Decision 22HDC00835
4 December 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care provided to 85-year-old woman in retirement village dementia unit

Complaint background

1. On 5 April 2022, Mr A submitted a complaint to HDC raising concerns about the care provided to his mother, Mrs A, whilst being cared for in the dementia unit of Lady Wigram Retirement Village in month7 year1 2022.

2. On day15 month7 year1 at 5.00am, Mrs A was noted to be sitting in a chair in the dining room looking 'quite able'. By 7.00am, she had been moved to a hospital chair that is not usually available on the dementia unit.[1]

3. Around 8.45pm, Mrs A's daughter received a phone call from Lady Wigram Retirement Village advising that Mrs A had suffered a fall and that St John Ambulance had been called. At around 6.30am the following day, an ambulance arrived and transported Mrs A to hospital.

4. When Mrs A arrived at hospital, an X-ray confirmed that Mrs A had broken her hip. Mrs A was then admitted to the Orthopaedic Unit.

5. On day17 month7 year1, Mrs A underwent surgery for her broken hip, which Mr A recalls being told 'went well'. However, sadly, Mrs A later passed away, having not recovered from the anaesthetic.

6. Prior to Mr A submitting the complaint to HDC, Lady Wigram Retirement Village contacted him to apologise for the care provided to Mrs A.

7. Mr A's complaint concerns the following issues:

- The delay between Mrs A suffering a fall and the subsequent transfer to hospital.
- A comment by a doctor at the hospital, who noted that Mrs A had high levels of sedative medications,[2] which may have impacted her coming out of the anaesthetic. Prior to this event, Mrs A had been a physically fit and able woman.

Scope of investigation

8. The following issue was investigated:

- *Whether Lady Wigram Retirement Village provided Mrs A with an appropriate standard of care between day15 and day17 month7 year1, inclusive.*

[1] These observations were made by Mr A after viewing video footage taken on day15 month7 year1.
[2] Having high levels of sleeping pills and calming medication in her system.

Names (except Lady Wigram Retirement Village and the in-house advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name. Relevant days, months and years are referred to as day1 -day23, month5-month10 and year1-year2 to protect privacy. Days and month numbers reflect sequence of events not consecutive calendar days.

Information gathered

9. Lady Wigram Retirement Village responded to the complaint by providing a statement from the registered nurse (RN), nurse practitioner (NP), and clinical manager at the time of the complaint.

10. Lady Wigram Retirement Village also provided copies of Mrs A's clinical records for the period being investigated. This included its Administration of Medications and its Challenging Behaviours policies, with details of its Falls Prevention Programme.

11. The hospital provided copies of Mrs A's clinical records relating to the admission post-fall until she passed away.

In-house advice

12. In-house Aged Care Advisor NP Isabella Wright provided advice on the care provided to Mrs A by Lady Wigram Retirement Village. Ms Wright identified the following departures from the accepted standard in relation to Mrs A's care:

- Moderate/severe departure: The prescribing of a PRN[3] sedative, antipsychotic, and hypnotic agent along with regular prescribed medication was not in line with safe prescribing guidelines. Ms Wright noted a lack of appropriate assessment, investigations and referral to Mental Health Support of Older Persons (MHSOP), as well as a lack of regular follow-up of treatment.
- Severe departure: The oversight and management of PRN administration for Mrs A during her time in the dementia unit and in the three days prior to her hospital admission was not in line with acceptable practice. Ms Wright noted the overuse of PRN medications. There was a lack of appropriate consultation and review with RNs of PRN medications administered by care staff, and consequently the NP. There was also a lack of clinical assessment to identify possible causes of behavioural and psychological symptoms of dementia (BPSD).
- Mild departure: Regarding the clinical oversight of Mrs A's unwitnessed fall prior to her hospital transfer, Ms Wright noted a lack of documentation of Mrs A's fracture assessment.
- Severe departure: The overall clinical management of Mrs A's functional needs from her initial admission to Lady Wigram Retirement Village through to her hospital transfer was not in line with acceptable practice. Ms Wright noted a lack of appropriate assessment by the NP, a lack of referral to MHSOP, and an absence of testing or follow-up despite worsening symptoms.

Decision

13. To achieve a timely and pragmatic resolution of the complaint, Lady Wigram Retirement Village was provided with details of the assessment and a copy of the in-house advice, and HDC proposed to find it in breach of Right 4(1) of the Code of Health and Disability Services

[3] 'Pro re nata', meaning 'as needed' or 'when required'.

Consumers' Rights (the Code), which states that services are to be provided with reasonable care and skill.[4] I proposed this option having accepted my Aged Care Advisor's findings that the oversight and management of PRN medication administration, the clinical oversight following Mrs A's unwitnessed fall, and the overall clinical management departed from the accepted standard of care. In response, Lady Wigram Retirement Village accepted the proposal of a breach finding of Right 4(1).

14. As such, I find that Lady Wigram Retirement Village breached Right 4(1) of the Code in the care it provided to Mrs A between day15 and day17 month7 year1.

15. Although I note that the departures identified above are significant and clearly identify that the care provided to Mrs A was not of an appropriate standard, I do not consider that these departures contributed to Mrs A's passing.

16. Lady Wigram Retirement Village were given an opportunity to comment on relevant parts of the provisional decision and had no substantive comments.

Recommendations

I recommend that Lady Wigram Retirement Village:

- Provide a written apology to Mrs A's family for the breach of Right 4(1) as identified in my investigation. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.
- As per my in-house Aged Care Advisor's advice, provide education for care staff and RNs about recognising acute deterioration, delirium, falls, and fractures as outlined by the Frailty Care Guides (2023).[5] Evidence that this has been completed is to be provided to HDC within six months of this final report.

Changes made since events

17. I am reassured that, as a result of this case, Lady Wigram Retirement Village made the following changes:

- Improved management structure with a dedicated care facility manager, clinical manager, and unit coordinator for each area of care.
- Instigated a new role of a full-time dementia unit clinical coordinator who reports to the Clinical Manager and is responsible for clinical oversight and care.
- Increased RN hours in the dementia unit.
- Increased hours dedicated to resident activity.

[4] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'
[5] Frailty care guides | Ngā aratohu maimoa hauwarea (2023 edition) | Health Quality & Safety Commission (hqsc.govt.nz).

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- Introduced closing central dividing doors in the dementia unit to enable a primary care focus with 20 residents in each wing, each having dedicated care staff.
- Instigated a full-time education coordinator dedicated to supporting the completion of mandatory education.
- Partnered with the Altura online learning platform to support ongoing education for care staff.

18. In addition:

- All care staff have completed or are in the process of completing mandatory NZQA Dementia Unit Standards.
- Two staff have completed the 'Walking in Another's Shoes' dementia programme, with further staff scheduled to undertake the programme in the future.

Follow-up actions

19. A copy of this report will be sent to Mr A, Lady Wigram Retirement Village, and HealthCert.

20. A copy of this report with details identifying the parties removed, except Lady Wigram Retirement Village and my in-house advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Isabella Wright, Aged Care Nurse Advisor for the Health and Disability Commissioner:

> **'CLINICAL ADVICE — AGED CARE**
>
> **CONSUMER** : Mrs A
>
> **PROVIDER** : Lady Wigram Village
>
> **FILE NUMBER** : C22HDC00835
>
> **DATE** : […] year2
>
> Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Lady Wigram Village care home. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> **1. Documents reviewed**
>
> All clinical documentation provided by Lady Wigram Village, Health New Zealand | Te Whatu Ora […])
>
> Specifically:
>
> Clinical notes (nursing, care staff, and NP) from day3 month5 year1 until day15 month7 year1.
>
> Medication chart and administration of medications records
>
> Bowel charts
>
> Admission assessments (day2 month5 year1)
>
> Statements from RN B — day19 month8 year1, NP C — day20 month9 year1, Clinical Manager Ms D — day21 month9 year1
>
> MHSOP letter — day1 month5 year1
>
> Administration of Medications Policy (dated day22 month9 year1)
>
> Challenging Behaviours of Concern management policy (dated day22 month9 year1)
>
> Falls Prevention Programme (dated day22 month9 year1)
>
> **2. Complaint**
>
> Complaint received in April 2022 from Mr A, who has raised concerns surrounding the care of his mother, Mrs A, while at Lady Wigram Retirement Village in relation to the nature of the unwitnessed fall, subsequent monitoring, and delay in transfer from the facility to the hospital. In addition, concerns surrounding substandard care.
>
> Complaint was reviewed by aged care navigator, Ms E, on 5/4/22.

Medical advice was provided by Dr F on day23 month10 year2.

3. Review of clinical records

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

4. Clinical advice

Background: (as per Ms E's report)

Mrs A (now deceased) was 85 years of age at the time of the event. She entered full-time care in the secure dementia unit at Lady Wigram Village from day3 month5 year1. Prior to this, she resided in a non-secure rest home environment.

On day15 month7 year1 around 5am, Mrs A was noted as sitting in a La-Z-Boy in the dining room, and around 7am noted to have been moved into a hospital chair not normally available in the dementia unit.

Around 8.45pm on day15 month7, the nurse called Mrs A's daughter notifying her of a fall and that the ambulance had been called. St John report notes time of initial call to be 9.15pm. The ambulance did not arrive until the following morning of day16 month7 around 6.30am.

Mrs A was transferred to hospital where an x-ray confirmed a subcapital fracture of the left neck of femur, necessitating surgical intervention on day17 month7. Despite the operation being noted as uncomplicated, Mrs A struggled postoperatively, requiring considerable naloxone to reverse sedation.

Mrs A, however, did not recover and [later] passed away […]. Of note, the family reported doctors advised them of high levels of sedative medications in her system that may have contributed to difficulty coming out of the anaesthetic.

Medical History:

Dementia — vascular

Frailty

Type 2 diabetes

Right internal carotid artery stenosis diagnosed in 2020

Cerebral hypoperfusion

Hypertension

Hyperlipidaemia

Gastro-oesophageal reflux (GORD)

Osteoporosis

Regular medications:

Metoprolol 47.5mg OD [once daily]

Felodipine 10mg OD

Omeprazole 20mg OD

Candesartan 4mg OD

Atorvastatin 40mg OD

Aspirin 100mg OD

Haloperidol 500mcg OD (antipsychotic — sedating effect)

Lactulose 15ml BD [twice daily]

Paracetamol 20ml TDS [three times daily]

PRN (as needed medications):

Haloperidol 500–1000mcg Q4H [every 4 hours] PRN (antipsychotic — sedating effect) — prescribed prior to admission to dementia unit (as per MHSOP)

Zopiclone one tab nocte [at night] PRN (hypnotic agent — sedating effect) — started on day7 month6 year1

Lorazepam 0.5–1mg QID [four times daily] PRN (benzodiazepine — sedating effect) — started on day9 month6 year1

Questions:

Do you consider the prescribing of PRN sedative, antipsychotic and anxiolytic along with regular prescribed medication for Mrs A to be in line with safe prescribing guidelines?

Review of documentation from day3 month5 year1 until day15 month7 year1 indicates that Mrs A presented with BPSD. Challenging behaviours included physical aggression towards staff and other residents, agitation, refusing assistance with ADLs [activities of daily living], refusing medications, refusing food and fluids, confusion, wandering – especially at night, entering other residents' rooms, sleeping in other rooms, packing up her belongings, removing her clothes, urinating in communal areas, and at times hallucinating.

These behaviours were prominent in late afternoons, evenings, and during the night. Mrs A had poor sleep patterns, at times averaging two hours of sleep per night.

The NP reviews were completed on day7 month6 and day9 month6 year1 — prescribing PRN zopiclone for insomnia and then PRN lorazepam for agitation. Behaviour chart was commenced with a view to refer to MHSOP. However, this referral did not happen. No documented evidence was found about discussions about treatment prescribed with EPOA [Enduring Power of Attorney] and potential side effects and increased falls risk.

The NP documentation did not indicate delirium assessment (such as CAM [Confusion Assessment Method]) or physical assessment to rule out reversible causes of delirium

such as constipation or infection, pain, hypoglycaemia, or dehydration. No blood tests (delirium screen) were ordered.

(Notably, during the review of progress notes, the BPSD was reported to be increasing on day 3 or 4 of no bowel motion.) Cholecalciferol (Vit D) was not prescribed as per best practice and Falls Prevention Programme. There was a lack of evidence of regular follow-up and monitoring of prescribed PRN sedating medications.

As per Dr F's comments:

However, I note the use of benzodiazepines for management of BPSD would be regarded as 'off label' in New Zealand, which requires discussion with the consumer or consumer's representative prior to prescribing. Guidance on use of benzodiazepines and other sedatives in BPSD[1] includes *Benzodiazepines and other sedative drugs have benefit for acute sedation in the very short term but have little evidence of efficacy beyond that. There are no adequate studies of benzodiazepines or other sedatives such as the z-drugs* [includes zopiclone] *in BPSD, but they may be used as a very short-term treatment for agitation, severe anxiety, and insomnia. If benzodiazepines are used, those with shorter half-lives are preferred given the risk of accumulation. Lorazepam (0.5–1mg daily) or oxazepam (15–30mg daily) may be considered in the very short-term (days) management of agitation or severe anxiety.* The cited BPAC[2] publication notes close monitoring of patients being prescribed antipsychotics is required, especially in patients who are taking medicines with the potential for interactions with antipsychotics. This includes monitoring for central nervous system depression, including sedation, increased confusion, or cognitive impairment. Benzodiazepines and zopiclone may exacerbate these symptoms and can also precipitate delirium. Benzodiazepines and zopiclone in combination with antipsychotics may also exacerbate symptoms of postural hypotension and dizziness and increase falls risk.

From the evidence reviewed to respond to this question, it appears that the prescribing of PRN sedative, antipsychotic, and hypnotic agent along with regular prescribed medication for Mrs A was not [in] line with safe prescribing guidelines. Lack of appropriate assessment, investigations, and referral to MHSOP as well as lack of regular follow-up of treatment and would be viewed similarly by my peers. **Departure from accepted practice: Moderate/severe.**

Do you consider the oversight and management of PRN administration for Mrs A in the 3 days preceding hospital admission to be within acceptable practice with consideration of her individual presentation during this time?

[1] NSW Ministry of Health and Royal Australian and New Zealand College of Psychiatrists. Assessment and management of people with behavioural and psychological symptoms of dementia (BPSD). 2013. www.ranzcp.org/files/resources/reports/a-handbook-for-nsw-health-clinicians-bpsd_june13_w.aspx Accessed day23 month10 year2.

[2] https://bpac.org.nz/2020/bpsd.aspx Accessed day23 month10 year2

It is important to consider the month of month6 year1 and first 5 days in month7 year1 (prior to admission to hospital) to understand the PRN medication use for Mrs A.

The PRN (as needed) medications were administered as per the table below.

PRN Medications

Medication	Dose	Time / Date	Administered by	Checked by	Comments	Outcome
ZOPICLONE 7.5 MG TABLET	1 tablet	22:48 [redacted]	[redacted]		unsettled, to aid in sleep	
LORAZEPAM 1 MG TABLET	1 tablet	21:14 [redacted]			Very agitated and unsettled	No effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	12:20 [redacted]			agitation	some effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	03:26 [redacted]			aggressive, pacing, very unsettled	no effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	00:13 [redacted]	[redacted]		agitated and unsettled	no effect
ZOPICLONE 7.5 MG TABLET	1 tablet	22:27 [redacted]			unsettled, to aid in sleep	no effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	19:42 [redacted]			Given for aid in sleep	Minimal effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	01:18 [redacted]			unsettled, aggressive, wandering	Administered with good effect
ZOPICLONE 7.5 MG TABLET	1 tablet	22:25 [redacted]			to aid in sleep	No Effect
LORAZEPAM 1 MG TABLET	1 tablet	18:33 [redacted]			Unsettled and wandering around	Minimal effect
ZOPICLONE 7.5 MG TABLET	1 tablet	21:30 [redacted]			to aid in sleep as she is very unsettled.	No effect
LORAZEPAM 1 MG TABLET	1 tablet	20:30 [redacted]			very agitated and unsettled	No effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	01:51 [redacted]			given due to being unsettled and agitated	good effect
ZOPICLONE 7.5 MG TABLET	1 tablet	20:38 [redacted]			to aid in sleep	No effect
LORAZEPAM 1 MG TABLET	1 tablet	18:49 [redacted]			agitated and unsettled	No effect
ZOPICLONE 7.5 MG TABLET	1 tablet	19:36 [redacted]			to aid in sleep	NO EFFECT
LORAZEPAM 1 MG TABLET	1 tablet	17:21 [redacted]			EXTREMELY AGITATED AND UNSETTLED	NO EFFECT
LORAZEPAM 1 MG TABLET	1 tablet	22:22 [redacted]	[redacted]		very unsettled, up and down, agitated	NO EFFECT
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	19:44 [redacted]			Agitated and unsettled	NO EFFECT
ZOPICLONE 7.5 MG TABLET	1 tablet	02:56 [redacted]			given at 2330 due to unable to sleep	with no effect
HALOPERIDOL 500 MICROGRAM TABLET	2 tablet	20:58 [redacted]			Given for extreme agitation.	No effect. She was still up and down.
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	23:34 [redacted]			given due to being unsettled and agitated Anxiety: 7	
HALOPERIDOL 500 MICROGRAM TABLET	2 tablet	20:18 [redacted]			Agitated and unsettled	Good effect
HALOPERIDOL 500 MICROGRAM TABLET	2 tablet	21:28 [redacted]			Agitated, aggressive and unsettled	short team effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	20:37 [redacted]			Unsettled	Good effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	20:46 [redacted]			Unsettled, agitated	Good effect
LORAZEPAM 1 MG TABLET	0.5 tablet	00:00 [redacted]			aggressive, agitated	good effect
HALOPERIDOL 500 MICROGRAM TABLET	1 tablet	20:49 [redacted]			unsettled and agitated	Good effect

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In addition to the times listed in the table,

PRN haloperidol 0.5 mg was administered on:

day4 month6 at 2339 hrs with good effect
day5 month6 at 0526 hrs with good effect
day6 month6 at 0553 hrs with good effect
day6 month6 at 2425 hrs with minimal effect
day9 month6 at 0533 hrs with good effect

PRN zopiclone was administered on:

day7 month6 at 2200 hrs — effect not documented
day8 month6 at 2151 hrs with no effect
day9 month6 at 2225 hrs with no effect

PRN lorazepam was administered on:

day9 mont6 at 2120 hrs with short-term effect
day10 month6 at 0035 hrs with good effect
day10month6 at 2256 hrs with short-term effect

Overall, Mrs A received a total of the following PRN sedating medications:

Haloperidol — 11 additional doses (to usual daily dose of 0.5 mg) in month6 year1 and 5 doses in first 5 days in month7 year1.

Zopiclone (7.5 mg) — 8 doses in month6 year1 and 2 doses in first 5 days in month7 day1.

Lorazepam — 10 doses in month6 year1 and 1 dose in first 5 days in month7 year1.

Clinical documentation by caregiving staff indicated ongoing and increasing agitation throughout month6 year1, and – on day11 month6 – it was noted that Mrs A became unsteady on her feet, increased physical aggression towards staff and other residents, and might have been hallucinating. Unwitnessed fall at 0320 hrs, Mrs A was kneeling in front of her bed and had a bruise on left shoulder. Assessed by RN G.

NP review was not initiated.

RN B's review on the following day day12 month6, indicated discussion with NOK [next of kin] about the fall, nil complaints of pain, new bruises, and to continue with PRN medications following discussion with clinical manager.

The progress notes contain only two RN reviews in the month of month6 year1, when Mrs A's BPSD was increasing. Caregivers continued to administer PRN medications (haloperidol, zopiclone, and lorazepam) without documented consultation with RNs (as

per Administration of Medications policy). On some occasions, multiple sedating medications were administered in a 24 period, e.g., day9 month6 PRN zopiclone and lorazepam were administered 1 hour apart.

Between the period of day13 to day15 month7 year1, there were three RN reviews due to the escalating BPSD, sedation, and loss of mobility. The following PRN medications were administered within 24 hours:

day13 month7 year1 — 2151 hrs — zopiclone with no effect
day14 month7 year1 — 2227 hrs — haloperidol with no effect
day14 month7 year1 — 0325 hrs — haloperidol with no effect
day14 month7 year1 — 1422 hrs — haloperidol with some effect
day14 month7 year1 — 2115 hrs — lorazepam with no effect
day14 month7 year1 — 2248 hrs — zopiclone with no effect

This constitutes many sedating medications in 24 hours given with no effect on BPSD or insomnia, the last two were administered two hours apart.

From the evidence reviewed to respond to this question, it appears that the oversight and management of PRN administration for Mrs A during her time in LW dementia unit and in the three days prior to hospital admission was not in line with acceptable practice. Overuse of PRN medications, lack of appropriate consultation and review of PRN medications administered by care staff with RNs and consequently NP, as well as lack of clinical assessment to identify possible causes of BPSD would be viewed similarly by my peers. **Departure from accepted practice: Severe.**

Do you consider the clinical oversight of Mrs A's unwitnessed fall prior to ambulance transfer to be within acceptable nursing practice? And do you feel Mrs A's condition should have been escalated sooner?

RN B assessed Mrs A on day15 month7 year1 at 1425 hrs as resident was reported to be sedated with loss of mobility. (Given 6 x PRN sedating medications in 24 hrs prior). Mrs A was independently mobile until day15 month7. Documentation indicates that resident was in [La-Z-Boy] chair, sleepy, refusing food and medications with stable observations.

Notably, BP [blood pressure] was 147/75 and HR [heart rate] was 97 — which were both an increase from usual baseline. RN B's documentation did not include assessment of limb fracture, e.g., leg shortening or external rotation but documented in her statement that no signs of fracture were observed.

RN G assessed Mrs A on day15 month7 at 1945 hrs, she was notified by caregivers that resident's left leg was shortened and externally rotated. Resident was unable to weight-bear, and ambulance was called to transfer to hospital.

From the evidence reviewed to respond to these questions, it appears that the clinical oversight of Mrs A's unwitnessed fall prior to ambulance transfer (on day15 month7 year1) to be a mild deviation from acceptable nursing practice due to a lack of documentation of fracture assessment by RN B; and was escalated within an acceptable timeframe by RN B and would be viewed similarly by my peers. **Departure from accepted practice: Mild.**

Do you consider the overall clinical management of Mrs A's functional needs from admission day3 month5 year1 through to events preceding hospital transfer to be within acceptable nursing practice?

As documented earlier:

Clinical documentation by caregiving staff indicated ongoing and increasing agitation throughout month6 year1 and – on day11 month6 – it was noted that Mrs A became unsteady on her feet, increased physical aggression towards staff and other residents, and might have been hallucinating. Unwitnessed fall at 0320 hrs, Mrs A was kneeling in front of her bed and had a bruise on left shoulder. Assessed by RN G.

NP review was not initiated.

RN B's review on the following day, day12 month6, indicated discussion with NOK about the fall, nil complaints of pain, new bruises, and to continue with PRN medications following discussion with clinical manager.

The progress notes contain only two RN reviews in the month of month6 year1, when Mrs A's BPSD was increasing. Caregivers continued to administer PRN medications (haloperidol, zopiclone, and lorazepam) without documented consultation with RNs (as per Administration of Medications policy). On some occasions, multiple sedating medications were administered in a 24-hour period, e.g., day9 month6 PRN zopiclone and lorazepam were administered 1 hour apart.

The two NP visits on day7 and day9 month6: the documentation did not indicate delirium assessment (CAM) or physical assessment to rule out reversible causes of delirium such as constipation or infection, pain, or dehydration. No blood tests (delirium screen) were ordered.

(Notably, during the review of progress notes, the BPSD was reported to be increasing on day 3 or 4 of no bowel motion.) Cholecalciferol (Vit D) was not prescribed as per best practice and Falls Prevention Programme. There was a lack of evidence of regular follow-up and monitoring of prescribed PRN sedating medications.

From the evidence reviewed to respond to this question, it appears that the overall clinical management of Mrs A's functional needs from admission on day3 month5 year1 through to events preceding hospital transfer was not in line with acceptable practice. Overuse of PRN medications, lack of appropriate assessment, follow-up, and escalation,

as well as referral to MHSOP, would be viewed similarly by my peers. **Departure from accepted practice: Severe.**

Do you consider there was a possibility of the fractured hip having potentially occurred following the documented fall on the day12 month6 year1 given Mrs A's presentation in the two weeks following and her underlying medical conditions? Please provide rationale.

I agree with Dr F's review regarding this question:

Any comment in this regard would be perceived as conjecture. Nevertheless, noting there was apparently no change noted in Mrs A's mobility or her general behaviour recorded between day12 month6 and day15 month7 year1 it seems most unlikely she had a hip fracture present over this period. While it is not uncommon for there to be difficulty diagnosing a hip fracture if the initial fracture is impacted and relatively stable (absence of clinical signs and patient may be mobile), it seems unlikely that the fracture would not have displaced and become significantly symptomatic sooner than day15 month7 year1, noting Mrs A's activity over this period, following her fall on day11 or day12 month6 year1.

(v) As a final comment, I believe the hospital clinician's comment regarding Mrs A's over-sedation noted post-operatively is far more likely to relate to the opioid analgesia administered to her in the hours prior to and during her surgery (25mcg IV fentanyl by paramedics prior to transport on day16 month7 year1 with further 5mg oral morphine on the afternoon and evening the same day then 130mcg IV fentanyl intra-operatively on day17 month7 year1) plus the lorazepam administered in the early hours of day17 month7 rather than the potentially sedating medications last administered at LW on day14 month7.

From the evidence reviewed to respond to this question, it appears that it would be difficult to establish whether there was a possibility of the fractured hip having potentially occurred following the documented fall on day12 month6 year1 given Mrs A's presentation in the two weeks following and her underlying medical conditions and would be viewed similarly by my peers. **Departure from accepted practice: Nil.**

Management of residents with significant BPSD in aged residential care facilities can be challenging, especially when the resident is agitated and physically aggressive towards others.

Antipsychotics are a second-line treatment for the treatment of BPSD if aggression, agitation, and psychotic symptoms are present, which can cause severe distress or risk of harm to the person or others. Non-pharmacological interventions are recommended to be tried first, as significant side effects can be experienced by people with dementia, such as sedation, increased falls risk, extrapyramidal side effects, pneumonia, stroke, cardiovascular events, and increased mortality (BPAC, 2020).

In addition to the provider's response and corrective actions, it is recommended that the care home considers education for care staff and RNs about recognising acute deterioration, delirium, falls and fractures as outlined by the Frailty Care Guides (2023).

Isabella Wright, NP, BHSC (Nursing), PGDipHSc (Advanced Nursing), MPH, Doctoral Candidate
Nurse Advisor (Aged Care)
Health and Disability Commissioner'