# Retirement Village
# Registered Nurse, RN B

## A Report by the
## Deputy Health and Disability Commissioner

## (Case 20HDC01228)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

## Contents

## Executive summary

1. A man in his nineties had resided at a retirement village since September 2019, in the rest home's special care dementia unit. The man had a medical history that included prostate cancer, high blood pressure, and severe cognitive impairment secondary to dementia.

2. This report concerns the care provided to the man by a registered nurse at the retirement village. In particular, it concerns the nurse's response to the man's challenging behaviours during an incident on 11 May 2020, and highlights the importance of treating vulnerable consumers with respect, that appropriate actions are taken after an event in line with a provider's policies, as well as good communication with a resident's family.

### Findings

3. The Deputy Commissioner found that the nurse treated the man in an unkind and disrespectful way when responding to his episode of his challenging behaviour, in breach of Right 1(1) of the Code.

4. In addition, the Deputy Commissioner found that the nurse failed to provide services to the man with reasonable care and skill for failing to ascertain whether assistance was needed from her when the resident assistance bell was activated by a healthcare assistant; for failing to wear a face mask during a COVID-19 outbreak in the country; for not completing the clinical assessments required following an unwitnessed event; for not contacting the residents' GP or EPOA; and for omitting to escalate and report the incident as per the retirement village's policies.

5. The Deputy Commissioner considered that the combination of suitable policies and the information in the man's care plan were sufficient to support the nurse in an event such as the incident on 11 May 2020, and did not find that the retirement village had breached the Code. However, Ms Wall considered that the retirement village's communication with the man's family could have been improved on this occasion.

### Recommendations

6. The Deputy Commissioner recommended that the nurse undertake further training related to documentation, post-incident management, and family/EPOA communication requirements, review the article "The Role of Empathy in Health and Social Care Professionals[1]", and provide the man's family with an apology for the breaches of the Code identified in this report. Ms Wall also referred the nurse 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.

7. In response to the provisional opinion, the retirement village provided HDC with details of additional training given to its care and management staff on post-incident management and communication.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7151200/.

## Complaint and investigation

8. The Nursing Council of New Zealand referred to the Health and Disability Commissioner (HDC) a complaint about the services provided to Mr A by a retirement village and a registered nurse, RN B. The following issues were identified for investigation:

- *Whether the retirement village provided Mr A with an appropriate standard of care on 11 May 2020.*
- *Whether RN B provided Mr A with an appropriate standard of care on 11 May 2020.*

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

10. The parties directly involved in the investigation were:

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|---|---|
| Retirement village | Provider/rest home |
| Registered Nurse (RN) B | Provider/registered nurse |

11. Further information was received from:

| | |
|---|---|
| Ms C | Healthcare assistant (HCA) |
| Mr D | Healthcare assistant |

12. Also mentioned in this report:

| | |
|---|---|
| RN E | Registered nurse |

13. Independent expert advice was obtained from RN Megan Sendall (Appendix A).

## Information gathered during investigation

### Background

14. Mr A (aged in his nineties at the time of events) had resided at the retirement village since 2019, in the rest home's special care dementia unit. Mr A had a medical history that included prostate cancer, high blood pressure, and severe cognitive impairment secondary to dementia.

15. Mr A's care plan stated that owing to his dementia, he could sometimes exhibit challenging behaviour, such as attempting to trip up other residents, wandering into other residents' rooms, starting arguments with other residents, and being aggressive. Triggers for these behaviours were documented as feeling abandoned, boredom when not getting one-on-one activities, and when it was the late afternoon. However, before the events of this case, it was noted that there had been no incidents of aggression recorded in Mr A's notes for over six weeks.

16. This report concerns the care provided to Mr A by RN B at the retirement village. In particular, it concerns RN B's response to Mr A's challenging behaviours during an incident on 11 May 2020.

**Incident on 11 May 2020**

17. On the evening of 11 May 2020, staff rostered to work in the dementia unit (which housed 28 residents at the time) included RN B, senior HCA Mr D, and HCA Ms C.

18. RN B was the most senior staff member and was in charge of the dementia unit for that evening. RN B had been a nurse at the retirement village since September 2015. However, she had resigned before the events of this case, and her last day of work was 12 May 2020.

19. Just before 8.20pm, Ms C heard screaming, abusive verbal language, and what sounded like begging coming from another resident's (Resident B's) room. When Ms C arrived in Resident B's room, she found her being pulled from the bed by Mr A. Ms C stated:

> "I immediately intervened between [Mr A] and Resident B and tried to remove [Mr A] from the room but was unable to do so on my own. I pressed the emergency button multiple times and ran out of the room to find the nurse or another caregiver to help me, however I couldn't find anyone."

20. The call bell report confirms that Ms C pressed both the resident call button and staff assist button at 8.19pm, to activate the emergency bell. In addition to pressing these buttons, Ms C also attempted to alert RN B via her pager. At the time of the incident, RN B was sitting at the nurses' station with her pager on charge behind her.

21. RN B told HDC that she would have noticed an emergency bell had it activated at the time of the incident, and stated that whilst the usual bell (from the resident call button) activated, the emergency one did not. She noted that at the time of the event, there were issues with the emergency bells and the pagers being activated by the system.

22. The retirement village acknowledged to HDC that there were issues with the call bell system, owing to construction in the dementia unit. However, the retirement village stated that the team were aware of the issues and put in extra safeguards such as increased rounding of the wards, as required. The retirement village also noted that when the usual bell was activated, RN B should have ascertained whether her assistance was needed.

23. Ms C stated that at this point, Resident B was shaking uncontrollably and she was trying to calm her down. Ms C noted blood on Resident B's neck and face in small patches, as well as small dots on her pyjamas.

24. As RN B did not attend, Ms C left the room again to try to find her.

25. Ms C stated that once she found RN B and they arrived back at Resident B's room, RN B "proceeded to yell/scream at [Mr A] commenting 'you're disgusting, you're a monster, I will be telling [your children] about this, f*****n disgusting'". Ms C stated that RN B forcefully

pulled Mr A up by his arm from the chair in which he was sitting and guided him back to his room.

26. Mr D was late to arrive at the scene, but stated that as he was on his way to Resident B's room, he heard RN B shouting at Mr A to get out of the room, and calling him "naughty". Mr D said that he then saw RN B grab Mr A by the arm forcefully and "propel him down the corridor to his room".

27. RN B denied that she yelled at Mr A, and stated that when removing Mr A from the room, she told him "you're naughty", and asked what his daughter would say. She stated that referring to his daughter always put a smile on Mr A's face.

28. Ms C settled Resident B back into bed, and she and RN B blocked off her room with chairs, and placed a sensor mat directly in her doorway in case Mr A tried to return.

29. Despite these events happening when New Zealand was at COVID-19 "Alert Level 3",[2] RN B was not wearing her face mask. RN B stated that she had been wearing her mask earlier, but had taken it off when she was by herself in the nurses' station. She told HDC that when she was alerted to the situation with Mr A and Resident B, she instantly ran to help and forgot to take her mask with her.

*Camera footage of incident*

30. Camera footage of the incident was obtained from the retirement village. The footage is from a camera in the hallway outside Resident B's room (not inside the room), and has no sound. The camera freezes from 8.23pm to 8.27pm.

31. The footage shows:

- Ms C walking into Resident B's room at 8.18pm, and then running out of the room shortly afterwards.
- Ms C running back to Resident B's room after approximately one minute (at 8.20pm).
- Mr A and Ms C walking out of Resident B's room at 8.21pm. Mr A sits on a chair in the hallway, while Ms C keeps walking down the hallway out of the camera's view.
- The camera skips forward to 8.22pm, and Mr A is no longer sitting in the chair and the hallway is empty. Ms C is seen running back towards Resident B's room, with RN B walking behind her.
- At 8.23pm, RN B is seen taking hold of Mr A's upper arm and gesturing towards his room. It is clear that RN B is talking to Mr A by her facial movements and because she leans in towards Mr A's face as she is speaking. RN B enters Resident B's room, while Mr A sits on the chair in the hallway again.
- The camera skips forward until 8.27pm.

[2] https://covid19.govt.nz/alert-levels-and-updates/alert-level-3/.

- RN B is seen coming out of Mr A's room, and Ms C is seen coming out of Resident B's room. RN B is seen talking to Mr D before leaving the area.

**Events after incident**

32. Ms C stated that she asked RN B if she needed to do anything else other than a "behaviour chart" in regard to the incident, and RN B told her that she would handle everything else.

33. Whilst Ms C was completing the behaviour chart, Mr A came into the lounge where Ms C and RN B were. Ms C stated that at this time, RN B told Mr A to go away, to not even breathe around her, and again how he was "disgusting, and a c**t", as well as other abusive words.

34. Mr D stated that when Mr A came into the lounge area, he heard RN B tell Mr A that she did not want him around her, and not to breathe around her.

35. In contrast, RN B stated that when he was back in the lounge, Mr A was laughing. She said that she told him, "I'm not talking to you, that was naughty," and that this was said in humour.

36. The behaviour chart completed in Mr A's clinical notes by Ms C stated: "Caught [Mr A] [pulling a resident out of bed]."

37. The behaviour chart was then sent to RN B to complete a challenging behavior report, as per the retirement village's policy,[3] but this was not done. RN B also did not escalate the event to the village manager as per the rest home's "incident reporting severity matrix[4]". RN B accepted that these things should have been done.

**Subsequent events**

38. As the incident occurred in the evening, RN B decided that informing the families could wait until the morning.

39. On the morning of 12 May 2020, it was discovered that Mr A had a bruised eye.

40. RN B told HDC that during handover to RN E (the nurse on the next shift) that morning, she discussed with RN E that she would need to complete a bruising report and telephone the family about the incident. In contrast, RN E told HDC that she was not asked by RN B to make a report about the incident, or to telephone the families of either party. RN E noted that RN B had first-hand knowledge of the incident. RN E said that she would never have felt comfortable reporting an incident third-hand. She stated:

[3] As per the rest home's "Management of Challenging Behaviour Policy", when a challenging behaviour occurs, a behaviour chart is to be completed by the person who witnessed the behaviour. The chart is then sent to the registered nurse on duty to review, and to complete a challenging behaviour report if there has been physical aggression. The report is to document any interventions required, and to assist in updating a patient's care plan.

[4] The "incident reporting severity matrix" states that in the event of physical aggression causing harm, or allegations of assault (along other events), the village manager is to be notified "immediately".

> "My recollection of the handover was that [Mr A] was found in [Resident B's] room having apparently [pulled her out of bed]. I did notice that [Mr A] had what appeared to be a black eye, it was reported to me that [Resident B] was quite feisty and was known to lash out."

41. As the behaviour report was not completed by RN B at the time, no alert of any aggressive behaviour went through to the village or clinical manager the evening the incident happened. It was not until the morning of 15 May 2020, when the village manager visited the special care unit and noticed the bruising on Mr A's face, that further action was taken.

42. An internal investigation into the incident was undertaken immediately (discussed further in paragraph 44), and on 16 May 2020 both families were contacted to advise them about what had happened. A challenging behaviour report for the incident was also completed on this day, and discussions were had with Mr A's general practitioner (GP) about his bruising. The GP was satisfied that there was no injury requiring further action.

43. While Mr A's daughter was informed of the incident of 11 May 2020 as Mr A's next of kin, she was not informed of RN B's conduct towards her father until the Nursing Council referral was made to HDC. The retirement village accepted that communication with Mr A's family should have been better in this regard.

**Further information**

*Internal investigation*

44. The retirement village's internal investigation into the event found the following:

- RN B failed to follow process, resulting in a failure to report/record the incident, failure to follow up, and failure to inform next of kin;
- RN B did not escalate the event to the clinical manager or village manager, as per the rest home's "incident reporting severity matrix";
- RN B did not instigate intentional rounding[5] post the incident to ensure resident safety was maintained;
- RN B did not follow process, in not carrying her pager; and
- RN B put residents at further risk by not wearing her face mask during COVID-19 restrictions.

*Retirement village*

45. At the time of these events, the retirement village had a policy for "Managing Challenging Behaviour", including aggression. In addition to the requirements for reporting of the behaviour and completing a behaviour chart and report, the policy outlines the expectations for de-escalation of a situation where a resident is aggressive. The process includes calming and redirecting the resident.

[5] A structured process whereby regular checks are carried out.

46. The retirement village provided HDC with a copy of RN B's training record, which showed that she had completed training on managing aggression and challenging behaviour while employed with them.

47. The retirement village noted that as RN B's last day at the rest home was 12 May 2020, no action relating to her behaviour was able to be taken. However, owing to the nature of the concerns, it notified the Nursing Council of her behaviour in July 2020.

48. The retirement village stated:

> "In our opinion, [RN B's] behavior showed very poor clinical leadership and risk management processes. Her behavior towards the resident was cruel and showed a total lack of understanding of care for the elderly residents with dementia."

*HCAs*

49. Mr D stated that he is very disappointed in RN B, and said that if she meant what she said to Mr A, it was very degrading.

50. In a further statement to HDC, Ms C said that she remembers the incident clearly. She stated: "I witnessed all of [the] incident and was present for all conversations."

51. Ms C also stated:

> "The way that [RN B] behaved made me feel extremely uncomfortable. [RN B] had used abusive, violent language and was swearing from the minute she arrived at the scene of the incident until the end of my shift. I felt awful that she would treat a resident in that way."

*RN B*

52. RN B told HDC that on reflection, she would have completed the challenging behaviour logs and matrix. She said that going forward in her practice, she is ensuring that all documentation follows the policies and procedures of her employer. She has since attended training on challenging behaviour from a dementia specialist nurse, through her current employer.

**Responses to provisional opinion**

53. Mr A's daughter was provided with the opportunity to comment on the "information gathered" section of the provisional opinion. She noted that she was not aware of her father's behaviours such as starting arguments, or being aggressive. She also expressed disappointment that she was not told about this incident, and congratulated Ms C for reporting RN B's behaviour. She stated:

> "I was so upset when I was made aware of how [RN B] had treated my father that night, her last night, I cannot believe anyone in the caring profession as a nurse can treat anyone like this …"

54. The retirement village was provided with the opportunity to comment on the full provisional opinion. The retirement village told HDC that it has since provided further education to its care and management staff, which included education relating to post-incident management, escalation, preventing complaints, identifying distressed behaviour, de-escalation, call bell training in the special care unit, and courageous conversations.

55. Additionally, the retirement village told HDC that it has focussed on effective and timely communication with families, residents, and internal and external team members, and held a clinical excellence webinar on "courageous conversations" in March 2021 with its management teams. This session explored indications for communication, effective communication, early identification of issues, and documentation. The retirement village also provided HDC with evidence that both communication and care have since improved at the rest home, by way of a residents' survey.

56. RN B was provided with the opportunity to comment on the sections of the provisional opinion that related to her. RN B accepted that she breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). She noted that since these events, she has undertaken significant further training to further educate herself, and that she continues to further her education to address her shortcomings from the incident. In addition, RN B noted that this is the first and only complaint that she has had in her long career, and that she prides herself on doing the best job she can for her patients.

57. However, RN B vehemently denies speaking to Mr A in a disrespectful manner or abusing him. She told HDC that this is completely out of character for her and does not align with her practice or values. RN B also disputes that she forcefully handled Mr A, and therefore does not accept that she breached Right 1(1) of the Code.

## Opinion: RN B — breach

### Introduction

58. RN B was one of four staff members on duty on the evening of 11 May 2020. She was also the staff member with the most seniority, and was in charge of the dementia unit for that evening. At the time of these events, RN B had been a nurse at the retirement village since September 2015 but had recently resigned, and her last day of work was due to be 12 May 2020, the following day.

59. As a registered health professional, RN B had responsibility for providing services to Mr A in compliance with the Code. This included providing services with reasonable care and skill, in a manner that respected the individual.

### Incident on 11 May 2020

60. On the evening of 11 May 2020, Ms C was alerted to an altercation between Resident B and Mr A, in Resident B's room. Ms C attempted to seek assistance from RN B by ringing the

emergency call bell. RN B acknowledged that while the emergency bell did not alarm owing to issues with the system, the usual bell did alarm. RN B did not attempt to ascertain the reason for the usual bell alarming, or whether or not she should intervene.

61. When Ms C found RN B, RN B followed her to Resident B's room but left her protective face mask behind. She also did not respond with the urgency the situation warranted. There are conflicting statements as to what occurred when RN B responded to the incident in Resident B's room. Ms C stated that once she and RN B arrived at Resident B's room, RN B "proceeded to yell/scream" at Mr A, and told him that he was "disgusting" and "a monster", and swore at him. Ms C stated that RN B forcefully pulled Mr A up from the chair by his arm and guided him back to his room.

62. Mr D was late to arrive at the scene, but stated that as he was on his way to Resident B's room, he heard RN B shouting at Mr A to get out of the room and calling him "naughty". He said that he then saw RN B grab Mr A by the arm forcefully and "propel him down the corridor to his room".

63. RN B denied that she yelled at Mr A, and stated that when removing Mr A from the room, she just told him that he was "naughty", and asked what his daughter would say about the situation.

64. The camera footage of the incident has no sound, and is missing footage of RN B escorting Mr A back to his room. However, at 8.23pm it shows RN B taking hold of Mr A's upper arm, and leaning in towards his face as she speaks to him before entering Resident B's room. I consider that on the balance of the evidence, it is more likely than not that RN B did yell at Mr A, and handled him forcefully when removing him from the scene back to his room. The statements by both HCAs are consistent with each other in this regard, and I note Ms C's comment that she remembers the incident clearly. Ms C's recollection of the sequence of events is also consistent with the available camera footage.

65. Ms C stated that after the events, while in the lounge, RN B told Mr A to "go away", to "not even breathe around her", and again how he was "disgusting, and a c**t", as well as other abusive words. Mr D stated that when Mr A came into the lounge area, he heard RN B tell Mr A that she did not want him around her, and "not to breathe around her".

66. In contrast, RN B stated that when he was back in the lounge, Mr A was laughing. She said that she told him, "I'm not talking to you, that was naughty," and that this was said in humour.

67. I note that both HCA statements are consistent that at this time, RN B told Mr A to go away and not even to breathe around her, and therefore I accept that this occurred. While I am unable to make a finding about the swear words Ms C alleges that she heard RN B say (noting that Mr D did not recall that RN B swore), I would be extremely concerned if this was this case.

68. My independent aged care advisor, RN Megan Sendall, advised that the expected standard of practice was that RN B would provide both residents with compassionate care following

a difficult incident. In my view, RN B's actions in response to the incident between Resident B and Mr A were extremely disrespectful to Mr A, and not at all compassionate. RN Sendall considered that RN B's actions "would not meet professional standards required of an RN on duty", and I agree.

69. On this evening, RN B was slow to respond to calls for help from the HCAs she was responsible for supporting, and acted inappropriately and disrespectfully towards Mr A, completely at odds with the retirement village's "Managing Challenging Behaviour" policy. RN B's communication and handling style would be inappropriate towards any resident, let alone a vulnerable resident such as Mr A, who had severe cognitive impairment. Further, her failure to wear a mask as required during the outbreak of COVID-19 placed both Mr A and Resident B at potential risk. RN B seemingly gave no consideration to actions to take at this point to further de-escalate the situation and mitigate as far as possible the likelihood of Mr A potentially inflicting additional harm on himself or other residents.

**Care provided after incident**

70. After the incident, RN B was required to complete a challenging behaviour report and escalate the event to the village manager. However, she failed to do so. These escalation and reporting requirements are set out clearly in the retirement village's policies (in particular its "incident reporting severity matrix" and "Management Challenging Behaviour" policy), and I note that RN B accepted that she should have done these things.

71. RN B did not contact the families of the residents to inform them of what had happened. RN B told HDC that during handover to RN E on the morning of 12 May 2020 she discussed with her that RN E would need to complete a bruising report and telephone the family about the incident. However, RN E does not recall this occurring. Regardless of whether the handover occurred or not, these were RN B's duties to complete, as the senior staff member on duty and the staff member who responded to the incident. It would have been inappropriate for RN B to expect another registered nurse to report the incident to the families, and I note RN E's statement that she would never have felt comfortable reporting an incident third-hand.

72. RN Sendall advised that completing an organisation's incident documentation is important for many reasons. For example, she noted that completed documentation can trigger an escalation pathway, notify senior staff, and initiate a corresponding investigation process. Additionally, she noted that it is a requirement to inform family/Enduring Power of Attorney (EPOA) and the resident's GP when there is an unwitnessed incident. In my view, recording incidents also serves to highlight emerging trends and patterns of behaviour that may warrant follow-up.

73. RN Sendall advised that the expected standard of practice in this situation was that RN B would:

> "• Complete the clinical assessments required following an unwitnessed event including neurological observations, documenting and responding to the findings;

- Inform the general practitioners of both residents to ensure medical assessment was completed following an unwitnessed event as soon as practicable, with timeliness based on results of the clinical assessment;
- Inform both residents' families/EPOA of the residents involved as soon as possible;
- Complete the required documentation in full (challenging behaviour report/incident report, progress notes, handover etc). These responsibilities should not be delegated to others; and
- Inform senior staff as required per policy/severity matrix."

74. It is clear in this case that RN B failed to do any of the above. I acknowledge that it was RN B's last day at the retirement village, but I do not consider this a reason to neglect her duties as a nurse. Escalating and reporting incidents is important to ensure that all follow-up actions are undertaken, so that steps can be taken to prevent a similar occurrence again, through actions such as updating the resident's care plan. Ensuring that appropriate clinical assessments are undertaken after a mostly unwitnessed event is also vital in ascertaining whether any injuries were sustained by either of the residents concerned. It is disturbing that had Mr A's facial bruising not been observed and followed up by the village manager on 15 May 2020, the incident may not have been investigated.

**Conclusion**

75. RN Sendall advised that, overall, she believes her peers would feel that RN B's actions on the evening of 11 May 2020 — both in response to the incident between Mr A and Resident B, and the care provided afterwards — did not meet the expected standard of care, and I agree. In my opinion, her actions toward Mr A in response to the incident in particular are a discredit to the Nursing profession. I agree with the sentiment of Mr A's daughter when she says: "I cannot believe anyone in the caring profession as a nurse can treat anyone like this."

76. Mr A had complex care needs owing to his dementia, limited cognitive ability, and his age. He was reliant on the retirement village staff to provide all his cares and, as such, he was a particularly vulnerable consumer. His vulnerability meant that it was critically important that care was provided to him with respect. Residents with dementia often display challenging behaviour, and it is important that this behaviour is managed calmly, as per the retirement village's policy. I have considered RN B's response to the provisional opinion where she denies that she spoke to Mr A in a disrespectful manner, or that she forcefully handled him. On balance, considering all of the evidence available to me and for the reasons set out above, I maintain that it is more likely than not that RN B did speak to Mr A in a disrespectful manner and handled him forcefully when removing him from the situation.

77. I consider that RN B treated Mr A in an unkind and disrespectful way when responding to this episode of his challenging behaviour. In particular I am critical that RN B:

- Shouted at Mr A;
- Handled Mr A forcefully when removing him from the scene back to his room; and
- Spoke to Mr A in a disrespectful manner following the incident.

78. As such, I find that RN B breached Right 1(1) of the Code.[6]

79. In my view, RN B also failed to provide services to Mr A with reasonable care and skill for the following reasons:

- For failing to ascertain whether assistance was needed from her when the usual bell was activated by Ms C;
- For failing to wear a face mask during a COVID-19 outbreak in the country, placing Mr A and other residents around her at potential risk;
- For not completing the clinical assessments required following an unwitnessed event;
- For not contacting the residents' GPs or EPOAs; and
- For omitting to escalate and report the incident as per the retirement village's policies.

80. The above actions negatively impacted on the care Mr A received. Accordingly, I find that RN B also breached Right 4(1) of the Code.[7]

## Opinion: Retirement Village

### Introduction

81. The New Zealand Health and Disability Services Standards (NZHDSS) require that rest homes ensure that they operate in an efficient and effective manner, in order to provide timely, appropriate, and safe services to consumers.[8] The retirement village had the ultimate responsibility to ensure that Mr A received care that was of an appropriate standard and that complied with the NZHDSS and the Code. The retirement village needed to have in place adequate systems, policies, and procedures, and to ensure compliance with those policies and procedures so that the care provided to Mr A was appropriate, and that any deviations from good care were identified and responded to.

### Care provided to Mr A — no breach

82. On 11 May 2020, Ms C was alerted to an incident between two residents — Mr A and Resident B. She attempted to summon RN B to assist her by pressing the call buttons multiple times, and activating her pager. RN B told HDC that while the emergency bell did not activate, the usual resident bell did.

83. Ms C and Mr D allege that when RN B was located and brought to the scene, she yelled at Mr A, made abusive comments, and handled him with force. As above, I have found that RN

[6] Right 1(1) stipulates: "Every consumer has the right to be treated with respect."
[7] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[8] NZS 8134.1:2008, Standard 2.2.

B did yell at Mr A and handle him inappropriately when trying to remove him from the situation.

84. After the incident, RN B did not contact the families to inform them about what had happened. She also did not complete a challenging behaviour report, as per the retirement village's policy, and did not escalate the event to the village manager as per the rest home's "incident reporting severity matrix".

85. My independent aged care advisor, RN Sendall, advised that there were sufficient staff on duty at the retirement village at the time of the event, and that the policies in place at the retirement village were appropriate for purpose. She said that the rest home had a suite of up-to-date policies suitable for the size and nature of the service, including its "Management of Challenging Behaviour" policy. She stated:

> "The five page document contained industry definitions of challenging behaviour, information related to training requirements, documentation requirements and appropriate staff response when behavioural incidents occur. I believe the organisation also provide[d] appropriate clinical policies to guide staff in the care of residents."

86. I agree, and note that the retirement village's "Managing Challenging Behaviour" policy clearly outlines the expectations of staff both during and after an event such as aggression from a resident.

87. RN Sendall also noted that Mr A's care plan included behavioural triggers, with actions outlined to manage this. She advised that the identified triggers, alongside policy and training, provided sufficient information and support for staff to manage the event. She stated:

> "In a shared care environment with staff providing services to several residents at the same time, incidents can happen quickly. In this case there was no history of [Mr A] behaving in a challenging manner for 6 weeks prior to this incident. I'm not aware of any preventative measures that could have been undertaken by the organisation related to this incident."

88. RN Sendall advised that overall, "[i]t appears it was RN B's approach to the incident [that] was the key factor in the suboptimal management of this incident".

89. I accept this advice. I consider that the combination of suitable policies and the information in Mr A's care plan were sufficient to support RN B in an event such as the incident on 11 May 2020. I believe that in this case, one staff member failing to follow policy does not indicate a broader pattern of staff non-compliance. I also note that RN B has acknowledged that she should have informed the village manager and completed a challenging behaviour report. I am satisfied that RN B knew what was required of her in these circumstances, but failed to do so on this occasion.

90. Although there were issues with activation of the emergency bell because of construction in the unit, I note that there were work-arounds for the issues. Staff also had pagers to alert

them to any issues, and I note in this case that the usual bell did alarm even if the emergency one did not, and I consider that this should have alerted RN B to investigate whether she was needed. Considering the above information, it is my opinion that there are no factors in this case that indicate wider systemic issues at the retirement village, and that RN B's actions and omissions were individual.

**Communication — adverse comment**

91. Once the village manager became aware of the incident on 11 May 2020, Mr A's daughter was contacted to inform her about what had happened between her father and Resident B. However, she was not informed of RN B's conduct towards her father at this time, and was not aware of the allegations against RN B until the referral of the concerns to this Office. The retirement village accepted that communication with Mr A's family should have been better in this regard.

92. RN Sendall advised:

> "It is a challenging situation for families when their loved one is involved in an incident and providing respectful, complete, and professional support to families is expected. I believe there has been a departure from expected practice related to communication. I believe my peers would expect timely, comprehensive, and complete communication to occur with a compassionate tone."

93. I agree with this advice and I consider that the retirement village's communication with Mr A's family could have been improved on this occasion. Communication is vital for the trusting relationship between families and the providers who care for their loved ones, and I believe that Mr A's daughter had a right to know of the allegations of RN B acting in a disrespectful manner towards Mr A.

## Recommendations

94. I acknowledge that RN B has since attended training on challenging behaviour through her current employer. In addition, I recommend that RN B:

a) Undertake further training related to documentation, post-incident management, and family/EPOA communication requirements. Evidence that this has been done is to be sent to HDC within six months of the date of this report.

b) Review the article "The Role of Empathy in Health and Social Care Professionals[9]" and provide a report to HDC highlighting her learnings. The report is to be sent to HDC within three months of the date of this report.

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7151200/.

c) Provide Mr A's family with an apology for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

95. I recommend that the Nursing Council of New Zealand consider whether a review of RN B's competence is warranted, and report back to HDC on the outcome of this consideration.

## Follow-up actions

96. RN 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.

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

98. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to HealthCERT (Ministry of Health) and Southern DHB, and they will be advised of the name of the retirement village.

99. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Aged Care Association and 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 Megan Sendall:

"Assessment of care provided by the retirement village and registered nurse (RN) [RN B] to [Mr A] was conducted through review of documents and closed circuit television (CCTV) footage supplied to the office of the Health and Disability Commissioner by [the retirement village], [the] District Health Board, and [a law firm].

Key areas for consideration relate to care provision, in particular actions taken following an incident involving [Mr A] and [Resident B] on 11 May 2020.

Comment was requested for the following questions:

[RN B]:

1. The adequacy of [RN B's] initial response (after the call bell was rung and [RN B] was paged) to the event between the two residents.
2. The adequacy of the care provided to [Mr A] by [RN B].
   i) If HCA [Ms C's] account of events is accepted.
   ii) If HCA [Mr D's] account of events is accepted.
   iii) If [RN B's] account of events is accepted.
3. The adequacy of the follow up actions taken by [RN B] after the event.

For all questions/statements the following is also requested:

- What is the standard of care/expected practice?
- If there has been a departure from the expected standard of care or accepted practice
- How this would be viewed by your peers?
- Recommendations for improvement that may help [prevent] a similar situation occurring in the future.

My response:

1. The adequacy of [RN B's] initial response (after the call bell was rung and [RN B] was paged) to the event between the two residents.

[Mr D] and [Ms C] reported [RN B] acted unprofessionally that evening. This included a delayed response to calls for assistance, shouting and using inappropriate language when addressing [Mr A]. This allegedly occurred after [RN B] was summoned to attend the incident with [Mr A] and [Resident B] and afterwards in the home's lounge. [RN B] denies this. It is noted that [RN B's] legal statement included the following 'I used the force necessary to remove [Mr A] from his room' and 'You are naughty [Mr A] and I'm not talking to you'.

On balance, after reviewing the CCTV footage, albeit without sound, provided and reading the statements from all parties, it appears the reports of shouting and inappropriate language probably happened and would not meet professional standards required of an RN on duty.

Completing the organisation's incident documentation is important for many reasons. Completed documentation can trigger an escalation pathway, notify senior staff and initiate a corresponding investigation process. Additionally, it is a requirement to inform family/Enduring Power of Attorney (EPOA) and resident's general practitioner (GP) when there is an unwitnessed incident. [RN B] failed to complete the required documentation, inform both families/EPOAs, GP and senior staff as required.

In her own statement dated May 2021, [RN B] confirmed on reflection she would have:

i) completed challenging behaviour logs and matrix

ii) documented at the time, her conversation with the clinical manger (CM)

iii) and followed through with family communication herself.

Regarding clinical assessment, I include the following comments:

In one HCA statement it was documented [Resident B] was pulled off the bed by her foot. In another statement, it referred to the resident being 'strangled'. A third document refers to both residents being on the floor '[Mr A] dragging another resident by her ankles as they lay on the ground screaming'. However, the total incident/event was not witnessed by staff. [Ms C] left the event in progress to summon assistance.

In an unwitnessed incident of this nature where parts are witnessed and parts are not, or when the event is not witnessed at all, physical assessment including vital sign assessment, plus a suite of neurological observations, should have been completed. As both residents were reported to have been on the floor, their method of falling could not be determined accurately and therefore required clinical assessment to be completed for an unwitnessed fall. This would ensure the residents were supported appropriately, policy, and industry standard requirements were met. Additionally, the organisation's incident report severity matrix includes rating for 'physical aggression causing harm' and/or 'allegation of assault' as extreme.

The expected standard of practice is that [RN B]:

- provide both residents with compassionate care following a difficult incident
- complete the clinical assessments required following an unwitnessed event including neurological observations, document and respond to the findings
- inform the general practitioners of both residents to ensure medical assessment was completed following an unwitnessed event as soon as practicable, timeliness based on results of the clinical assessment

- inform both residents' families/EPOA of the residents involved as soon as possible
- complete the required documentation in full (challenging behaviour report/incident report, progress notes, handover etc). These responsibilities should not be delegated to others
- inform senior staff as required per policy/severity matrix.

As identified by [RN B] in her statement (May 2021) the required documentation, plus a detailed incident report should have been completed. It is noted that [RN B] had resigned and was completing her final shifts when these events occurred. I also note, to her credit, her reflective comments were insightful into her gaps in practice that evening. I believe there has been a moderate departure from the expected standard of care. Further reflection by [RN B], could support changes in her communication style to all residents especially residents with cognitive change. Alongside this, [RN B] could improve her understanding of the support required for HCAs.

I believe my peers would feel that [RN B's] actions that evening did not meet the expected standard of care. Her reflective statements in 2021, confirm she had gained insight in the time between the event and her 2021 statement identifying gaps in practices and identified what she might change in the future. Her current employer reports that she has not observed gaps in her current practice.

I speculate that if [Mr A's] facial bruising was not observed and followed up by the village manager on 15 May, then the incident may not have been investigated. Recommendations for improvements would include:

1. ensuring [RN B] revisit her responsibilities (attend education sessions and competency assessment) related to documentation, post incident (unwitnessed fall) clinical assessment and family/EPOA communication requirements.

2. clarify, through policy review and clinical supervision, her responsibilities regarding HCA support and oversight. This could also be achieved through education related to delegated authority.

3. managing challenging behaviour training and competency review. This would include the support required for residents with cognitive change, who were involved in incidents and how to manage this compassionately to meet [the] care values and philosophy of care. It is noted [the] Managing Challenging Behaviour policy includes calm interventions expected.

<u>Question 2. The adequacy of the care provided to [Mr A] by [RN B].</u>

i) If HCA [Ms C's] account of events is accepted.

ii) If HCA [Mr D's] account of events is accepted.

iii) If [RN B's] account of events is accepted.

I have responded to all three areas as follows:

The accounts of the incident vary including those by [Mr D], [Ms C] and [RN B]. However, it is confirmed that various RN clinical requirements were not completed that evening or followed up the next day by [RN B].

Therefore, there is evidence and reflective comments documented by [RN B] that confirm the gaps in practice outlined in question 1. It also appears that it is likely that unprofessional communication did occur. I also believe [RN B] was not as calm and careful when responding to the incident with [Mr A] as expected or outlined in policy.

I believe there has been a moderate departure from expected practice. I believe my peers would expect a higher standard of care in this incident. I believe prompt RN response to the event when summoned by call bell, calm professional management of the event, sound clinical follow up to meet both policy, best practice requirements and compassionate care for the residents involved would be standard practice.

Recommendations for improvement that may help [to prevent] a similar situation occurring in the future include:

- education and training including unwitnessed incident management and documentation
- delegated authority training
- vital sign requirements (neurological observations) competency and policy review.

[Retirement village]:

1. The adequacy of the staffing levels at [the retirement village] at the time of these events

[The] staffing levels are consistent with other providers at this level of care. They undertake review each shift to meet current guidelines for care and manage staff with senior staff oversight to maintain safe staffing levels. I believe there was sufficient staff on duty at the time of the event. I do not believe there has been a departure in practice and my peers would believe there were sufficient staff available to manage the incident appropriately in a group home of this nature at this level of care. There are no recommendations for improvement related to staffing levels.

2. The adequacy of the actions taken by [the retirement village] once they became aware of the event.

By their own admission, [retirement village] staff reported they did not notify the family as required after reviewing the CCTV footage and ascertaining staff investigation was required. I am not aware that [retirement village] staff identified the need for appropriate clinical assessment for the unwitnessed event to include neurological observations therefore, their own policy was not followed. Communication to families was scant as described in response to the next question. GPs were not advised

promptly. These areas fell short of expected practice, and I believe my peers would view this as not meeting industry expectations.

Recommendations for improvement that may help [prevent] a similar situation occurring in the future would be to provide additional training, policy and competency review for staff involved in the post incident management of this event.

3. The adequacy of the communication between [the retirement village] and [Mr A's] family.

Communication modes utilised to inform the families after the incident were limited to texting and messenger. I believe, a phone call and offer of meeting with family/EPOA was required to provide an opportunity for appropriate information transfer. It is a challenging situation for families when their loved one is involved in an incident and providing respectful, complete, and professional support to families is expected. I believe there has been a departure from expected practice related to communication. I believe my peers would expect timely, comprehensive, and complete communication to occur with a compassionate tone.

Recommendations for improvement that may help [prevent] a similar situation occurring in the future would be to ensure all staff complete further training in communication. This would include the requirements for timely communication with families, appropriate forms of communication and the style/tone required to ensure families are sensitively informed.

4. The adequacy of the organisation's policies and procedures.

[The retirement village] has a suite of up to date policies suitable for the size and nature of the service. Following review of the Management of Challenging Behaviour policy, particularly relevant to this incident, I note the policy was up to date (reviewed October 2020) and appropriate for use. The five page document contained industry definitions of challenging behaviour, information related to training requirements, documentation requirements and appropriate staff response when behavioural incidents occur. I believe the organisation also provided appropriate clinical policies to guide staff in the care of residents.

There is no departure from expected practice noted in relation to policies and procedures. My belief is that my peers would find the policies provided consistent with those meeting best practice. There are no recommendations for improvement identified related to the organisation's policies.

5. The adequacy of the training provided to [retirement village] staff.

The organisation provided training in keeping with industry requirements. [RN B] had undertaken regular training during her tenure. Opportunity to revisit competency is always available to an organisation if they believe ongoing work is required to maintain skills and knowledge. External education training is additionally available for staff. Training is also the responsibility of each staff member. In the case of RNs, they are

required to complete twenty hours of education to fulfil their annual practising certificate requirements. It is noted [RN B's] First Aid training was last recorded in October 2017. There may be additional records to support more recent refreshers.

I do not believe there has been a departure from expected practice regarding the adequacy of training. [RN B] attended regular organisation training sessions covering a range of suitable subjects. I believe my peers would see this as suitable for the nature of the service. There are no recommendations regarding the staff training schedule/ annual training plan, or the adequacy of training provided to [RN B] or other staff.

6. Whether [Mr A's] behaviour was managed appropriately including appropriate plans and interventions.

[Mr A's] care plan was reviewed and included behavioural triggers. These were identified in the plan and actions to manage these outlined. The identified triggers, alongside policy and training, I believe, provide sufficient information and support to staff to manage this event. In a shared care environment with staff providing services to several residents at the same time, incidents can happen quickly. In this case there was no history of [Mr A] behaving in a challenging manner for 6 weeks prior to this incident. I'm not aware of any preventative measures that could have been undertaken by the organisation related to this incident.

It appears it was [RN B's] approach to the incident [that] was the key factor in the suboptimal management of this incident. Documents confirm he often misplaced his room/bed for others, not uncommon for people with Dementia. I believe there has been no departure from expected practice by [the retirement village] related to their usual management of challenging behaviour and that my peers would view this similarly.

There are no other matters in relation to the care provided to [Mr A] by [retirement village] staff warranting comment or that amount to a departure from accepted practice prior to the incident. There are no recommendations regarding care provision, managing challenging behaviour prior to the event other than those related to the incident.

Yours sincerely,

Megan Sendall"