mr F] visited [Mrs A's] apartment sometime after 11–11:30am. From here there are 2 versions of events; one that [Mr F] reported that he spoke to her and did not see any blood or that she looked uncomfortable/hot sitting in her chair. [Mr F] went back in the early afternoon and found her disorientated/she did not recognise him, so he called an ambulance. The second version of events was the information provided by [the ambulance service] from [Mr F] — when he was asked by [Ms D] to check [Mrs A] he called in — saw she was asleep and went back later just before the ambulance was called. It is not easy to determine which version of events is correct, whether [Mr F] spoke to [Mrs A] the first time he called in just after 11am ([retirement village] records) or; he called in to see her and thought she was sleeping so left her (as the [ambulance service] report states). However, it seems the most likely series of events was that [Mr F] did not speak to [Mrs A] the first time he visited and therefore did not identify the situation as an emergency. It appears to the Family that the Selwyn Foundation has not asked [Mr F] to review his initial report and [ambulance service] information. Doing this and providing the information may have assisted in answering the concerns [Mr B] has with the information provided.

Given that [Mrs A] reported she had fallen and injured her head the correct action would have been to speak with her as part of a first aid assessment, [and] not doing [so] is a serious departure from the expected standard of care.

1a. What policies and procedures govern the care and responsibility to independent living people? [The Selwyn Foundation's] letter identifies the policies/procedures for the independent living units at the Selwyn Foundation are not the same as the facility policies/procedures, this is because it is not covered by the Code of Health and Disability Services Consumers' Rights 1996. Given that this service has been identified as a health and disability service there do need to be policies that cover health and disability services such as falls. There will be a suite of policies/procedures that cover the independent living residents as the Retirement Villages Code 2008 requires these cover all aspects of Part 3 of the code which includes emergency management. The emergency call response for independent living policy (implemented in Dec 2013) has not been updated which would be expected by [the time of these events in 2018]. The policy describes the On-Site responder role as available from 0700–2100 during the day who are the Independent Living Staff, from 2100–0700 the role is undertaken by the Village Nurse. It has been determined that these services are health and disability services which means that right 4 (below) — right to services of an appropriate standard applies. This means that appropriate policies/procedures should be available and covers such events as falls. Along with many other Village providers [the retirement village] does not believe the Code of Health and Disability Services Consumers' Rights 1996 is applicable to independent living units. Given this there are no policies and procedures and associated training to cover such events as [Mrs A's] fall. This is seen as a severe departure from the standards expected.

2. Adequacy of the Emergency Response Policy for Independent living residents. The procedure outlined in Emergency Call Response Independent Living Procedure was each Resident is to go down to the reception area and sign themselves in for the day. The policy and procedure are adequate however the practice of a staff member signing for Residents is not the procedure and does not support the purpose of the sign in sheet. Staff should not be signing for Residents, this is seen as a serious departure from the expected standards. No staff or senior management has appeared concerned that [Mr F] had signed the log, and it is likely that a staff member has signed the log for a resident in the same way on other occasions, this then means that this is not something the staff member is responsible for it has become a practice and therefore is a system issue. A potential improvement would have been to note that [Mrs A] was called and the time, that she had not signed the sheet herself as she had had a fall and was feeling unwell — with an offer to call family — the registered nurse or GP. If the resident declined this then a call to the registered nurse to assist with the decision-making process would be an ideal process.

3. The timeliness of contacting [Mrs A's] family. [Mrs A] had fallen and hit her head and said she was unwell to staff when they called to see why she hadn't signed the register for herself. Given this situation the family believe they should have been advised when staff became aware of the fall. [Mrs A] had a self-identified head injury and as such this

was an emergency and privacy should not have been a consideration. Further to this when [Mrs A] didn't go to lunch — this was a further opportunity to identify this situation as an emergency as she had said she was unwell and then was not to be participating to her normal level, so staff could have called her family. [The Selwyn Foundation] stated in [a] letter the reason given for not calling family was based on ensuring her privacy as she was in an independent living unit and was not receiving any health services. Privacy is an important consideration and there are ways that services are expected to manage privacy aspects with a resident. One such way would be a suggestion by staff to [Mrs A] that she call her family — if she had been unable to then staff could have offered to do it on her behalf and taken responsibility to make the call and advised the family members of the situation. This example is a common way that would be used by staff working in independent living environments. The timeliness of contacting [Mrs A's] family is reliant on whether [Mr F] spoke to [Mrs A] at 11–11:30am. If he had seen and spoken to her as the [retirement village] version of events suggests then it is likely he would have seen the dried blood. Given this he should have sought further professional help such as the registered nurse or GP. However, it is not easy to determine if the information that [Mr F] provided is accurate and whether he spoke to [Mrs A] or if he called in to see her and thought she was sleeping so left her (as [the ambulance service's] report states). It appears that the Selwyn Foundation has not asked [Mr F] to review his initial report alongside the [ambulance service] information — this may have assisted in answering the concerns [Mr B] has with the information provided.

In conclusion, the central element of this complaint is when was this situation identified as an emergency and what policies and procedures cover the independent living units. The HDC legal team have identified that the independent living units are covered by The Code of Health and Disability Services Consumers' Rights 1996 and as such residents are entitled have services provided to an appropriate standard (as identified in right 4). This means that [the retirement village] does not have adequate policies and procedures for this area. Each of the points reviewed are identified as departures from the expected standard of care.

1. Adequacy of the care provided, and the assessments undertaken by [the retirement village] in light of the fact this is an independent living apartment. The actions taken by [Ms D] were correct in getting [Mrs A] checked. However once the staff member went to see her, he should have spoken to her as part of a first aid assessment. Given the two versions of events it seems that it is most likely he did not speak to her and not doing so is a serious departure from the expected standard of care. An area of potential improvement would be the Selwyn Foundation providing information to [Mr B] regarding their follow up with [Mr F] to determine which version of events was correct.

1a. What policies and procedures govern the care and responsibility to independent living people? [The retirement village] along with many other Village providers do not believe the Code of Health and Disability Services Consumers' Rights 1996 is applicable to independent living units. Given that there seems to be a practice of not considering

the Code and therefore not providing policies and procedures and associated training to cover such events as [Mrs A's] fall is seen as a serious departure from the standards expected.

2. Adequacy of the Emergency Response Policy for Independent Living Residents. The policy is adequate however the log was completed by staff. By not recording more information or following up with [Mrs A] as it appears [Mr F] did not do is seen as a serious departure from the expected standards. An area for improvement would be clarifying what policies do cover the Independent Living Units and ensuring there are relevant policies to cover falls etc.

3. The timeliness of … contacting [Mrs A's] family. It appears the reason for not calling [Mrs A's] family was because at that time of the visit by [Mr F] this situation was not identified as an emergency. The family were called when the situation had been identified as an emergency. Determining the nature of when this was identified as an emergency relied on the staff member making the correct assessment when he first visited the room. There are two versions of events and clarifying which version of events is correct is central to this complaint. This has been covered in point 2 above, as the situation should have been identified as an emergency and this is seen as a serious departure from the standards. Head injuries are difficult to identify, and often speedy deterioration of a person occurs. Given the increasing age and co morbidities of independent living residents there will be increased likelihood of episodes of acute injury and ill health and these will need to be considerations that villages and providers of independent living consider about the provision of services and expectations of service.

End of report.

Julia Russell, RN, MN (Nursing)"

The following further advice was received from RN Russell:

"23 September 2019

Re: [Mrs A] (dec) 21HDC00912

This report is in response to a request to review the Floor Register Check Procedure used for [retirement village] staff to check Village Residents and whether the care provided by [Mr F] as a first aid trained Resident Services staff was appropriate in the circumstances. It is acknowledged here that [Mr F's] written statement on what occurred has been accepted by the Office of the Health and Disability Commissioner.

The Floor Register Check Procedure is written to meet the requirements of particular situations — none of which exactly meet the requirements of this situation. The situation in the process which is most like [Mrs A's] situation is in the response level 2 (see below). [Mrs A] had not signed the register and staff were aware of that and had contacted her, when she did not come down to lunch. [Mr F] was asked to visit [Mrs A]

at approx. 11–11:30 am as she had not signed in (staff had already contacted and spoken with her). At that time, he offered her the support of a Registered Nurse which she declined. [Mrs A] did not come down for lunch so [Mr F] went back to check on her after lunch at approx. 2pm. He went into the room — spoke with her/she did not recognise him — was concerned and called the ambulance.

It appears from the material provided that [Mr F] completed all of the actions required except to offer to call the family — given she did not recognise him urgent action was required. Family contact was made after the ambulance was called."