Enrolled Nurse, EN B

Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01185)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly man by an enrolled nurse at a rest home. The report highlights the importance of providing appropriate care in a manner that is consistent with the needs of the consumer.

2. The man had dementia and Parkinson's disease and was at risk of falling. On 12 May 2019, an interaction between the man and the nurse resulted in a fall, which was recorded on CCTV. The nurse did not complete an incident form, and did not identify corrective actions to prevent or minimise a recurrence.

Findings

3. The Deputy Commissioner considered that the CCTV footage demonstrated that the nurse's management of the man's behaviour was inappropriate and not consistent with his needs. The Deputy Commissioner was also critical that the nurse did not complete all required actions following the incident. The Deputy Commissioner found the nurse in breach of Right 4(1) and Right 4(3) of the Code.

4. The rest home was not found in breach of the Code, and it was noted that appropriate action was taken by staff to investigate the incident and advocate on behalf of a vulnerable consumer.

Recommendations

5. The Deputy Commissioner recommended that the nurse participate in further training related to dementia and behavioural challenges, and provide a letter of apology to the family for her breaches of the Code.

6. The Deputy Commissioner also recommended that the Nursing Council of New Zealand consider whether a review of the nurse's competence is warranted.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from the Nursing Council of New Zealand, referring concerns raised by the rest home about the services provided by a former employee, Enrolled Nurse (EN) B, to Mr A. The following issues were identified for investigation:

- *Whether EN B provided Mr A with an appropriate standard of care in May 2019.*
- *Whether the rest home provided Mr A with an appropriate standard of care in May 2019.*

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

9. The parties directly involved in the investigation were:

Mrs A	Consumer's wife
Provider/rest home	
EN B	Provider/enrolled nurse

10. Further information was received from:

Registered Nurse (RN) C	Registered nurse
Healthcare assistant	

11. Independent expert advice was obtained from an aged-care nursing advisor, RN Rachel Parmee (Appendix A).

Information gathered during investigation

Background

12. This report concerns the care provided to Mr A by EN B at the rest home — in particular, an incident on 12 May 2019, whereby an interaction between EN B and Mr A resulted in a fall.

13. Mr A (in his seventies at the time of events)[1] had dementia and Parkinson's disease. He was admitted to the rest home in September 2017, and resided in the rest home's secure level 3 dementia unit.

14. Mr A's interRAI assessment[2] documented that he was a medium falls risk,[3] and to refer to his care plan for more details. The interRAI assessment noted: "Requires support with A[ctivites of] D[aily] L[iving] due to Parkinson's disease and dementia — cognitive decline. Significant bilateral hand tremor, poor mobility …"

15. The interRAI assessment also recorded that Mr A's primary mode of mobility was walking with the use of an assistive device such as a walker, that he had an unsteady gait, and that he required "supervision — oversight/cueing" for walking and moving between locations on the same floor. The assessment noted that his "conditions/diseases make cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating)".

[1] Sadly, Mr A passed away during the HDC investigation.
[2] Dated 29 March 2019. An interRAI assessment is a standardised instrument for evaluation of the needs, strengths, and preferences of residents in long-term care.
[3] Mr A was assessed as a medium falls risk CAP L1. The Clinical Assessment Protocol (CAP) identifies areas in which a resident has a higher than expected rate of decline, an increased potential to improve, or symptoms that could be alleviated if a problem is addressed. With respect to Mr A, a CAP had been "triggered" in relation to falls risk.

16. EN B had been employed by the rest home since 20 March 2012, and had been working in the secure dementia unit for approximately 18 months at the time of events. The rest home's internal investigation[4] noted that EN B had worked with Mr A regularly, and therefore was familiar with his patterns of behaviour.

Incident on 12 May 2019

17. The incident occurred at approximately 11pm on 12 May 2019, when Mr A approached EN B at the nurses' station to request stationery items.

CCTV footage

18. The CCTV footage of the incident does not have audio, and the visual quality is low. It shows EN B inside the nurses' station during handover. Mr A is seen standing at the internal window at the nurses' station with both hands on the window sill, while EN B remains inside the nurses' station. The footage then appears to show one of several options:

- EN B touched or picked up Mr A's hands on the window sill, and he pulled away and fell;
- EN B picked up Mr A's hands, leaned out the window while holding his hands directing him backwards, then dropped his hands; or
- EN B picked up Mr A's hands, leaned out the window while holding his hands directing him backwards, then pushed him backwards.

19. Mr A is seen losing his balance, stumbling backwards and then falling heavily.

EN B's recollection[5]

20. EN B told the rest home that she told Mr A that he would "have to wait for a little bit" for his request, and then moved to close the internal window. She denied pushing Mr A, and stated that she did not believe the footage showed that.

21. EN B later told the rest home during an investigation meeting that she did not push Mr A, and that Mr A had grabbed her arms and would not let go.

Report of incident

22. RN C started night duty for 12/13 May 2019, and was given a handover that Mr A had had a fall and needed a dressing done, as he had a skin tear on his elbow. RN C noticed that no report for the fall had been completed.

23. RN C found EN B in the nurses' station, who had finished her shift by that point (the rostering system shows that she had logged out at 11.48pm), and asked EN B to complete

[4] The rest home conducted an internal investigation into this incident. Further detail can be found below under the heading "Subsequent events".

[5] At the time of issuing the opinion, EN B had not engaged with HDC's investigation. Her recollection of events are therefore taken from the rest home's internal investigation and related documentation of the incident.

the progress notes and incident report. EN B reportedly responded, "I forgot, I was busy," so RN C requested that she do so before leaving.

24. On Mr A's Behaviour Identification and Interventions Chart, EN B documented (at an unknown time):

> "[At 11pm I] asked [Mr A] to wait a little while we finish our handover and went to shut the window as he wanted to come in and get paper sellotape and stapler he pulled at the window sill then went flying backwards and fell on his right side would not let the male caregivers help him up got up on his own did not hit his head."

25. Under "Intervention Description", EN B documented: "[G]iven cup of tea to relax." Under "Triggers If Known", she documented: "[W]anting things from office for his cd obs[ervations] at this time were 148/83."

26. EN B documented the following progress note at 12.22am on 13 May 2019:

> "Subject: Fall — Injury
>
> During handover [Mr A] came to the window for stationary [sic] asked him to wait for a little bit and the career [sic] would come and see him went to close the window [Mr A] pulled on the window sill and fell backwards and was on his left side. He didn't hit his head. Asked him if he would let the men careers [sic] help him up but he wouldn't. He got up on his own asked career [sic] to take his obs 148/83. Sat him in chair and cup of tea given."

27. EN B did not complete an incident form that day or subsequently, and did not identify corrective actions to prevent or minimise recurrence.

28. RN C documented at 7.13am on 13 May 2019 that she had checked Mr A post-fall, and no injuries had been found apart from a minor graze on his left elbow.

29. On 13 May 2019 around 10am, Mrs A was informed of the fall.

30. An incident form was completed by the Care Services Manager retrospectively on 2 June 2019.

Subsequent events

31. On 14 May 2019, the Care Services Manager received an email of the progress note reporting that Mr A had had a fall on the evening of 13 May 2019. The Care Services Manager stated that the manner in which it was written alerted her that further investigation would be prudent.

32. The rest home told HDC that the record of the incident was reviewed by two senior staff within 12 hours of the incident occurring, who sought further detail as the incident appeared "untoward".

33. The CCTV footage was reviewed, and it was the opinion of the Care Services Manager, the Team Leader for the secure unit, and the Village Manager, that this appeared to show EN B pushing Mr A, resulting in the fall.

34. On 14 May 2019, EN B was given a notice of suspension pending the outcome of the investigation of the allegation that she had pushed Mr A.

Internal investigation

35. As noted above, the rest home conducted an internal investigation into these events. As part of this, several witnesses were consulted. One staff member declined to provide a statement, and two other staff members who were present in the nurses' station during handover provided statements, but said that they could not see whether Mr A was pushed or had fallen by himself.

36. A healthcare assistant was noted to be reluctant to provide a statement, but recalled that Mr A was standing at the window and would not move, so EN B removed his hands from the piece of wood on the window ledge, and that was when Mr A fell back.

37. On 31 May 2019, an investigation meeting occurred. Rest home management, EN B, and EN B's representative attended. As noted above, EN B maintained that she had not pushed Mr A. When asked about why she had not completed an incident form for the fall, EN B reportedly stated that she did not know how to complete one.

38. The rest home formed the opinion that EN B had pushed Mr A during the incident, based on the evidence provided to them. The rest home found the following:

a) EN B ought reasonably to have had enough knowledge, skills, and experience to manage Mr A more appropriately, thus preventing the situation where the window was being closed while he was standing there. This was based on EN B being familiar with Mr A and having worked with him regularly, and she had not worked any additional hours to her regular roster, had taken regular leave, and had attended recent training on dementia, including communication and responding to behavioural symptoms of dementia.

b) EN B should have gone out of the nurses' station and spoken to Mr A directly, listened to his concerns, and distracted/redirected him away from the window. Closing the window on someone is a form of closed communication, and is not appropriate when dealing with episodes of challenging behaviour. Alternatively, EN B should have directed another staff member to attend to Mr A's concerns.

c) This behaviour failed to uphold appropriate standards of care, was contrary to policies, and did not uphold the professional standards of an enrolled nurse, and reached the threshold of serious misconduct.

39. EN B resigned on 31 May 2019, effective immediately.

40. The Nursing Council of New Zealand was notified of the incident and EN B's actions.

Further information — the rest home

41. The rest home advised that all staff in its dementia unit complete an annual in-service update on challenging behaviour, and are enrolled in, or have completed, their level 4 career force dementia papers. The rest home's expectation is that staff manage episodes of challenging behaviour in line with its policy, using the skills that they have learned and from previous experiences with the resident, to de-escalate or redirect the situation in a calm and safe manner.

42. The rest home told HDC that it considered that EN B was a well-qualified and experienced enrolled nurse who had been provided with many training opportunities to grow her skills around the management of people with dementia and their behaviour, including training on Parkinson's disease and the associated mobility challenges this diagnosis brings.

43. The rest home also noted that training had been provided to all staff on completing incident reports, and that in EN B's case, there were other staff members present who could have assisted with this if needed.

44. The rest home told HDC that in its view, EN B's actions in telling Mr A to go away and then putting her hands on him to try to make him move were grossly inappropriate, and put the well-being of a vulnerable elderly person at risk.

Rest Home Policies

45. The "Incident Management Policy"[6] provided:

> "The standard is met when
>
> 1. All incidents/accidents/near misses are safely managed, and the affected person is given the appropriate treatment (first aid where appropriate) and support.
> 2. All resident incidents/accidents/near misses are reported and documented in the resident's progress notes and incident register in their [electronic] file as soon as practicable and always within 24 hours.
> 3. An employee **accident/incident notification and investigation form**[7] is completed for each staff member involved in any incident."

46. The "Falls Prevention and Management Policy"[8] provided:

> "*Falls Management*
>
> In the event of a fall,
>
> — The resident must be assessed immediately for injury prior to moving and first aid given as required.

[6] The policy was noted to have been reviewed in April 2019.
[7] Emphasis in original.
[8] Last reviewed in April 2019.

— A **Resident incident progress note** and a **resident incident register**[9] entry must be completed.

— Any hazard causing the fall must be removed or minimised.

— Corrective actions must be identified and implemented to prevent or minimise recurrence …"

Responses to provisional decision

Mrs A

47. Mrs A was given an opportunity to comment on the "information gathered" section of the provisional decision, and advised that she had no comment to make.

Rest home

48. The rest home was given an opportunity to comment on the provisional report, and advised that it had no further comment to make.

EN B

49. EN B was given an opportunity to comment on the provisional report, but did not provide a response.

Relevant standards

50. The Standards New Zealand *Health and Disability Services (Core) Standards 8134.1:2008* state:

> "Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy and independence.
>
> 1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect."

51. The Nursing Council of New Zealand *Code of Conduct for Nurses* (June 2012)[10] states:

> "Respect the dignity and individuality of health consumers
>
> Standards
>
> 1.1 Respect the dignity of health consumers and treat them with kindness and consideration. Identify yourself and your role in their care.
>
> 1.2 Take steps to ensure the physical environment allows health consumers to maintain their privacy and dignity.

[9] Emphasis in original.

[10] The Code of Conduct applies to enrolled nurses (Glossary: "Nurse [m]eans a registered nurse, nurse practitioner or enrolled nurse.")

…

1.6 Practise in a way that respects difference and does not discriminate against those in your care on the basis of ethnicity, religion, gender, sexual orientation, political or other opinion, disability or age.

1.7 Do not prejudice the care you give because you believe a health consumer's behaviour contributed to their condition.

…

1.10 Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers."

Opinion: EN B — breach

52. As a healthcare provider, EN B was required to provide services to Mr A with reasonable care and skill, and in a manner consistent with his needs.

Incident on 12 May 2019

53. On 12 May 2019, there was an incident whereby an interaction between EN B and Mr A resulted in his fall. The following facts are agreed upon or evident from the CCTV footage:

a) Mr A was standing at the window of the nurses' station.

b) EN B did not come out from the nurses' station.

c) There was an interaction between EN B and Mr A, and also apparent physical contact of some form.

d) Mr A lost his balance and fell.

54. From the CCTV footage, it appears that the interaction/physical contact involved either:

a) EN B touching or picking up Mr A's hands on the window sill, and Mr A pulling away and falling;

b) EN B picking up his hands, leaning out the window while holding his hands directing him backwards, then dropping his hands; or

c) EN B picking up his hands, leaning out the window while holding his hands directing him backwards, then pushing him backwards.

55. The rest home's internal investigation determined that EN B had pushed Mr A. Although I have not received a direct statement from EN B, I note that she maintained throughout the rest home's investigation that she did not push Mr A.

56. I do not consider it necessary to make a definitive finding on which scenario occurred, as in my view, any of the potential scenarios above was inappropriate.

57. EN B was working in the secure dementia unit where Mr A resided. She was familiar with Mr A and his needs, having worked at the unit for 18 months, and had seven years of experience at the rest home. Mr A's falls risk, mobility, and behaviour were well documented in his clinical notes and assessments. I am satisfied that EN B was aware of his diagnoses and related needs.

58. EN B documented that Mr A wanted to enter the nurses' station to get tape and a stapler, and she asked him to "wait a little while we finish our handover and went to shut the window".

59. My expert advisor, RN Rachel Parmee, advised:

> "I do not believe that the situation was managed according to accepted practice in terms of care of a person with Parkinson's disease and Dementia.
>
> One of the more significant features of advanced Parkinson's disease is decreased control over mobility and balance. In any situation which has the potential for a person with Parkinson's disease to lose balance it should be foremost in a nurse's mind to take steps to prevent this happening.
>
> Accepted practice with a person with Dementia would be to use interventions such as distraction, reassurance and redirection. Each of these are clearly documented in [Mr A's] careplan and in the interventions described in the Behavioural identification and interventions chart. The philosophy of person-centred care, by definition, focusses on the needs of the resident rather than those providing care.
>
> [Mr A] needed to have his needs met by either giving him what he asked for or using a distraction or diversion technique, rather than physically excluding him by closing the window or moving his hands from the windowsill. It appears from the CCTV coverage that he may have been using the windowsill for balance instead of or as well as trying to prevent the window being closed."

60. RN Parmee advised that EN B's care was a severe departure from accepted standards in terms of not providing person-centred care, and in light of the effects of Mr A's diagnoses on his physical and mental abilities.

61. I agree. In my opinion, regardless of whether or not EN B pushed Mr A, her interaction on 12 May 2019 with Mr A, and her management of his behaviour, was inappropriate and not consistent with his needs. Mr A was a particularly vulnerable consumer who was put at risk of injury as a result of the deliberate actions of a single staff member who was responsible for his care and well-being and, above all else, should have been keeping him safe. None of the potential scenarios shown on the CCTV footage demonstrate a safe and appropriate approach by EN B.

Actions taken by EN B following incident

62. I am also concerned by EN B's actions following the incident. From the information gathered through the investigation, EN B was prepared to leave work that night without having completed Mr A's progress notes and an incident report, in contravention of the rest home's policies.

63. EN B did complete the progress notes and Behavioural Identification and Interventions Chart once prompted, but did not complete the incident report, that day or subsequently. RN Parmee advised that corrective actions were not identified by EN B, and her record did not provide detail of the assessment carried out, the skin tear injury, observations completed, plan to contact family, and recommendations for ongoing care.

64. While EN B has declined to provide HDC with an explanation for her actions, and acknowledging her statement during the rest home's internal investigation that she did not know how to complete certain actions, I am critical that EN B did not complete all required actions following the incident. RN Parmee advised that EN B received appropriate training and ongoing education. I note that she had been employed at the rest home for seven years, and the relevant policies clearly outlined the required actions following an incident, and, as the rest home noted, other staff members present could have assisted her. I note that RN Parmee considered this to represent a severe departure from accepted standards.

65. I agree. If the incident had not been documented at the time, Mr A would have been placed at significant risk. In the event Mr A incurred an injury as a result of the fall, a deterioration in his condition may have gone unnoticed, and emerging symptoms may have not been recognised and acted upon appropriately.

Conclusion

66. For the reasons outlined above, in my opinion, EN B failed to provide Mr A services with reasonable care and skill and, accordingly, breached Right 4(1)[11] of the Code of Health and Disability Services Consumers' Rights (the Code). In addition, she failed to provide services to Mr A in a manner consistent with his needs, and therefore also breached Right 4(3)[12] of the Code.

Opinion: Rest home — no breach

67. As a healthcare provider, the rest home is responsible for providing services in accordance with the Code. My expert advisor, RN Parmee, advised that the policies in place at the rest home met all requirements, there was no evidence to suggest that EN B was working outside her scope of practice, and she had received appropriate training and ongoing

[11] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[12] Right 4(3) states: "Every consumer has the right to have services provided in a manner consistent with his or her needs."

education. In this case, I do not have concerns about broader systems or organisational issues at the rest home, and therefore I do not consider that the rest home breached the Code directly.

68. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) of the Act if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

69. In May 2019, EN B was an employee of the rest home, and therefore the rest home is an employing authority for the purposes of the Act. As set out above, I have found that EN B breached Rights 4(1) and 4(3) of the Code.

70. As noted above, the rest home had appropriate policies in place and had provided EN B with training and ongoing education, in particular around dementia and responding to behavioural challenges of dementia.

71. I am satisfied that the rest home took such steps as were reasonably practicable to prevent this act or omission occurring. Accordingly, I do not find the rest home vicariously liable for EN B's breaches of the Code.

Other comment

72. I commend the Care Services Manager and other relevant staff who took action upon receiving the progress note of the incident, and promptly investigated their suspicion. Mr A's conditions made him a particularly vulnerable consumer, and I consider that the rest home's actions to advocate on his behalf and ensure his safety were appropriate. I note also that the rest home appropriately reported the matter to the Nursing Council of New Zealand. These actions are commendable.

Recommendations

73. I recommend that the Nursing Council of New Zealand consider whether a review of EN B's competence is warranted.

74. I recommend that EN B:

a) Provide a written letter of apology to the family for her breaches of the Code. The letter is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.
b) Participate in further training related to dementia and behavioural challenges. Evidence of this training should be provided to HDC within three months of the date of this report.

Follow-up actions

75. EN B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

76. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of EN B's name.

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

Addendum

78. The Director of Proceedings decided not to issue proceedings.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"HDC REPORT

REFERENCE: C19HDC01185

1. Thank you for the request to provide clinical advice regarding the care provided by [EN B] at [the rest home] to [Mr A] in May 2019. 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 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is co-ordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr A] by [EN B] and [the rest home] was reasonable in the circumstances and why, with particular comment on:

1. [EN B's] actions in response to [Mr A] on 12 May 2019. In particular my advice on her actions for each potential scenario:

a) [EN B] touched or picked up his hands on the windowsill, he pulled away and fell.

b) [EN B] picked up his hands, leaned out the window while holding his hands directing him backwards, then dropped his hands.

c) [EN B] picked up his hands, leaned out the window while holding his hands directing him backwards, then pushed him backwards; or

d) Any other scenario I consider may have occurred.

2. Whether the actions [EN B] took following [Mr A's] fall, including completion of relevant documentation was adequate/appropriate.

3. The adequacy of [the rest home's] policies relevant to the incident.

4. The adequacy of training/supervision provided to [EN B] by [the rest home].

5. Any other matters in this case that I consider amount to a departure from the standard of care or accepted practice.

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, and clearly identify whether I consider the departure to be mild/moderate/severe.

c. How would it be viewed by my peers?

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

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

1. Letter of complaint dated 20 June 2019.
2. [The rest home's] responses dated 22 July 2019 and 12 December 2019 and attached appendices
3. Clinical records from [the rest home] covering the relevant period
4. CCTV footage from 12 May 2019.

Background

[Mr A] is [a man in his seventies] with dementia and Parkinson's disease, who lives in the secure dementia unit. He is assessed as having a high risk for falls.

On 12th May 2019, there was an incident between [Mr A] and [EN B], resulting in [Mr A] falling.

The CCTV footage appears to show [Mr A] at the internal window of the nurses' station and either

a) [EN B] touched or picked up his hands on the windowsill, he pulled away and fell; or
b) [EN B] picked up his hands, leaned out the window while holding his hands directing him backwards, then dropped his hands; or
c) [EN B] picked up his hands, leaned out the window while holding his hands directing him backwards, then pushed him backwards.

Review of Documents and CCTV footage

[EN B's] actions in response to [Mr A] on 12 May 2019. In particular my advice on her actions for each potential scenario:

a) [EN B] touched or picked up his hands on the windowsill, he pulled away and fell.
b) [EN B] picked up his hands, leaned out the window while holding his hands directing him backwards, then dropped his hands
c) [EN B] picked up his hands, leaned out the window while holding his hands directing him backwards, then pushed him backwards; or
d) Any other scenario I consider may have occurred.

In the absence of any comment from [EN B] (either in the form of a statement or access to the minutes of the meeting following the incident), the information I have to base my advice on is the CCTV footage, [EN B's] progress notes, the comments from [EN B's] peers and the documentation relating to [Mr A].

Without the benefit of sound and clearer images on the CCTV footage I am inclined to believe that the first scenario occurred, i.e. [EN B] touched or picked up [Mr A's] hands on the windowsill, he pulled away and fell. The CCTV footage shows [Mr A] beginning to lose balance prior to [EN B's] hands coming into view, hence negating the scenarios that she was directing him backwards.

[Mr A's] InterRAI assessment and careplan clearly indicate that as a result of his Parkinson's disease and associated dementia he had poor balance and insight, both of which would have contributed to his fall especially if his hands had been moved while he was holding on to the windowsill.

[EN B] states in her entry into the Behaviour identification and intervention that:

Asked [Mr A] to wait a little while we finish our handover and went to shut the window as he wanted to come in and get paper, Sellotape and stapler he pulled at the window sill then went flying backwards and fell on his right side …

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

While I am willing to accept that [Mr A] was not directed backwards contributing to his fall, I do not believe that the situation was managed according to accepted practice in terms of care of a person with Parkinson's disease and Dementia.

One of the more significant features of advanced Parkinson's disease is decreased control over mobility and balance. In any situation which has the potential for a person with Parkinson's disease to lose balance it should be foremost in a nurse's mind to take steps to prevent this happening.

Accepted practice with a person with Dementia would be to use interventions such as distraction, reassurance and redirection. Each of these are clearly documented in [Mr A's] careplan and in the interventions described in the Behavioural identification and interventions chart. The philosophy of person-centred care, by definition, focusses on the needs of the resident rather than those providing care.

[Mr A] needed to have his needs met by either giving him what he asked for or using a distraction or diversion technique, rather than physically excluding him by closing the window or moving his hands from the windowsill. It appears from the CCTV coverage that he may have been using the windowsill for balance instead of or as well as trying to prevent the window being closed.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.
I consider the departure to be severe in terms of not providing person-centred care and in the light of the effects of [Mr A's] Parkinson's disease and Dementia on his physical and mental abilities.

c. How would it be viewed by my peers?
My peers in practice and education would agree with my findings.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.
As this is the practice of an individual nurse, who is no longer employed in the facility, I do not have any recommendations. From information provided I believe the Facility has appropriate education and orientation for nurses and caregivers to the area of dementia care. The care plan for [Mr A] and the Behaviour identification and intervention document provide evidence that the Facility advocates and practices appropriate person-centred care.

7. Whether the actions [EN B] took following [Mr A's] fall, including completion of relevant documentation was adequate/appropriate.
According to the information provided by the oncoming night registered nurse [RN C] and the letter dated 12th December 2019 to the HDC from [the] General Manager, [EN B] did not complete progress notes and an incident report following [Mr A's] fall until prompted by RN C. [EN B's] response was reported as 'I forgot; I was busy'. [EN B] completed progress notes following this prompting. She did not however complete an incident report. This was completed by [the] (CSM).

[Mr A] also sustained a skin tear following the fall which was dressed by the night RN on [EN B's] request.

In her complaint to the Nursing Council of New Zealand [the CSM] states that in a meeting following the incident [EN B] stated that she did not know how to report an incident in [the electronic file].

a. What is the standard of care/accepted practice?
The standard of care in the event of a fall is to follow the requirements of the Facility's Falls Management and Incident Management policies.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe

There was a severe departure by [EN B] in terms of meeting the requirements of the Falls Prevention and Management Policy ([Rest Home] Policies and Procedures).

- The Resident's progress note, and resident incident register were not voluntarily completed by [EN B]
- Corrective actions were not identified by [EN B]
- No provision appears to have been made by [EN B] to inform [Mr A's] family. I note that [Mr A's] family were contacted the following day which is reasonable given the time of the incident.

With reference to the Incident Management Policy ([Rest Home] Policies and Procedures) the standard was not met by [EN B] in terms of:

- The requirement that all resident incidents are reported and documented in the resident's progress notes and incident register in the [electronic] file as soon as practicable and always within 24 hours. While the standard was met it was after direction of an RN and the report was completed by the CSM, not [EN B]. As [the CSM] states in her complaint to the Nursing Council that it was implausible that [EN B] did not know how to complete an incident report on [the system].
- The requirement that the detail in the progress notes must be sufficient to provide an auditable record of the event, assessment, observations and action. [EN B's] record in the progress notes (as quoted above) did not provide detail of the assessment carried out, the skin tear injury, observations completed, plan to contact family and recommendations for ongoing care.

c. How would it be viewed by my peers?
My peers would agree that the standard was not met by the nurse responsible as I have detailed above.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.
As this is the practice of an individual nurse, who is no longer employed in the facility, I do not have any recommendations. The policies for both incident and falls management are robust and provide clear guidelines and expectations.

8. The adequacy of [the rest home's] policies relevant to the incident.
a) What is the standard of care/accepted practice?
The policies relevant to this incident are those relating to incident and falls management.

These policies should have adequate detail in terms of rationale and direction for staff covering all areas and eventualities within the Rest Home.

b) If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.
There has been no departure from the expected standard. The policies meet all requirements.

c) How would it be viewed by my peers?
My peers would agree.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.
No recommendations.

e) The adequacy of training/supervision provided to [EN B] by [the rest home].

a) What is the standard of care/accepted practice?
As an Enrolled Nurse [EN B] was required to work within the scope of practice of an Enrolled Nurse (New Zealand Nursing Council). The facility is also expected to provide ongoing education to staff in order to provide the knowledge and skills to care for the residents they are caring for.

b) If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.
There has been no departure from the accepted standard of practice. There is no evidence to suggest that [EN B] was working outside her scope of practice as an Enrolled Nurse. The education record provided indicates that [EN B] had taken advantage of numerous opportunities for ongoing education. With relevance to this incident are:

- Dementia and communication
- Challenging behaviour, restraint, residents' rights
- Falls prevention
- Responding to behavioural symptoms of dementia
- Understanding your role and responsibility

c) How would it be viewed by my peers?
My peers in education and practice would agree.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.
No recommendations.

e) Any other matters in this case that I consider amount to a departure from the standard of care or accepted practice

There are no other matters that I consider amount to a departure from the standard of care or accepted practice.

Report completed by:

Rachel Anne Parmee,
16th February 2020
19HDC01185"