Golden Pond Private Hospital Limited

Registered Nurse, RN C

Registered Nurse, RN D

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02311)

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 3
Opinion: Golden Pond — breach 12
Opinion: RN C — breach 17
Opinion: RN D — adverse comment 19
Opinion: RN L — adverse comment 20
Opinion: RN J — adverse comment 20
Opinion: RN E — adverse comment 21
Opinion: RN F — other comment 21
Opinion: Ms H — other comment 22
Changes made 22
Recommendations 23
Follow-up actions 24
Appendix A: In-house aged-care advice to Commissioner 25
Appendix B: Falls Policy 33
Appendix C: Inpatient Falls Clinical Pathway 34
Appendix D: Falls Risk Assessment Guidance Document 35
Appendix E: Falls Risk Standardised Assessment of Risk Factors 37
Appendix F: Policy on Rationale for Equipment Use 39
Appendix G: Hoist Procedure 42
Appendix H: Care of Slings 44
Appendix I: Care planning 45
Appendix J: Policy on: Incident Form 46
Appendix K: Policy on Family Notification re Adverse Events 48

Executive summary

1. This report concerns the care provided to an elderly woman by Golden Pond Private Hospital Ltd in 2019. She was a highly vulnerable consumer who was unable to communicate or advocate for herself and was reliant on others to protect her and keep her safe.

2. The woman fell when she was being transferred by a single healthcare assistant via a standing hoist.

3. The healthcare assistant informed a nurse about the incident, but the nurse did not assess the woman for injury. The nurse also did not keep clear and accurate records of the discussions she had with the healthcare assistant and other nursing staff about the incident.

4. Following her fall, the woman suffered pain and discomfort, and exhibited multiple signs to indicate a functional decline. However, a lack of critical thinking by the health professionals involved in her care meant that there was a three-day delay before the woman's injury was assessed and her fractured left femur was diagnosed and treated.

5. Over this three-day period, there was general non-compliance with existing policies and procedures by multiple staff members, and poor documentation.

Findings

6. The Deputy Commissioner found that Golden Pond did not provide services with reasonable care and skill, in breach of Right 4(1) of the Code. The Deputy Commissioner considered that there was a pattern of poor care provided to the woman over a three-day period following a serious fall, non-compliance by staff with existing policies and procedures, and poor documentation and record-keeping.

7. In addition, the Deputy Commissioner considered that Golden Pond's policies and procedures, and its staff training and competency assessments were inadequate.

8. The Deputy Commissioner also found that the nurse did not provide the woman services with reasonable care and skill, in breach of Right 4(1) of the Code, as she failed to take appropriate action upon being informed of the incident, and her documentation was poor.

9. The Deputy Commissioner made adverse comments about the care provided to the woman by a number of other staff members.

Recommendations

10. The Deputy Commissioner noted that a number of changes have been made by Golden Pond since the events. A Ministry of Health certification audit was undertaken in March 2021, and Golden Pond was found to be compliant with the Health and Disability Services Standards and was certified for a four-year term, ending 2 June 2025.

11. In light of the changes made by Golden Pond since the events, the Deputy Commissioner recommended that Golden Pond provide a written apology to the woman's family for the deficiencies in care outlined in this report.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

12. The Deputy Commissioner also recommended that Golden Pond provide its nursing staff and healthcare assistants with training on documentation and effective handovers, and implement a formal training programme for relevant staff, developed in conjunction with its funding district health board and/or HealthCERT.

13. Further, the Deputy Commissioner recommended that Golden Pond undertake a review of all its clinical policies, procedures, and guidelines, in conjunction with its funding district health board and/or HealthCERT, to ensure that they are consistent with current accepted best practice. The Deputy Commissioner also recommended that Golden Pond implement a handover policy that guides staff sufficiently in providing adequate handover.

14. The Deputy Commissioner recommended that both the nurse and the Clinical Nurse Manager provide a written apology to the woman's family for the deficiencies outlined in this report.

15. Further, the Deputy Commissioner recommended that the Nursing Council of New Zealand undertake a competence review of two nurses, should either nurse return to practice in the future.

Complaint and investigation

16. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the care her mother received from Golden Pond Private Hospital Limited. The following issues were identified for investigation:

- *Whether Golden Pond Private Hospital Limited provided Mrs A with an appropriate standard of care in 2019.*
- *Whether registered nurse RN C provided Mrs A with an appropriate standard of care in 2019.*
- *Whether registered nurse RN D provided Mrs A with an appropriate standard of care in 2019.*

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

18. The parties directly involved in the investigation were:

Ms B	Complainant
RN C	Registered nurse
RN D	Registered nurse
Golden Pond Private Hospital Limited	Rest Home

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

19. Further information was obtained from:

RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse/clinical nurse
Ms H	Healthcare assistant (HCA)
Ms I	Healthcare assistant

20. Also mentioned in this report:

RN J	Registered nurse
Ms K	Healthcare assistant
RN L	Registered nurse
Ms M	Healthcare assistant
RN N	Registered nurse
Ms O	Healthcare assistant

21. Independent advice was obtained from RN Hilda Johnson-Bogaerts (Appendix A). Also appended is Golden Pond Private Hospital Limited's "Falls Policy" (Appendix B), "Inpatient Falls Clinical Pathway" (Appendix C), "Falls Risk Assessment Guidance Document" (Appendix D), "Falls Risk Standardised Assessment of Risk Factors" (Appendix E), "Policy on Rationale for Equipment Use" (Appendix F), "Hoist Procedure" (Appendix G), "Care of Slings" policy (Appendix H), "Care planning" policy (Appendix I), "Policy On: Incident Form" (Appendix J), and "Policy on Family Notification re Adverse Events" (Appendix K).

Information gathered during investigation

Background

22. Mrs A was in her eighties at the time of events. She had resided at Golden Pond Private Hospital (Golden Pond)[1] for several years. Her medical history included advanced dementia, osteoarthritis, insulin dependent Type 2 diabetes, and bilateral knee replacements. As a result of advanced dementia, Mrs A was unable to express or communicate her needs or urgent problems, and she would rarely understand what was communicated to her. Her daughter, Ms B, held her enduring Power of Attorney (EPOA).

23. Mrs A's care plan report dated 2019 noted that she was dependent on nurses for her daily cares and to mobilise from one location to another. She was to be moved with the aid of a standing hoist. She was prescribed and administered fentanyl patches[2] for intermittent pain.

[1] Golden Pond has been operating since 1989 and has a total of 61 beds.
[2] A patch placed on the skin that releases fentanyl for a prolonged duration.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

24. This report relates to the care provided to Mrs A (dec) leading up to and following a fall at Golden Pond.

25. Golden Pond is a private rest home and hospital. At the time of events, it had approximately 60 residents, some requiring residential care, but most requiring hospital-level of care. At Golden Pond, the residents are divided into two wings, Wing A and Wing B. Wing A generally has more dementia residents and also incorporates the Studio Wing, where some of the residents are fairly independent.

26. The facility is managed by a nurse manager and a clinical nurse. During the morning shift (which commenced at 6.45am and finished at 3.15pm), there was one registered nurse who was assisted by either another registered nurse, an enrolled nurse, or by an HCA, and 11 other HCAs worked various shifts. During the afternoon shift (which commenced at 2.30pm and finished at 11.00pm), there was one registered nurse who was assisted by either another registered nurse, an enrolled nurse, or an HCA, and eight other HCAs worked various shifts. During the evening shift (which commenced at 10.45pm and finished at 7.15am), there was one registered nurse and three HCAs.

Relevant policies

27. Golden Pond provided copies of its relevant policies to assist with HDC's assessment of these matters. The policies are appended as Appendices B to K.

Falls policies and documents

28. The Golden Pond "Falls Policy" dated 1 February 2013 defines a fall as "unintentionally coming to rest on the ground, or at some lower level, not as a result of a major intrinsic event or overwhelming hazard". Golden Pond said that this includes falls that occur whilst being assisted by others.

29. The "Falls Policy" states that all falls are to be recorded on the interRAI and printed off and left in the handover folder. As per the policy, family are to be notified of all falls, and any falls that cause serious harm must be reported to Worksafe. The policy does not explicitly state that in the event of a fall, healthcare assistants should contact a registered nurse.

30. The "Inpatient Falls Clinical Pathway" dated 7 December 2013 also does not explicitly state that healthcare assistants should contact a registered nurse in the event of a fall. However, the pathway does state that a post-fall assessment should occur, and such assessments are undertaken by registered nurses.

31. The "Falls Risk Assessment Guidance Document" dated September 2014 prompts the assessing nurse to document a resident's history of falls; their current mobility; whether the resident has any concerns with vision, hearing, or language; their cognitive ability; continence issues; the medication the resident is taking; and any other risk factors.

Hoist and equipment use policies and procedures

32. The "Policy on Rationale for Equipment Use" dated 24 October 2009 outlines when and what equipment should be used (such as standing hoists, sliding boards, sliding sheets, and transfer belts), and health and safety factors to be aware of for each type of equipment.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

33. The "Hoist Procedure" dated 24 October 2009 outlines how to fit the hoist sling when a resident is in a chair, in bed, or on the floor, and outlines the procedure to lift the resident. It states that when moving a resident with a hoist, there should always be two carers.

34. The "Care of Slings" policy dated 27 September 2006 states that slings should be visually inspected monthly by the team leader, and slings should be inspected for signs of wear and tear before each use. The policy provides an outline of the things staff should check for when considering wear and tear, and how to clean and store the slings.

Care Planning policy

35. The "Care Planning" policy dated 12 November 2013 provides a definition of care planning, and states that a care plan should indicate specific actions that should or should not be performed. It provides a brief outline of what should be considered when care planning.

Incident reporting policies

36. The "Policy On: Incident Form" dated 3 May 2009 states that an incident form should be completed any time there is something out of the ordinary, any patient or staff injury, and any patient incident, even if no apparent injury results. The policy also provides that incident forms must be filled out as soon as possible, and certainly before going off duty.

37. The "Policy on Family Notification re Adverse Events" document dated 5 January 2018 states that families should be well informed by effectively communicating falls; medication changes; any infection requiring antibiotics; any significant change in current health status; and significant skin tears. It states that documentation of communications with family about adverse events should be recorded on the "relative/whānau notification form" in the resident's file.

Day 1[3] — evening shift

38. On the evening of Day 1, Mrs A was moved by HCA Ms H with the aid of the standing hoist.[4]

39. While being moved, Mrs A's left foot unintentionally slipped off the hoist foot plate, and both the sling and Mrs A became unbalanced. In response to this, Ms H placed a pillow on the floor and lowered Mrs A to the ground. Ms H told HDC that this occurred between approximately 5.45pm and 6pm.

40. Ms H called for assistance, and Ms K attended. Ms K told HDC that upon entering the room, Mrs A was on the floor next to the bed. Ms K said that she and Ms H used the full hoist to move Mrs A onto the bed.

[3] Relevant days are referred to as Days 1–4 to protect privacy.

[4] Standing hoists assist patients from a sit to a stand position and vice versa. A per Golden Pond's policy, to use a standing hoist, a client must be able to push down on both legs as the hoist is activated, must be unable to fully weight bear, and able to follow simple commands. Full hoists assist patients from any location, for example the floor, bed, bath, and seated positions. To use a full hoist, a client must be unable to physically weight bear through both lower limbs, unable to physically assist with the transfer, and unable to follow commands.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

41. Ms K stated that Mrs A was calm and did not appear to be experiencing any stress. Ms K stated that both she and Ms H checked, but did not find any bruises or markings on Mrs A.

42. Ms H said that following this, she notified the registered nurse on the evening shift — RN C. Ms H said that RN C told her that she would check on Mrs A after her dinner break, which would be between 6.30pm and 7pm.

43. RN C told HDC that the incident occurred during her break, and she was not informed of the incident until 30 minutes after it had occurred. She was informed by Ms H that Mrs A had slipped, but that she had not injured her foot or her head as she had been lowered to the ground. RN C said that Ms H told her that Mrs A was "absolutely fine" and that she could finish her break prior to reviewing Mrs A. RN C said that she told Ms H that an incident form did not need to be completed. RN C said that she recalled that at a recent nurses meeting, the Clinical Nurse, RN G, advised that "if a 'fall' is not actually a fall, such as when someone is intentionally being lowered by nursing or care staff to the ground, that it does not have to be recorded on InterRAI". However, RN C said that she told Ms H to record the incident in Mrs A's progress notes.

44. In the notes, Ms H wrote: "Tonight [Mrs A's] foot slipped off standing hoist so I lowered her to the ground, didn't put her on bed at first was worried she might fall off. No obvious injuries."

45. RN C said that after her break, she completed other duties before attending to Mrs A at approximately 7.30pm to administer her insulin. RN C said that she did not undertake any further assessment of Mrs A because she had forgotten about the incident. RN C told HDC that Mrs A was not displaying any unusual behaviour, and did not appear to have any symptoms of distress or pain that would indicate that an injury had been sustained.

46. Mrs A's family were not informed of the fall at this time. The Golden Pond "Policy on Family Notification re Adverse Events" states that families should be well informed about falls and any significant change in current health status.

47. RN C told HDC that she passed Mrs A's room several times up until approximately 9–9.30pm while Mrs A was sleeping. RN C said that Ms H and Ms K changed Mrs A's night pad prior to 9pm, and they did not report any concerns.

48. RN C informed HDC that in the evening she was required to complete a care plan review on another patient. She said that she had not been provided with adequate training to complete care plan reviews on interRAI, so the task required concentration. She said that as a result of this, she did not see Mrs A again on her shift, and did not write about the incident in the handover book. RN C finished her shift at approximately 11.15pm and handed over care to RN F.

49. RN C told HDC that it is clear that neither she, Ms H, nor Ms K considered the incident to be a fall.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Day 1–Day 2 overnight shift

50. RN F told HDC that during handover, RN C informed her that Mrs A's foot had slipped off the standing hoist and that RN C did not know whether Mrs A was injured. RN F said that RN C told her that she was passing this information to RN F and it was up to her what she did with it. On the other hand, RN C told HDC that she did not discuss the incident during her handover to RN F.

51. Golden Pond's own internal investigation into the above events noted that RN F felt that the information given to her by RN C was inadequate. The investigation notes state: "[V]ery poor handover from afternoon RN to night RN."

52. RN F said that she did not want to wake Mrs A during her shift, and that she noted that an incident report had not been completed. RN F told HDC that the progress notes gave no indication as to whether the incident was serious.

53. RN F said that during handover, she advised the healthcare assistants on shift that Mrs A needed to be checked when she was woken for her nightly pad change. RN F stated that when she checked with the healthcare assistants later, she was informed that the pad had already been changed and that they had forgotten to call her. RN F said that she was told that Mrs A did not appear any different to normal.

54. RN F told HDC that at the end of her shift, at approximately 7.30am, she informed the morning nurse of the incident and handed over care.

Day 2

55. RN L started work at approximately 6.30am and received handover from RN F. RN L recollected that she was advised that Mrs A's foot had "come off" the hoist during transfer, but there was no mention of any injury or recommended monitoring, or which foot it was. The morning healthcare assistants were not made aware of the incident.

56. RN L said that following breakfast, she went to Mrs A's room to change her fentanyl patch. RN L said that she noted slight discoloration on Mrs A's left knee, and bruising on her right shin. She said that this was not unusual because Mrs A sat all day with her legs crossed. RN L stated that she palpated both of Mrs A's knees, and Mrs A did not show any signs of discomfort, pain, or distress. RN L said that she did not consider Mrs A's knees to be any more swollen than usual, having had bilateral knee joint replacements. At 1.15pm, RN L documented that she changed Mrs A's fentanyl patch, but there is no record that any palpations and/or assessments were carried out as described above.

57. RN L did not discuss Mrs A's incident at the handover meeting in the afternoon. Ms M, who worked the afternoon shift, said that she was not made aware of Mrs A's incident until her colleague, Ms K, informed her sometime after the handover meeting in the afternoon.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

58. When Ms M and Ms K assisted Mrs A to the commode using the standing hoist, they noted that Mrs A could not stand straight. Ms M told HDC that they lowered Mrs A back down onto her chair, and noticed that her left knee was more swollen than usual. [5]

59. RN N (the evening nurse on a separate wing) recollected being informed by Ms M that Mrs A appeared to be in pain when she used the standing hoist. RN N said that she attended and that Mrs A appeared comfortable. RN N said that she noted that Mrs A's right knee was more swollen than the left, and was told that "this was normal" for Mrs A; however, she cannot recall who said this to her. RN N also noted a bruise on Mrs A's shin on her right leg. RN N said that she recommended that Ms M use the full hoist. RN N advised HDC that at that time, she did not know about Mrs A's fall. This assessment was not documented.

60. RN G, an afternoon nurse, said that at the end of her shift, the afternoon healthcare assistant asked her to look at Mrs A's right knee. RN G said that on examination, the right knee was larger than the left, and she noted that Mrs A had bruising to her right leg. Neither this assessment nor the findings were documented. RN G told HDC that she asked the evening nurse, RN J, to document this in the progress notes. RN G told HDC that RN J informed her that the findings were not new, and they were caused by Mrs A crossing her legs.

61. Ms M said that she informed RN J that Mrs A was unable to stand properly, and noted her swollen left knee, and advised that they would need to start using the full hoist. Ms M said that at this time, the Clinical Nurse Manager, RN D,[6] came past, and she informed her that Mrs A was unable to stand properly, and that her left knee looked more swollen than normal. Ms M said that RN D "felt" Mrs A's knee and said: "[Mrs A] has always had one big knee." This was not documented.

62. Ms M advised HDC that at times during the evening of Day 2, Mrs A's breathing was heavier than usual. When changing Mrs A's night pad, Ms M noticed a mark behind Mrs A's left knee cap, but noted that Mrs A did not appear to be in any pain when moving her.

63. At the end of her shift, Ms M documented:

> "[N]oticed [Mrs A] couldn't stand properly. Notified [RN J] + [RN G] to check her legs. When [lying] in bed on her back both legs (knees) are bent facing [right], legs very loose compared to before [and] she is not crossing her legs [at] her ankles as normal. She is also gripping tight with her hands more than normal. She doesn't seem to have any extra pain …"

---

[5] The relevant statements from support staff and clinical staff about which knee was reported as swollen have been correctly recorded in this report and it appears staff noticed issues with both knees, but mainly the left knee. RN E said she noticed bruising on the left knee, and also that her right knee was much bigger, but that this was normal for Mrs A (presumably on account of her history of bilateral knee replacements). RN N also noted that the right knee was bigger than the left, and Ms M noted a swollen left knee. The GP noted that the left knee appeared to be causing Mrs A discomfort. The hospital discharge summary refers to bruising around the right thigh and fracture of the left femoral shaft.

[6] RN D told HDC that she has since retired from nursing.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Day 3

64. RN L arrived to work for the morning shift on Day 3. She said that she reviewed the handover notes, which stated to read Mrs A's progress notes. She said that she noted Ms M's documentation in Mrs A's clinical notes that Mrs A now required use of a full hoist, and that the evening nursing and clinical nurse, RN G, had reviewed Mrs A's knee. RN L said that she informed the morning healthcare assistants of the changes to Mrs A's hoist use. RN L was informed that Mrs A's blood sugar levels (BSLs) were high, and she advised the healthcare assistants to ensure that Mrs A was drinking enough fluids.

65. RN L said that around lunch time, she noticed that Mrs A's face was darkened. RN L said that she considered that it might be a sign of infection, particularly in light of the raised BSLs. She told HDC that Ms I noted that Mrs A had not been crossing her legs as usual.

66. At 1.50pm, RN L documented: "Left knee (inner aspect) appears to be causing [Mrs A] discomfort — flinching when touched. Pamol given at 1130hrs. Appears more comfortable …"

67. RN L told HDC that she palpated both of Mrs A's knees, and that when her left knee was touched, Mrs A flinched but did not show other signs of "real" pain or distress. Although not documented, RN L stated that she moved the bottom half of both of Mrs A's legs and noted that they were both moving freely without signs of discomfort or pain. RN L said that she told Ms I that Mrs A had had bilateral knee joint replacements, and it was normal for knees to look that way.

68. RN L said that she discussed Mrs A with RN D, and RN D thought that the fentanyl patches might be masking pain. RN L said that she checked Mrs A's vital signs,[7] which did not raise any immediate concerns, so she gave Mrs A paracetamol.

69. In the afternoon, Ms M and Ms O were assisting Mrs A to the commode when Mrs A's husband, Mr A, arrived. Ms M stated that on Mr A's arrival, she asked him whether he knew about Mrs A slipping off the standing hoist, and he replied that he did not know this. When Ms M and Ms O were attempting to place Mrs A in the full hoist, they noticed that Mrs A's leg bent outwards, and they noted a large bruise on the outside of Mrs A's left knee. Ms M described this as a "blood looking blister". Ms M said that they "were shocked", and that she asked Ms O to get the evening nurse, RN E.

70. RN L told HDC that whilst RN E was being called, Ms M approached her and asked if she was aware of the large bruise behind Mrs A's left knee. RN L said that she attended, and she told HDC that the bruise had not been present earlier in the day. She stated that she recommended using a towel behind Mrs A's knee when transferring her to protect her skin. RN L said that she did not document the recommendation because the evening nurse, RN E, had arrived. In Ms M's statements to HDC, she does not mention this interaction.

[7] BP: 138/66; HR: 63; Temp: 37.4°C, SPO_2: 98%.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

71. RN E told HDC that she attended at approximately 3.45pm. She said that Mrs A's legs were not crossed at the ankles as usual, and she had some bruising on the left knee. RN E said that Mrs A's right knee was much bigger than the left, but that this was normal for Mrs A. RN E said that she informed Mr A that she "could see [Mrs A] ha[d] sustained some injury".

72. RN E said that she informed RN D about their "concern for [Mrs A's] left leg, raised BSL and raised temperature that day". RN E stated that RN D reviewed Mrs A and agreed that Mrs A was unwell. They planned to observe her for the remainder of the shift, and for her to be reviewed by a doctor the next day. RN E gave Mrs A paracetamol and applied bruise cream.

73. Ms M said that when assisting Mrs A to the commode, she noticed that she was gripping the arm rests. Ms M said that Mr A noticed that Mrs A was moving her toes back and forth, and that her foot was shaking as she was resting with her eyes closed. He expressed his concern to Ms M, who informed RN E of this. RN E also stated that she observed Mr A to be concerned.

74. At 4pm, RN E noted that she had applied cream, and that Mrs A did not show any signs of pain when being moved.

75. Mrs A's daughter, Ms B, advised HDC that her father called her, and so she called Golden Pond and spoke to a nurse. She asked whether a formal assessment had occurred, and was informed that it had not. Ms B said that she asked for this to happen as soon as possible. In the clinical notes, RN E documented: "[Ms B] (daughter) rang concerned about [Mrs A]. She requested [Mrs A] be seen by Dr [and] problem with leg and BSL [increase] followed up. She will phone in [the morning]."

Subsequent events

76. Mrs A was reviewed by the GP at 10am on Day 4. He noted extensive bruising behind her left knee, and that her lower leg was very mobile. It is noted that Mrs A had extensive range of motion, which was unusual for Mrs A, and that her bone was possibly distending from her knee. Mrs A's pain was measured as minimal, but it was acknowledged that Mrs A was on fentanyl patches. The GP requested that Mrs A be transferred to the Emergency Department for further assessment.

77. RN G completed an incident form at this time.

78. Mrs A was diagnosed with a fracture in her lower thigh bone[8] and underwent surgery.

Further information

Ms B

79. Ms B told HDC that while Mrs A was in hospital, Golden Pond did not make any enquiries to ascertain Mrs A's condition. Ms B said that discussions with rest home management since the event did not provide satisfactory answers, and she and her family did not feel confident in Golden Pond's ability to conduct an investigation into the incident.

[8] Left distal femoral fracture.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

80. Ms B said that documentation of the incident in subsequent days appeared to be poor, and nobody took overall responsibility for ensuring that the care provided reflected best practice.

Golden Pond

81. Golden Pond wrote to Mr and Mrs A and their family, and apologised for poor assessments and the subsequent delay in Mrs A's treatment for a leg fracture. It also apologised for not informing the family of the event, and of the change in Mrs A's condition when she became less mobile. Golden Pond said that it is its policy to notify families of changes or events.

82. Golden Pond said that prior to January 2021, any education provided to staff was part of general meetings and orientation. It said that at a nurses meeting at the time of these events, falls reporting was discussed, and there may have been some confusion about what a fall is. It explained that some dementia patients do have intentional falls,[9] which are monitored on an intentional fall form, and not entered on interRAI as a fall.

Responses to provisional opinion

83. Golden Pond, RN C, RN D, and Ms B were given an opportunity to respond to the provisional opinion.

84. Golden Pond advised that following the incident, it had apologised to Mr A and his family. Golden Pond told HDC that Mr A was grateful that Mrs A could remain in care at Golden Pond until her eventual passing in 2020.

85. Golden Pond also provided HDC with a copy of its Ministry of Health Certification Audit from 8 March 2021. Golden Pond stated that it has been caring for the community since August 1989, and that its staff of long-serving nurses and carers are particularly proud of its recent certification result.

86. RN C was given an opportunity to respond to the provisional opinion. RN C told HDC that she had no further comment to make and would be happy to provide an apology to Mrs A's family.

87. RN D was given an opportunity to respond to the provisional opinion. RN D told HDC that the investigation has resulted in good learning outcomes for her. She stated that as a result of Golden Pond's internal investigation, and as she had a managerial role rather than a clinical role, she immediately instigated a process so that whenever her input was needed, nursing staff had to complete a full assessment with the history of events and the desired intervention they required. All of the information would then be available whenever her input was needed.

88. Ms B was given an opportunity to respond to the "information gathered" section of the provisional opinion. Ms B stated that a failure by staff, throughout all levels of seniority, to follow policies and procedures, resulted in an unacceptable delay in recognising Mrs A's

[9] A patient may intentionally and voluntarily position their body from a higher level to a lower level.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

fractured femur. She stated that the failure to assess Mrs A resulted in prolonged suffering, and the communication and documentation was extremely poor.

89. Ms B also stated that the "dismissive manner" of senior staff, who were alerted that Mrs A was behaving differently, gave rise for concern as Mrs A, having been a resident of Golden Pond for several years, was well known to staff, and a change in habit should have been a red flag. Ms B said that it took urging from both herself and Mr A for action to finally be taken two and a half days after Mrs A's fall.

90. Further, Ms B stated that Golden Pond's failure to notify Mrs A's family of the incident was unacceptable and contrary to policy.

Opinion: Golden Pond — breach

Introduction

91. Golden Pond is obligated to provide services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code) and the New Zealand Health and Disability Services Standards. Specifically, standard 2.2 states:

> "[T]he organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

92. Additionally, standard 2.4 states:

> "[A]ll adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner."

93. Mrs A's foot slipped whilst she was being transferred via sling hoist. Mrs A was in her eighties, physically frail, and vulnerable. This case highlights the importance of effective communication between care staff, adequate assessments following an adverse event, and critical thinking. In circumstances where the consumer is less able to articulate their needs or communicate a change in their condition, they are reliant on the support staff caring for them to draw upon both their clinical expertise and robust assessment tools to identify problems and objectively measure their significance. It also requires staff to recognise the importance of escalating issues in a timely manner. It is Golden Pond's ultimate responsibility to have in place processes and systems that enable the delivery of safe and appropriate care.

94. I have obtained advice from my in-house aged-care advisor, RN Hilda Johnson-Bogaerts.

95. From the outset, I acknowledge that at the time, there was confusion about whether or not the event that occurred on the evening of Day 1 was a "fall". However, based on Golden

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Pond's definition of a fall, and the advice obtained from RN Johnson-Bogaerts, it is clear that the event constituted a fall. However, even if it was not considered to be a "fall", it was still an adverse event that required the appropriate actions to be taken by staff. Further, in my opinion, staff should have recognised the significance of Mrs A's symptoms as they began to manifest, and should have monitored their progression systematically. This is discussed further below.

Policies and procedures

96. RN Johnson-Bogaerts identified a number of deficiencies in Golden Pond's policies and procedures in place at the time of the events. Golden Pond's policies and procedures are attached (Appendices B to K).

97. RN Johnson-Bogaerts advised that the purpose of policies and procedures is to communicate to employees the desired outcome of the organisation, and to help employees to understand their roles and responsibilities. Policies and procedures set the foundation for the delivery of safe and cost-effective quality care.

98. RN Johnson-Bogaerts considers Golden Pond's "Falls Risk Standardised Assessment of Risk Factors" policy and "Falls Risk Assessment Guidance" document to be inadequate as assessment tools, as they are not representative of current evidence-based practice, and are not the recommended tools as set out in the Health Quality & Safety Commissioner (HQSC) Frailty Care Guides.

99. RN Johnson-Bogaerts also considers that Golden Pond's "Care Planning" policy is inadequate, as it is very brief, does not provide adequate guidance, and is not based on current best practice.[10]

100. RN Johnson-Bogaerts also found the "Policy on Rationale for Equipment Use" to be inadequate and not in line with current good practice. She advised that this policy does not address who is responsible to determine what equipment should be used to transfer a resident, and whether it is the responsibility of the nurses, or whether some equipment requires assessment by a physiotherapist. The policy also does not address where this information should be kept.

101. Further, RN Johnson-Bogaerts found the "Hoist Procedure" to be inadequate, as it does not outline who is allowed to use a hoist. She advised that, usually, staff need to be educated on using a hoist, and they need to be assessed as being competent to be able to assist with transferring a resident using a hoist. This is a high-risk intervention, and the policy does not provide for this. The policy also does not provide where the information, such as what equipment to use for which resident, should be kept.

[10] RN Johnson-Bogaerts referred to the "Implementation of care planning in long term care. A Bruyère Rapid Review" issue No. 7 dated January 2017, which provides that individual resident-centered care plans have been developed to facilitate coordination of care provided by various healthcare providers for elderly people living with multiple, complex, and chronic health conditions.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

102. In addition, RN Johnson-Bogaerts advised that the "Care of Slings" policy is inadequate, as it does not allocate responsibility by setting out who is responsible for checking the slings. Further, RN Johnson-Bogaerts advised that the Golden Pond "Inpatient Falls Clinical Pathway", the "Falls Policy", and the "Policy on Family Notification" are too brief, and the contents are too general.

103. RN Johnson-Bogaerts advised that overall, the policies at Golden Pond are inadequate to guide employees in relation to falls management and patient handling. She stated that the procedures are not person/experience centric, which means that the focus is on the nursing process, without integration of the consumer experience. A person-centric approach to care is a requirement as part of the Aged Residential Care agreement.

104. The policies also do not reflect current best practice (as outlined in the HQSC Frailty Care Guides), or the use and interpretation of interRAI[11] assessments. RN Johnson-Bogaerts explained that interRAI is a suite of evidence-based assessment tools, which have been mandatory in New Zealand residential aged care since 2015 as primary assessment tools. Procedures should integrate the mandatory use of interRAI outcomes.

105. RN Johnson-Bogaerts also noted that the policies and procedures do not appear to have been updated in the last ten years. The policies were last reviewed between 2009 and 2018, and do not include new emerging best practice.

106. RN Johnson-Bogaerts concluded that Golden Pond's policies and procedures in operation at the time of the events represented a moderate to significant departure from accepted practice.

107. I accept this advice. I consider that the above policies are not fit for purpose, and it is clear that they had not been updated in a significantly long time. In my view, robust policies and procedures in an aged-care setting are basic and fundamental to providing consumers with appropriate services. Without robust policies and procedures, it is likely that staff will not be receiving adequate guidance and support to provide safe and effective health services. I am highly concerned about the various inadequacies identified in Golden Pond's policies, which indicate that Golden Pond was not providing services consistent with current best practice at the time, and not enabling its staff to do so either.

Training

108. Golden Pond informed HDC that prior to January 2021, any education staff received was part of general meetings and orientation. This means that no formal training occurred at Golden Pond until 2021. Golden Pond has been operating since 1989. The only training that occurred at Golden Pond prior to 2021 was orientation training, or refresher training. This would also suggest that there was no transparent way of monitoring which staff were attending which training, or for quantifying the learnings individual staff were taking from these education sessions.

[11] interRAI is a collaborative network of researchers and practitioners in over 35 countries committed to improving care for persons who are disabled or medically complex.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

109. The New Zealand Health and Disability Services Standards, standard 2.3.2 states that service providers shall ensure that their healthcare and support workers have the skills, attitudes, qualifications, experience, and attributes for the services being delivered. Standard 2.3.3 states that service providers shall implement systems to determine and develop the competencies of healthcare and support workers to meet the needs of people equitably. Standard 2.3.4 states that service providers shall ensure that there is a system to identify, plan, facilitate, and record ongoing learning and development for healthcare and support workers so that they can provide high-quality safe services.

110. It is clear that Golden Pond has not met the above standards in this regard. This is concerning, and is reflective of a wider issue of inadequate support provided to staff at Golden Pond. Aged-care staff should be receiving regular refresher training and competency assessments to ensure that they are providing services consistent with current evidence-based, accepted practice to a vulnerable population. Not providing regular training to its clinical staff could have reasonably posed a significant risk to residents at Golden Pond, and as with the inadequate policies in place at Golden Pond, underpins my consideration of the overall care provided to Mrs A.

111. I consider it to be more likely than not that the lack of ongoing training by Golden Pond affected the standard of care that was provided to Mrs A by the various staff involved in her care over this period. It may also have contributed to RN C's lack of recognition that the incident met the definition of a "fall". RN C said that she recalled from a meeting that a fall "is not actually a fall, such as when someone is intentionally being lowered by nursing or care staff to the ground …". In the absence of any evidence to prove otherwise, it is apparent that RN C did not receive adequate training around the meaning of a fall, and what actions should be taken following an incident.

Non-compliance with policies and procedures, poor documentation, and a pattern of poor care

112. Despite the issues with Golden Pond's policies and procedures identified above, I acknowledge that they did contain some guidance for staff that was relevant in this case. However, between Day 1 and Day 3, there was consistent non-compliance with the policies and procedures across multiple staff members. These include the following:

- Ms H's failure to comply with the "hoist procedure" (which requires two carers), by not having the assistance of another carer when Mrs A was being moved;
- RN C's failure to take the appropriate actions set out in the "Falls Policy", the "Inpatient Falls Clinical Pathway", and the incident reporting policies by failing to assess Mrs A for injury, failing to document the incident, and failing to notify Mrs A's family of the incident;
- RN D's, RN J's, and RN L's failure to recognise that the requirements of the "Incident Management" policy and the "Policy on Family Notification" had not been met, and their failure to take the appropriate actions to ensure that these requirements were met (even if they did not appreciate that the incident constituted a fall).

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

113. In addition, there was a lack of record-keeping and poor documentation by multiple nurses, as on numerous occasions, assessments and events that occurred were not documented. Examples of these failures include:

- RN C's failure to document in the progress notes when she attended Mrs A on Day 1 to administer insulin, and when Mrs A's night pad was changed on the same evening;
- RN L's failure to document her assessments on Day 2 and Day 3; and
- RN G's and RN J's failure to document their assessment on Day 2.

114. The Nursing Council of New Zealand Code of Conduct (Appendix C) states that nurses are to keep clear and accurate records of the discussions they have, assessments they make, the care and medicines given, and how effective these have been. It is clear that between Day 1 and Day 4, multiple nurses did not comply with the Nursing Council of New Zealand's expectations of documentation.

115. Further, there were a number of inactions and/or failures by multiple staff members who provided care to Mrs A. These include, but are not limited to, the following:

- The failure of Ms H to safely transfer Mrs A correctly when she used the standing hoist without the assistance of a second staff member;
- The failure to assess Mrs A for injury by RN C, RN D, and RN J;
- The failure to adequately assess Mrs A for pain by RN C, RN D, RN J, and RN L;
- The failure to inform Mrs A's family of the incident by RN C, RN D, and RN J; and
- The failure to escalate care of Mrs A by RN L and RN E.

116. The above inactions and/or failures by multiple staff members, their poor record-keeping, and their failure to adhere to the policies and procedures, demonstrate a pattern of poor care and a culture of non-compliance with policies. This indicates failures at a systemic level, which had a negative impact on the care provided to Mrs A.

Conclusion

117. In conclusion, the care provided by Golden Pond outlined above was not in accordance with accepted standards. This is exceptionally concerning, as Mrs A was a highly vulnerable consumer who was unable to communicate or advocate for herself. She was totally reliant on others to both protect and keep her safe. Mrs A's family were not informed of the incident until they visited, which meant that they were not able to advocate for Mrs A either. Ultimately this meant that there was an unacceptable delay in the diagnosis and treatment of Mrs A's fractured femur.

118. I consider that Golden Pond failed to provide services to Mrs A with reasonable care and skill for the following reasons:

- Golden Pond's policies and procedures were inadequate;
- Golden Pond's staff training and competency assessments were inadequate;

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- There was a pattern of poor care provided to Mrs A over a three-day period, non-compliance by staff with existing policies and procedures, and poor documentation and record-keeping.
- There was a lack of critical thinking, and matters were not escalated in a timely manner, which meant that Mrs A more than likely was subject to avoidable pain and suffering until her fractured left femur was eventually diagnosed and treated. There were multiple signs exhibited by Mrs A over the three days following her fall to indicate that she was experiencing a functional decline, pain, and discomfort.

119. Accordingly, I find that Golden Pond breached Right 4(1) of the Code.[12]

Opinion: RN C — breach

120. RN C was informed by Ms H that Mrs A's foot had slipped during a hoist transfer. RN C said that based on information provided during a nurses meeting, she believed that being lowered to the ground did not constitute a fall, and she told Ms H not to complete an incident form. She noted that Ms H told her that Mrs A did not have any injuries.

121. Approximately 30 minutes after finishing her break, RN C administered Mrs A's routine medication. RN C did not undertake any kind of assessment. She told HDC that she did not undertake a post-falls assessment because she had forgotten about being informed of the incident.

122. RN C did not see Mrs A again during that shift, and did not write about the incident in the handover book or contact Mrs A's family.

123. Golden Pond's "Inpatient Falls Clinical Pathway" states that after a new fall, a post-fall assessment and an incident report are to be completed. Golden Pond's "Falls Policy" states that all falls are to be recorded on interRAI and printed off, and left in the handover folder. None of these actions were undertaken by RN C.

124. Golden Pond's "Falls Policy" defined a fall as "unintentionally coming to rest on the ground, or at some lower level, not as a result of a major intrinsic event or overwhelming hazard". It is concerning that RN C did not recognise that the incident constituted a fall. I acknowledge her comment that she had been told during a staff meeting that being lowered to the ground did not comprise a fall, and that there was a lack of training for staff. However, the policy was clear. In any case, as identified by my expert, this was still an incident that required RN C to act immediately to assess Mrs A for injury, document the assessment, and inform Mrs A's family about what had occurred. RN C did not undertake any of these actions.

---

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

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

125. Consequently, as RN C failed to undertake an assessment of Mrs A, she was able to provide only a limited handover to the oncoming night nurse, RN F. A post-fall assessment was critically important for the reasons highlighted in this case, and I consider that ultimately this failure on the part of RN C (being her lack of assessment and the resulting limited handover) led to the poor care that followed.

126. I also acknowledge that there were conflicting accounts from RN C and RN F as to what was said about Mrs A's fall at the handover that evening, which is a further matter of concern that I have not been able to reconcile fully.

127. The Nursing Council of New Zealand Code of Conduct[13] also provides that nurses must act immediately if a health consumer has suffered harm for any reason. They must minimise further harm and follow organisation policies related to incident management and documentation. A full and prompt explanation should be made by the appropriate person to the health consumer's family about what has occurred and the likely outcome.

128. RN Johnson-Bogaerts considers that RN C's actions on the evening of Day 1 represent a moderate to significant deviation from accepted practice. I accept this advice and consider that RN C failed to take appropriate action. I also note that RN C relied on Ms H's judgement as to whether Mrs A was injured, which is not appropriate following an adverse event, and RN C should have undertaken her own assessment of the situation.

129. When RN C was informed of the incident, she was responsible for ensuring that adequate post-fall actions occurred. I would have expected her to attend to Mrs A immediately and undertake an assessment to check for injury, complete an incident form, and notify Mrs A's family. Not only did RN C not do this, she did not take adequate steps to ensure that Mrs A would receive adequate ongoing support for any possible injury by documenting the incident in the handover book and thoroughly informing the oncoming nurse of the steps taken and what further action, including further monitoring and review, was required. I do not accept RN C's reasoning that her preoccupation with undertaking a care plan for another resident resulted in her not undertaking the post-fall actions required of her, over a five-hour period, justifies her omissions in this case. Also, Mrs A had Type 2 diabetes, which in itself called for regular monitoring. I consider that RN C's actions are a departure from accepted practice.

130. In addition, RN C's documentation was poor, as she failed to keep clear and accurate records of the discussions she had with Ms H and RN F about the incident.

131. As a result of the above, I consider that RN C did not provide services to Mrs A with reasonable care and skill, and did not provide services that complied with professional standards. Accordingly, I find that RN C breached Right 4(1) and Right 4(2)[14] of the Code.

[13] Principle 7.4 of the Code of Conduct for Nurses.

[14] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: RN D — adverse comment

Day 2

132. On Day 2, Ms M informed RN J that Mrs A was unable to stand properly. RN D, the Clinical Manager, was also informed. It was noted that the position of Mrs A's legs had changed. No in-depth assessment occurred, no incident form was completed, and Mrs A's family were not contacted by RN J or RN D at this time.

133. RN Johnson-Bogaerts advised that she is concerned that Mrs A's inability to stand, and the changes in the position of her legs, did not trigger a more in-depth assessment by RN J and RN D (as Clinical Manager). RN Johnson-Bogaerts said that even without the history of a fall, these concerns point to either an acute functional decline or potential serious injury, and should have triggered an in-depth assessment and review of the situation. RN Johnson-Bogaerts considers the actions of RN J and RN D on this day to be a minor to moderate deviation from accepted practice.

134. I agree with RN Johnson-Bogaerts that a full assessment should have occurred by RN D and RN J. This represented a missed opportunity for Mrs A to obtain the medical care that she required.

Day 3

135. Mrs A's symptoms worsened on Day 3. She was unable to stand, and a large bruise had appeared on the back of her left knee. RN L and RN E conveyed their concerns to RN D, the Clinical Manager. It was decided that Mrs A should be monitored and reviewed the next day by the GP.

136. RN Johnson-Bogaerts advised that this was inadequate in the circumstances, and that Mrs A's symptoms warranted Mrs A's GP being contacted immediately. RN Johnson-Bogaerts considers the actions of RN D to be a moderate to significant deviation from accepted practice, in light of her seniority and responsibility.

137. I accept this advice, and consider that RN D in particular, as Clinical Manager, failed to escalate Mrs A's care to a GP adequately. This represented another missed opportunity for Mrs A to obtain the medical care she required sooner, and for Mrs A's family to be contacted.

Conclusion

138. The care RN D provided to Mrs A on Day 2 and Day 3 was inadequate. RN D should have identified that a nursing assessment was needed on Day 2, and GP review warranted on Day 3. RN D should also have ensured that Mrs A's family were contacted when she was informed of the change to Mrs A's condition on Day 2, and on Day 3.

139. On three different occasions, Mrs A's care was escalated to RN D, as Clinical Manager. This was once on Day 2 (when Ms M informed RN D that Mrs A was unable to stand properly, and that her left knee looked more swollen than normal), and twice on Day 3 (when RN L discussed it with RN D, and again when RN E advised RN D about her concerns). However,

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

RN D failed to appreciate the seriousness, and did not manage the situation with the urgency it required.

140. Given that RN D was the Clinical Manager at Golden Pond, I find the care she provided concerning. She should have provided services that mirrored what was expected of registered nurses at Golden Pond. However, as discussed earlier in my opinion, I consider that the care RN D provided was informed by RN C's poor initial assessment and the limited handover that followed. As a result of RN C's lack of initial assessment and the resulting limited handover, RN D did not have all the information in relation to Mrs A's condition, and what might have caused it. This mitigates any individual accountability on the part of RN D and, accordingly, I do not find that RN D breached the Code.

Opinion: RN L — adverse comment

141. RN L told HDC that on Day 2, she reviewed Mrs A and assessed her knee. However, this assessment was not documented. On Day 3, Mrs A's symptoms had worsened. RN L relayed her concerns to RN D. However, this assessment was also not documented. It was decided that Mrs A would continue to be monitored, and would be reviewed by the GP the next day.

142. RN Johnson-Bogaerts advised that RN L's actions on Day 3 were inadequate, and that Mrs A's care should have been escalated to a GP immediately. RN Johnson-Bogaerts considers that the actions taken by RN L represent a minor deviation from accepted practice, as she should have advocated for an immediate escalation of Mrs A's care more strongly.

143. As above, I accept RN Johnson-Bogaerts' advice. While I accept that RN L may have relied on RN D's opinion as the Clinical Manager, I consider that RN L, as a trained health professional, also had a duty to think critically and recognise when a patient's condition indicates that she needs to speak up and advocate for the patient.

Opinion: RN J — adverse comment

144. As mentioned above, RN J was informed alongside RN D that Mrs A was unable to stand and that she had a large bruise on the back of her knee. It was decided that Mrs A would be monitored, and reviewed the next day by the GP.

145. RN Johnson-Bogaerts considers that a more in-depth assessment should have been undertaken, and that the care provided jointly by RN J and RN D was a minor to moderate deviation from accepted practice.

146. I agree. However, I accept that this relates to the care provided by RN J and RN D jointly, rather than by RN J individually. While I accept that RN J may have relied on RN D's opinion

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

as the Clinical Manager, I consider that RN J had a professional responsibility to think critically and recognise when a patient's condition indicates that she needs to speak up and advocate for the patient.

Opinion: RN E — adverse comment

147. On Day 3, following RN L's review, RN E relayed her concerns about Mrs A to RN D. It was decided that Mrs A would continue to be monitored, and would be reviewed by the GP the next day.

148. As outlined above, RN Johnson-Bogaerts advised that Mrs A's care should have been escalated to a GP immediately. RN Johnson-Bogaerts considers that the actions taken by RN E represent a minor deviation from accepted practice, as she should have advocated for an immediate escalation of Mrs A's care more strongly.

149. I accept RN Johnson-Bogaerts' advice. I also note that while it was reasonable for RN E to have sought the advice of RN D as the Clinical Manager, I consider that RN E had a duty to think critically and recognise when a patient's condition indicates that she needs to speak up and advocate for the patient.

Opinion: RN F — other comment

150. On the evening of Day 1, RN F received a handover from RN C about Mrs A. RN F asked the healthcare assistants to inform her when Mrs A's night pad was to be changed, so that she could check on Mrs A. The healthcare assistants did not do this, so Mrs A was not checked by RN F for injury.

151. RN F said that she told the oncoming nurse, RN L, of the incident. However, RN L said that there was no mention of any injury or recommended monitoring.

152. As I have stated in paragraph 126, I am faced with conflicting accounts from RN C and RN F as to what was said about Mrs A's fall at the handover that evening, which is a further matter of concern that I have not been able to reconcile fully.

153. However, I am prepared to acknowledge that as RN C failed to undertake an assessment of Mrs A, she was able to provide RN F with only limited information about the incident and Mrs A's condition. As discussed earlier in my opinion, I consider that it was this failure on the part of RN C (her lack of assessment and the resulting limited handover to RN F) that ultimately led to the poor care that followed. In my view, this mitigates any individual accountability on RN F's part. In the circumstances, I am not critical of the care provided by RN F.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Ms H — other comment

154. On Day 1, Mrs A slipped while being moved by Ms H in a standing hoist and was lowered to the ground. As discussed above, I am satisfied that this met the definition of a "fall" as per Golden Pond's falls policy.

155. Mrs A was initially lowered to the ground by Ms H, but was then moved to her bed by Ms H and Ms K.

156. Ms H did not have the assistance of another healthcare assistant when moving Mrs A. This is contrary to Golden Pond's "Hoist Procedure", which requires two carers when moving a patient with a hoist. As discussed above, however, Golden Pond's policies were not fit for purpose and, without robust policies and procedures, staff are not receiving adequate guidance and support to provide health services safely. In addition, staff at Golden Pond received no training prior to 2019, apart from orientation training or refresher training.

157. RN Johnson-Bogaerts advised that prior to moving Mrs A, Ms H should have called the registered nurse on duty so that they could assess Mrs A for injury. However, of note, Golden Pond's falls policies do not explicitly outline that a fall should be reported to a registered nurse, or that a registered nurse should be notified before moving a resident who has fallen.

158. I consider that the absence of adequate policies and procedures and staff training mitigates Ms H's individual accountability for failing to follow Golden Pond's policies. In reaching this conclusion, I note that RN Johnson-Bogaerts also advised that Ms H's reaction following the incident, by gently lowering Mrs A to the ground and then bringing it to the attention of the registered nurse, was appropriate. I accept this advice and am not critical of the care provided to Mrs A by Ms H.

Changes made

159. In March 2021, a certification audit of Golden Pond was conducted against the Health and Disability Services Standards by the designated auditing agency, DAA Group Limited, for submission to the regulatory body HealthCERT at the Ministry of Health. The audit process included a review of Golden Pond's policies and procedures, a review of residents' and staff records, observations, and interviews with residents, family members, managers and staff and a general practitioner. No areas were identified as requiring improvement at this audit. Golden Pond was certified for a four-year term and, as noted earlier in this report, its staff of long-serving nurses and carers are particularly proud of this result.

160. Since this incident occurred, Golden Pond has made the following changes, as set out in the certification audit report.

a) The falls risk assessment has been reviewed, redeveloped, and implemented, and is used in conjunction with the interRAI assessment.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

b) All staff completed further training in patient handling and hoist management competencies.

c) The resident handling procedure was revised and updated.

d) The registered nurses have had refresher training on reporting requirements.

e) An early alert tool was introduced for carers, and a tool was introduced for nursing staff when assessing situations or changes in a patient, and formal education on the use of these tools has been provided to staff.

f) The implementation of more accurate documentation of events that occur.

g) All changes were evaluated on several occasions and discussed at the registered nurses and care meetings.

Recommendations

161. I recommend that Golden Pond:

a) Provide a written apology to Mrs A's family for the deficiencies in care outlined in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

b) Undertake a review of all its clinical policies, procedures, and guidelines, in conjunction with its funding district health board and/or HealthCERT, to ensure that they are consistent with current accepted practice. Evidence of this and the outcome of the review are to be provided to HDC within six months of the date of this report.

c) Implement a handover policy that guides staff sufficiently in providing an adequate handover. This should be consistent with the training that is provided as mentioned in point e) below. Evidence of this is to be provided to HDC within three months of the date of this report.

d) Implement, if it has not done so in the interim, a formal training programme for relevant staff, developed in conjunction with its funding district health board and/or HealthCERT, to ensure that staff are receiving adequate training that is consistent with the aged-care industry standards. Evidence of this is to be provided to HDC within six months of the date of this report.

e) Provide nursing staff with current training on effective handovers. Evidence of this is to be provided to HDC within three months of the date of this report.

f) Provide nursing staff with training on documentation, particularly in relation to documentation frameworks. Evidence of this is to be provided to HDC within three months of the date of this report.

g) Provide healthcare assistants with training on documentation. Evidence of this is to be provided to HDC within three months of the date of this report.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

162. I recommend that the Nursing Council of New Zealand:

a) Undertake a competence review of RN D, should she begin practising again in the future.

b) Undertake a competence review of RN C, should she begin practising again in the future.

163. I recommend that RN C provide a written apology to Mrs A's family for the deficiencies in care outlined in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

164. I recommend that RN D provide a written apology to Mrs A's family for the deficiencies in care outlined in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

Follow-up actions

165. A copy of this report with details identifying the parties removed, except Golden Pond Private Hospital Ltd and the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN C and RN D.

166. A copy of this report with details identifying the parties removed, except Golden Pond Private Hospital Ltd and the expert who advised on this case, will be sent to HealthCERT and the district health board, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Golden Pond Private Hospital and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: In-house aged-care advice to Commissioner

The following expert advice was obtained from RN Hilda Johnson-Bogaerts:

"CLINICAL ADVICE — AGED CARE

CONSUMER	:	[Mrs A]
PROVIDER	:	Golden Pond
FILE NUMBER	:	C19HDC02311
DATE	:	2 August 2020

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Golden Pond to [Mrs A] in relation to a fall she suffered [in 2019]. 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.
2. I was asked to review the incident when [Mrs A] sustained a fall and comment on:
   a. The actions taken by the Health Care Assistant at the time of the fall
   b. The actions taken immediately after the fall
   c. The adequacy of the clinical documentation
   d. The communication between staff and shifts
   e. Adequacy of corrective actions taken
   f. Adequacy of Policies and any other observations

3. **Documents reviewed**
   - Provider response
   - InterRAI assessments … 2019 and … 2019
   - Incident reports and staff reports
   - Document relating to changes in practice
   - Policies and procedures

4. Review of clinical records

[Mrs A] was [in her eighties] at the time of her fall on [Day 1]. She had been living at Golden Pond Rest Home [for several years]. Her medical history includes Diabetes, Advanced Dementia and Osteoarthritis, past knee replacements both knees. She was dependent on the nurses for her daily cares and to mobilise from one location to another. Transfer from bed to chair would happen with the aid of a standing hoist. Due to advanced Dementia she was unable to express or communicate her needs or urgent problems and she would rarely understand what is communicated to her. She was prescribed Fentanyl patches for intermittent pain. [Mrs A] was very well supported by her family, her husband visited most days.

[Day 1], the clinical notes describe the incident as follows: *Tonight [Mrs A's] foot slipped off standing hoist so lowered her to the ground, didn't put her on bed first, was worried she might fall off, no obvious injuries.'* This entry was signed by [RN C]. The provider's response explains that it was a carer who was transferring [Mrs A] at the time of the incident. The registered nurse was notified of the incident who then transferred her to bed with the full hoist with the help of another carer. A statement from the second carer called to help states that [Mrs A] *'was calm, did not appear to be in any stress at all'* and that '*both checked for any marks or bruising and found none'*.

[Day 2], the notes include that the nurses experienced that she could not properly stand when in the evening they tried to use the standing hoist again. The RN was called and the healthcare assistant's notes report on this as follows: *When lying on her back both legs (knees) are bent facing, legs very loose compared to before and she is not crossing her legs at her ankles as normal, she is also gripping tight with her hands more than normal, she doesn't seem to have any extra pain and is fine when in full hoist sling.' [Day 3] 'Left knee (inner aspect) appears to be causing discomfort — flinching when touched. Panadol given — appears more comfortable.'* The nurse also documented vital signs which were all within normal range.

In the afternoon of the same day bruising was noted on the left knee and 'bruise cream' was applied as well as pain relief. That evening [Mrs A's] daughter rang concerned and requested she would be seen by the GP because of the problem with her leg and blood sugar levels being high.

When the GP examines her, he notes extensive bruising behind the knee, lower leg very mobile. He notes that shortening of the leg is difficult to assess because she is unable to straighten knee. Pain is minimal possibly due to Fentanyl patches. Blood sugar was normal that time. He recommends that she be transferred to emergency department.

The provider included in the response the Inpatient Falls Clinical Pathway. This pathway includes that after a new fall a post fall assessment is to be completed followed by implementation of changes based on the assessment followed by the completion of an Incident Report which then needs to be entered in the Incident Report Database.

I also reviewed the provider's Falls Policy — this policy requires for falls to be recorded on the interRAI system, printed off and left in the handover Folder. That falls are collated and discussed monthly. Family is to be notified of all falls.

5. Clinical advice

The actions taken by the Health Care Assistant at the time of the fall

At the time of the incident the reaction of the carer to lower [Mrs A] to the ground after her foot slipped off the footplate was an appropriate reaction to prevent her from slipping out of the shoulder sling and falling to the ground from a height. She then called the registered nurse for help. Good practice requires for a registered nurse to be called for any fall and for this nurse to assess the person before the person is moved.

In the circumstances I consider the actions taken by this caregiver to be appropriate.

Deviation from accepted practice — nil.

a. The actions taken immediately after the fall
From the second carer's statement it would appear that the post fall assessment was limited to checking for marks and bruises. Good practice requires for the nurse to do a comprehensive assessment including as a minimum, checking for bleeding, limb misalignment, and pain with palpation of hip, shoulder, elbow, groin, back pain, and level of consciousness before deciding to move the person. In my opinion, and in the circumstances where [Mrs A] was lowered slowly to the floor it would have been appropriate to do a comprehensive assessment and not to only focus on the leg that slipped off the standing hoist's footplate. Noting that [Mrs A] was on Fentanyl patches which is used to relieve severe pain this should be taken into account when assessing for pain as an indicator for injury. Appropriately a sling hoist which is a full body hoist was used to help [Mrs A] back on her bed. The registered nurse concluded '*no obvious injuries*' as noted in the progress notes.

In the situation that the registered nurse limited her assessment to only checking for marks and bruises **this would be seen in the circumstances as a moderate deviation from accepted practice.**

b. The adequacy of the clinical documentation
For the purpose of caring for an older person after a fall, coordination of care across the shift, and learning from such incidents, it is important that the clinical documentation includes a detailed account of the events, findings, interventions, who was notified, what follow up is needed. Following the provider's Falls Policy an incident report in the interRAI electronic notes was also required. I did not find such a report included in the provided clinical notes. The quality of the post fall documentation would be seen by my peers as inadequate. **Deviation from accepted practice: moderate to significant.**

c. The communication between staff and shifts
The provider's response includes an account of the handover communication between registered nurses of the different shifts. The afternoon registered nurse had handed over to the night nurse of the incident but she had not done a check or assessment. The night nurse did not assess as [Mrs A] was asleep, but had read the notes relating to the fall which '*did not appear as a serious incident or injury'.* There was *'no mention in the trigger book to alert staff to read the notes'.* The next day '*morning carer unaware of the incident'.* This indicates that there had been a significant breakdown in communication between the shifts, due process was not followed by the different nurses involved so far. **This would be seen by my peers as a significant deviation from accepted practice.**

d. Adequacy of policies
Reviewing the following policies: Policy on rationale for equipment use, Policy on Family Notification, Patient Handling Policy, Inpatient Falls Clinical Pathway and the Falls Policy, I found that these documents are too brief and content too general. They do not sufficiently guide/prompt the required actions from the registered nurses and do not reflect or refer to evidence based practices as can be found in the Health Quality & Safety

Commission's published Frailty Care Guides[i]. **I do not consider these policies as adequate and to be moderately deviating from accepted practice.**

e. Adequacy of corrective actions taken

I note from the provider's response the following corrective actions:

- Introduction of a reporting tool to help recognise acute changes in older people for cares to complete and give to the registered nurse to further perform and assessment and review of the resident.
- Adoption of the Frailty care guides and the SBARR tool
- Education of the registered nurses regarding resident deterioration and using the 8 steps of assessment from the frailty care guides
- Staff meeting to discuss events and where changes in documentation are introduced
- Apology to [Mrs A] and her husband

I consider these actions appropriate and recommend in addition that the care home's policies and procedures be reviewed against the Frailty care guides, and to be more detailed.

f. Additional notes

Reading in the clinical notes that [Mrs A's] ankles are 'usually crossed' I question the appropriateness of the use of a standing hoist to mobilise [Mrs A] as documented in her care plan. The organisation's policy includes that a standing hoist should not be used with precautions when painful or disfigured knees. It would be of interest to review the documentation regarding [Mrs A's] physical assessments and the reasoning for the decision to use a standing hoist for her transfers.

Reading the progress note entries of the [Day 2], the day after the fall I question the actions of the registered nurse called in the morning by the worried health care assistant. This nurse did not document her findings in the clinical notes and did not seem to have picked up the severity of the injury, did not manage the situation with the urgency it required. The description from the health care assistant shows that there were changes in the position of the legs and that she grips more than normal. These observations are an indicator of potential serious injury and should have been escalated for follow up with urgency. There did not appear to be critical thinking from the part of the nurse. **Deviation from accepted practice, moderate to significant.**

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner

[1] https://www.hqsc.govt.nz/assets/ARC/PR/Frailty_care_guides/Falls-prevention.pdf

29 November 2020 — Addendum to above clinical advice

Thank you for giving me the opportunity to review the provider's response and provide additional advice on this complaint. Specifically I was asked

i. To further comment about the care provided by the individual registered nurses
ii. To comment further on the appropriateness of the provider's policies at the time of the incident
iii. Whether the issues identified were due to systemic issues at Golden Pond

New information reviewed:

- Response from Golden Pond dated 21 September 2020
- Statements [RN N]
- Statement [RN C]

i. Further comment about the care provided by the individual registered nurses

A statement was received from [RN C], the RN on duty at the time of the fall. In this statement she explains that she was on her dinner break when she was told of [Mrs A's] incident by [Ms H] who was involved in the incidents: '*she told me that she had gently lowered [Mrs A] to the floor …' '[Ms H] also told me that as she had lowered [Mrs A] to the floor, [Mrs A] had not injured her foot or knocked her head …'*. Once on the floor this HCA went and called another HCA to help her to get [Mrs A] back on to her bed with use of the full hoist, both caregivers checked for any bruising but found none. The HCA assured the RN that [Mrs A] was fine and therefore that she could check later after her break was finished. The HCA asked if she needed to complete an incident form relating to the event, [RN C] advised not to complete one. The RN explains in her statement that at the time she was focusing on the definition of a fall, being the '*unintentional movement to the ground …'* and because the care staff intentionally lowered [Mrs A] to the floor she considered this not to be a fall. In her statement [RN C] recognizes that in any case this was still an incident and therefore should have been documented accordingly. The RN's account further explains that she later that evening administered [Mrs A's] insulin and did not pick up anything unusual but at no point in time did she further assess [Mrs A] or document the incident.

Recognising that the incident did not exactly fit the working definition of a fall, generally this would still be classed as a fall. It was not the intention of the transfer to lower [Mrs A] to the floor, it was as a result of her foot slipping off the plate putting her at risk of slipping out of the sling and falling to the ground from a height.

As such and following the organisation's falls policy, the HCA should have called the Registered Nurse on duty at that time to assess for injury before using the sling hoist and putting her to bed.

I would have expected that [RN C] when she was notified of the incident that she would have went to assess [Mrs A] with no further delay and assess the situation including checking for injury. In such a situation it would be expected that the RN educates and reminds the HCA of always calling the RN to check for injury before moving a resident. Further the RN is expected to fully investigation the incident with the HCAs who were

involved, completing due documentation (including an incident report, progress notes, putting an alert on the file) and discussing the incident at the time of shift handover.

The care provided by [RN C] would be seen by my peers as significantly deviating from accepted practice.

A statement was received from [RN N] where she explains that on [Day 2] she did not work in the part of the facility where [Mrs A] resided but in a different part of the facility and therefore that she was not responsible for updating [Mrs A's] progress notes for that shift. In the situation that another RN was responsible for the area where [Mrs A] was residing this would be congruent with accepted practice.

ii. Further comments on the appropriateness of the provider's policies
The following additional policies were received that were in place at the time of the event and reviewed for appropriateness.

- Falls risk standardized assessment of risk factors (12/11/13), and Falls risk assessment guidance document (Sept 2014). I have found both falls risk assessment documents inadequate as an assessment tool and not representative of current evidence based practice.
- Care Planning (12/11/13). It is not clear what the status of this document is. Is it a guide, procedure? It is very brief and inadequate as a care planning procedure or policy.
- Clinical Pathway for safe patient handling (17/9/20). This pathway provides a flow chart and is in line with good practice.
- Policy on rationale for equipment use (24.10.09). I have found this policy inadequate and not in line with current good practice. For example the documents do not include whose responsibility it is to determine what equipment to use to transfer a resident and where the information is kept. These documents can easily be misunderstood.
- Hoist procedure (24.10.09). I have found this procedure inadequate. It does not include who is allowed to use a hoist and where the information can be found, which equipment to use for which resident as an example.
- Care of slings (reviewed 27.9.06). I have found this procedure inadequate for the reason that it does not allocate responsibility for the process.
- Patient Handling Policy (reviewed 29.09.06). I have found this policy comprehensive and appropriate.

The purpose of policies and procedures is to communicate to employees the desired outcomes of the organization and help employees to understand their roles and responsibilities and sets the foundation for the delivery of safe and cost effective quality care. Overall I have found these documents to be inadequate as a suite of documents to guide employees in relation to falls management and patient handling. The procedures are not person (experience) centric and do not reflect the current best practice (refer Frailty Care Guides) or the use of and interpretation of interRAI assessments. They do not appear to have been updated in the past 10 years. **Deviation from accepted practice moderate to significant.**

26 March 2021 — Addendum to above clinical advice

Thank you for giving me the opportunity to review further response to above advice and advise whether these responses change any aspect of my previous advice.

New information reviewed:

- Response from Golden Pond dated 9 February 2021
- Response [RN C] 16 March 2021

i. Further comment about the care provided by the [RN C] and change in advice.

In the first addendum of this report the sequence of events was adjusted. It was the health care assistants who helped [Mrs A] back on to her bed with use of the full hoist before notifying [RN C]. I considered [RN C's] actions as significantly deviating from accepted practice because she did not recognize the event as either a fall or an incident that needed her follow up. She advised the HCA that no incident report was needed and she did not check [Mrs A] for injury knowing that [Mrs A] was unable to express or communicate her needs or possible discomforts.

I agree that in the situation that in house training included that '*a fall is not a fall when the person is intentionally lowered to the ground'* that this would mean that (albeit wrongly) the process for documentation of the incident as a fall was not required by the care home however there was still an incident which required the registered nurse to check for injury, document, and hand over to the next shift for further observation.

For the reasons above and in the situation where the content of in-house training was such that this incident would not be seen as a fall I would consider that in the circumstances the actions of [RN C] that day in relation to the management of the incident of which she was notified by the HCA **was a moderate to significant deviation from accepted practice.**

5 May 2021 — Addendum to above clinical advice

Thank you for giving me the opportunity to review the provider's response to the request to provide a copy of the content of falls training that was provided to staff prior to [Day 1] and/or a copy of any updated falls training, credentials of the person who provided the training and how competency was assessed.

New information reviewed:

- Email response from Golden Pond dated 15 April 2021
- Patient Handling Competency updated 2/21
- Health and Safety checklist dated 11/20
- Falls risk assessment tool dated 2/21
- Moving and Handling Recap

I reviewed the provided Patient Handling Competency document and the Health and Safety checklist and conclude that the content is in line with accepted good practice.

I would like to recommend that some of the language could be updated. Specifically the use of language such as 'patient handling' is outdated. Good practice uses terms such as 'moving and handling of people'. This subtle difference in language is more respectful to the health consumer as a resident in long term care.

Reviewing the Falls Risk Assessment Tool I recommend that the risk assessment tool be reviewed to include a more multifactorial risk assessment in line with the HQSC information resource on the topic of falls risk assessment:
https://www.hqsc.govt.nz/assets/Falls/10-Topics/2020-update/Topic-THREE-June-2020.pdf

Content of Moving and Handling education was provided however no content was forwarded relating to the Management of Falls in-house training and no credentials were forwarded of the person who provided the in-house training. Therefore I could not establish if the education provided to [RN C] and the care staff included the incorrect definition of what entails a fall and if there may have been an issue with staff education on falls management."

Appendix B: Falls Policy

FALLS POLICY

Definition: Unintentionally coming to rest on the ground, or at some lower level, not as a result of a major intrinsic event or overwhelming hazard.

Objective: Need to ensure residents well being and safety to preserve independence and mobility, achieve a balance between minimisation of restraint and prevention of falls.

Many falls can be prevented

- Risk factors identified on admission and documented on mobility and patient handling assessment.
- Mobile residents' families are encouraged to purchase hip protectors as a preventative measure against possible fractures.
- All falls are recorded on the INTERRAI and printed off and left in handover Folder, these Falls are collated and discussed monthly by falls committee.
- Family notified of all falls
- Any trends related to falls monitored and documented.
- Any falls causing serious harm must be reported to OSH.
- A series of processes used to achieve a positive outcome being: No Falls
- Glasgow Coma scale filled in for unwitnessed falls

Threshold for falls for aged care: 6.38 falls per 1000 occupied bed days. Threshold for falls for dementia care: 1.09 falls per 1000 occupied bed days.

Figures obtained from NZ Standards Indicators for Safe Aged Care and Dementia Care.

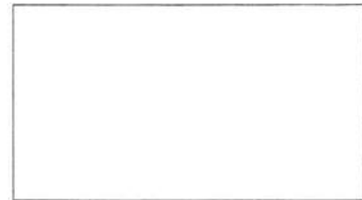
[RN G]

GP0311 3/02/2013

Appendix C: Inpatient Falls Clinical Pathway

CLINICAL PATHWAY FOR SAFE PATIENT HANDLING

**This tool illustrates appropriate application of safe handling Principles which are part of Universal Fall Precautions.*



Start Here → Can patient bear weight?

- Fully → Caregiver assistance not needed; stand by for safety as needed.
- Partially → Is the patient cooperative?
  - Yes → Does the patient have upper extremity control & strength?
    - Yes → Stand and pivot technique using a gait/transfer belt (1 caregiver) or Standing hoist (1 caregiver)
    - No → Use full body sling. Hoist 2 caregivers
  - No → Use full body sling. Hoist 2 caregivers
- No → Is the patient cooperative?
  - No → Use full body sling. Hoist 2 caregivers
  - Yes → Does the patient have upper-extremity strength?
    - No → Use full body sling. Hoist 2 caregivers
    - Yes → Full hoist transfer. 2 caregivers. Toileting sling or full sling.

- If patient has partial weight-bearing capacity, transfer towards stronger side.
- Toileting slings are available for toileting.
- Careful placement of furniture so the transfer occurs in the shortest distance and shortest time.

Outcome: Patient transfer recommendation: ____________________

____

Signed: ____________________

GP0358 17/9/2020

Appendix D: Falls Risk Assessment Guidance Document

Insert your logo here

Attach patient label here

Falls risk assessment

Item	Circle	COMMENTS
Patient input	Yes / No	
Family/Whānau input	Yes / No	
Carer input/other	Yes / No	
History of falls		**COMMENTS**
Frequency of falls		
Cause of fall *(slip, trip, fall, medical event)*		
Injuries from previous fall		
Fear of falling: Does the patient worry about falling or losing their balance?	Yes / No	
Consider: *Occupational therapy referral* *Physiotherapy referral*		
Mobility		**COMMENTS**
Unstable gait or looks unsafe walking	Yes / No	
Is this new for the patient?	Yes / No	
Does the patient use mobility aids?	Yes / No	
What mobility aids does the patient use?		
Consider: *Occupational therapy referral* *Physiotherapy referral*		
Vision, hearing, language		**COMMENTS**
Patient has hearing deficit	Yes / No	
Hearing aids are functional	Yes / No	
Consider: *Audiology referral*		
Patient has visual deficit	Yes / No	
Patient wears glasses?	Yes / No	
Consider: *Ophthalmology referral*		
Patient speaks and understands English?	Yes / No	
Consider: *Use of interpreter*		

Falls risk assessment guidance document

Sept 2014 version 1.0

Cognitive assessment		COMMENTS
Patient has communication impairment?	Yes / No	
Patient has confusion/disorientation?	Yes / No	
Patient has memory loss?	Yes / No	
Patient is agitated, impulsive, or unpredictable?	Yes / No	
Patient overestimates/ forgets limitations?	Yes / No	
Patient has neurological condition?	Yes / No	
Consider: *Watch* *Medical review* *Written visual prompts* *Social work referral*		
Continence		**COMMENTS**
Patient has frequency, urgency or incontinence?	Yes / No	
Patient has a UTI?	Yes / No	
Consider: *Commode/bottle by bed* *Assessing for appropriateness of incontinence aids* *Referral to incontinence nurse*		
Medications		**COMMENTS**
Patient takes four or more drugs/day?	Yes / No	
Patient on psychotropic or sedative drugs?	Yes / No	
Patient on drug that may cause postural hypotension?	Yes / No	
Patient within 24-hr post-anaesthetic / sedation?	Yes / No	
Consider: *Pharmacy review* *Monitoring lying and standing BP* *Assistance with mobilisation*		
Other risks		**COMMENTS**
Does the patient have any other risk factors?	Yes / No	
Further comments and observations:		

Name of clinician who completed this falls risk assessment:

Name	Signature	Date

Falls risk assessment guidance document Sept 2014 version 1.0

Appendix E: Falls Risk Standardised Assessment of Risk Factors

FALL RISK

STANDARDISED ASSESSMENT OF RISK FACTORS

- ☐ History of falls
- ☐ Mobility problems
    - Gait and balance impairment
    - Lower limb muscle weakness
    - Use of frames, sticks
- ☐ Medications
    - Large nocte medications
    - Psychotropic, hypotensive
- ☐ Mental Status
    - Delirium, Dementia, Psychosis
- ☐ Continence
    - Urinary frequency
- ☐ Age over 80 years
- ☐ Visual Defect
- ☐ Hearing deficit
- ☐ Medical Conditions
    - Arthritis, Depression
    - Hyper/hypotension
    - Neurological disorders
    - Diabetes

Risk factors reviewed 6 monthly or more often if condition changes.

Note:

Fall Risk	Medication	Side Effects
HIGH RISK	Analgesics	Sedation, dizziness
	Antipsychotics	Postural Disturbance
	Anticonvulsants	Altered gait and balance
	Benzodiazepines	Impaired Cognition
MEDIUM	Antihypertensives	Induced orthostasis

GP0360 12/11/2013

RISK	Cardiac Drugs	Impaired Cerebral
	Antiarrhythmics	Perfusion
	Antidepressants	Poor Health Status
LOW RISK	Diuretics	Increased ambulation, induced orthostasis

GP0360 12/11/2013

Appendix F: Policy on Rationale for Equipment Use

POLICY ON RATIONALE FOR EQUIPMENT USE:

HOISTS:

Uses:

1. Client completely unable to physically bear weight through both lower limbs.
2. Client completely unable to physically assist with the transfer.
3. Client unable to follow commands or has unpredictable/aggressive behaviours.

Precautions:

1. Requires 2 persons to safely roll client side-side to place sling in correct position prior to hoist activation.
2. Large turning angle required. Environment must be set out to accommodate this factor.
3. Hoists legs need clearance height or check adequate width to spread hoist legs around object and still allow close positional setting down of client.

STANDING HOISTS:

Uses:

1. Client must be able to push down on both legs as hoist is activated.
2. Client unable to fully weight bear.
3. Client able to follow simple commands.

Precautions:

1. "Dragging" effect
2. Painful or disfigured knee joints
3. Clients with vulnerable shoulders

C:\Documents and Settings\Owner\My Documents\Golden Pond\POLICY ON RATIONALE FOR EQUIPMENT USE.doc

SLIDING BOARDS:

Uses:

1. Wide variety in shape and size
2. Designed for active client participation
3. Client needs reasonable upper limb strength
4. Client can be sat unsupported
5. Client can be displaced sideways for initial "fitting"

Precautions:

1. Easiest transfer is between even height surfaces low to high requires greater upper limb strength.
2. Non-removable armrests require "Banana" shaped board.
3. Careful placement of board to prevent slippage.
4. Client should Slide on surface.

SLIDING SHEETS:

Uses:

1. Moving clients around the bed, frictionless surfaces minimises the risk of skin tears.
2. Rolling a client into full side lying.
3. Moving buttocks firmly to the back of a chair. ONE WAY GLIDES will help prevent forward slippage.
4. Getting clients out of awkward positions before hoisting them off of the floor.

Precautions:

1. Requires the correct size sheet to cover the whole body.
2. Infection control issues.

C:\Documents and Settings\Owner\My Documents\Golden Pond\POLICY ON RATIONALE FOR EQUIPMENT USE.doc

TRANSFER BELTS:

Uses:

1. To aid sit to stand with 2 carers
2. To aid walking with clients
3. To assist trunk forward flexion before the client stands from sitting.

Precautions:

1. Staff may be tempted to LIFT a client when getting up from a chair.
2. Staff may be tempted to save a client from falling rather than allowing them to slide to the floor under control.

Nurse Manager
24.10.09

Appendix G: Hoist Procedure

HOIST PROCEEDURE

- **Explanation to the patient**
- **Always check sling for signs of wear / fatigue before each use.**

Fitting the sling – Chair

1. Hold sling so label is away from the patient
2. Slide the sling down the patients back until the base is level with the base of the spine.
3. Pass the leg section under each thigh and pull the leg piece firmly.

In Bed / Floor

1. Position sling next to the resident so the base of the sling is level with the base of the spine.
2. Roll the resident towards you, push sling under.
3. Roll the resident the other way, ease the sling out so it is evenly spaced under the back.
4. Pass the leg straps under each leg.

Lifting Procedure

- Lower yoke
- Attach the straps to the opposite hook on the yoke.
- Reassure resident
- Ensure brakes are on bed/chair
- Check sling attachments are still in place on the yoke.
- If resident looks uncomfortable or maligned stop and reposition sling.
- Lift and once clear of bed/chair rotate to correct position to complete transfer.

Moving Patient

Hoists are designed for lifting primarily. If you need to move patient always

1. Lower the patient so that feet are just off the ground therefore lowering the centre of gravity.

2. 2 carers

3. Walk the back of the machine around so that it is heading in the new direction.

4. Always observe patient and reassure.

Lowering the Patient

1. Position over chair or bed

2. Handles are provided on the General purpose slings to pull patient back into the correct position.

3. Lower.

Remove the Sling

Reverse of fitting procedure

Implemented
June 2004

I
Nurse Manager
24.10.09

Appendix H: Care of Slings

CARE OF SLINGS

INSPECTIONS:

Slings are to be visually inspected monthly by the Team leader and signed. However – check for signs of wear or fatigue should be carried out before each use.

Examination of fitting – Buckles, D Rings:

- Absence of rust cracks
- Ease of adjustment of fittings
- Buckles checked for keeper operation and the locking / unlocking mechanism opens & closes freely
- Absence of sharp fittings likely to abrade webbing.

Examination of stitching:

- Check for unravelled stitches or excessive abrasion of stitches.

Cleaning:

- Washed on gentle cycle monthly or when soiled.
- Air dried in laundry.

Storage:

- Store away from direct sunlight on hook in Hospital Bathroom alcove.

f in doubt about the condition of the sling DO NOT use it. Remove it ıse.

ncident form to be filled out and reported to Management.

Appendix I: Care planning

CARE PLANNING:

Care planning is a process by which the patients Risk Assessment is translated into an action plan to address the identified patient needs. The care plan indicates specific actions that should or should not be performed.

1. Altered Mental Status
   Cognitively impaired patients
   - Review medications
   - Closer/scheduled rounds visits
   - Low beds, fall mats, night lights
   - Stop sign to remind patients not to get up
2. Impaired gait or mobility
   - Needs assess, walkers, walking stick
   - Patient handling assessment
3. Frequent toileting needs
   - Scheduled rounding protocol
4. Visual impairment
   - Corrective lenses
   - Glasses in reach
5. High Risk Medication
   - Review Medications
   - New /medication, observe, hypotension
6. Frequent falls
   - Injury risk assessment e.g. Osteoporosis
   - Vitamin D supplements
   - Low beds
7. Families
   - Aware of Risks

GP0359 12/11/2013

Appendix J: Policy on: Incident Form

INCIDENT MANAGEMENT

The collection of incident forms allows for management to analyse and look at the potential consequence of the risk to patients staff and visitors to Golden Pond . Any indications that Statistics are trending away from the norm will prompt corrective action

An incident form is to be completed for any of the following situations but is not limited to:

- Any time there is anything out of the ordinary
- Any patient or staff injury
- Any patient incident even if there is no apparent injury resulting.
  Pressure areas , bruises ,skin tears, wounds, are recorded on InterRAI system
- Falls are also recorded on interRAI and printed off for the clinical Nurse to assess
- Patient behaviours eg: aggressive, abusive clients on behaviour form
- Patient threatening to self harm or if profound – separate incident form
- Any missing items (razors, rings, money etc)
- Any broken equipment. Please fill in hazard form at reception if necessary
- Any breakdown of equipment. Please fill in hazard form at reception, if urgent note to Manager.
- Any visitor incidences
- Medication errors and missing Medication
- Any incidences in units or grounds
- Any Biological Spillage
  - needle stick injury
  - unintentional bodily fluid contact
- Any conflict:

GP0081 3/05/09

- Staff — Staff
- Staff — Patient
- Staff — Family

The incident forms **MUST** be filled out as soon as possible after the incident

The RN will be aware and sign the incident form and assess any risk or consequence that may require immediate intervention and document samei n clinical notes

The incident forms are looked by the Manager and any interventions needed as appropriate are commenced

The Incident forms are collated each month and a report written and presented to the monthly care committee for discussion A copy is on the board in the staff room and a copy to the Director

Golden Pond benchmark with the group monthly other aged care facilities in the

A yearly report is done and a

I
Nurse Manager

Appendix K: Policy on Family Notification re Adverse Events

POLICY ON FAMILY NOTIFICATION

To ensure families are well informed by effectively communicating the following incidents:

- Falls
- Medication changes
- Any infection requiring antibiotics
- Any significant change in health status
- Significant skin tears
- Any untoward incident of significance
- Care planning

The RN is to notify the family as soon as possible up to 2100hrs, any later is at the RN's discretion.

If family are not immediately informed then it is the responsibility of the RN on the subsequent shift to inform the family.

Documentation of the above needs to be recorded on the relative/whanau form in the front of the resident's file and in the resident's progress notes/care plan.

Clinical Nurse 04/09/2020 [amended]

GP0550