Chatswood Lifecare Limited
Caregiver, Ms B

A Report by the
Aged Care Commissioner

(Case 20HDC01617)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 1
Information gathered during investigation 2
Opinion — Introduction 11
Opinion: Ms B 12
Opinion: Chatswood Lifecare Limited — breach 15
Changes made 17
Recommendations 18
Follow-up actions 18
Appendix A: Independent clinical advice to Commissioner 19

Executive summary

1. This report concerns the care provided to a woman when she was a resident at a care home.

2. In 2020, the woman had two recorded falls at the care home in one day. The second fall, in the evening, occurred when the woman was left on the toilet by a caregiver, and it resulted in the woman being admitted to hospital. The woman subsequently passed away.

Findings

3. The Aged Care Commissioner found that Chatswood Lifecare Ltd failed to provide services to the woman with reasonable care and skill and breached Right 4(1) of the Code. The Aged Care Commissioner considered that Chatswood Lifecare Ltd failed to provide the caregiver with the tools to enable her to provide adequate caregiving services to the woman. The Aged Care Commissioner also considered that the care home did not ensure that the woman was reviewed sufficiently frequently given her frailty and deterioration, did not take adequate steps to ensure that the caregiver was made aware of the woman's short-term care plan, and did not provide compatible policies. The Aged Commissioner was also critical that the caregiver did not note down important information about residents at handover, and that she did not assess the woman adequately before moving her after her last fall.

Recommendations

4. The Aged Care Commissioner recommended that Chatswood Lifecare Ltd and the caregiver provide written apologies to the family. The Aged Care Commissioner also recommended that Chatswood Lifecare Ltd review its process for handover to ensure that incoming staff are adequately informed of key requirements and resident issues; put in place a system to provide support for caregivers in the rest-home wing during medication rounds; establish a programme of regular in-service training for staff on the assessment of falls risk, monitoring, maintaining mobility in the elderly and the importance of exercise for balance and strength, and accurate documentation in regard to falls management; consider developing a flow chart of the process to manage a falls incident; and develop more comprehensive policies covering the review of falls risks and when the use of a hoist is required.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mrs C about the services provided to her mother, Mrs A, by the care home. The following issues were identified for investigation:

- *Whether Chatswood Lifecare Limited provided Mrs A with an appropriate standard of care during Month1[1] to Month5 2020 (inclusive).*

[1] Relevant months are referred to as Months 1–5 to protect privacy.

- *Whether Ms B provided Mrs A with an appropriate standard of care in Month5 2020.*

6. This report is the opinion of Aged Care Commissioner Carolyn Cooper and is made in accordance with the power delegated to her by the Commissioner.

7. The parties directly involved in the investigation were:

Ms B	Caregiver/provider
Mrs C	Consumer's daughter
Care home	Provider

8. Further information was received from Ms D, a caregiver at the care home.

9. Independent advice was obtained from a registered nurse, Dr Karole Hogarth (Appendix A).

Information gathered during investigation

10. Mrs A (aged in her nineties) had a medical history that included hypothyroidism,[2] atrial fibrillation,[3] asthma, and congestive heart failure. Mrs A had been a resident at a care home owned and operated by Chatswood Lifecare Limited for several years.

11. The care home provides rest-home[4] level and hospital (medical and geriatric) level of care for up to 101 residents. At the time of this event, the rest-home wing had 31 residents.

12. This report concerns the care provided to Mrs A at the care home when she suffered falls in 2020.

Ms B

13. At the time of the events, Ms B had worked as a caregiver at the care home for four years. She said that mainly she worked in the hospital wing and only occasionally would go to the rest-home wing, where the residents were more independent than those in hospital care.

14. Ms B said that she had been appointed team leader, and her role included having to check emails for clinics, laboratory results, appointments, doctors to contact, and correspondence to answer. Ms B stated that there was never enough time to do everything required and also look at the patient records. She said that they relied heavily on what they were told at handover from shift to shift, and this was harder when she was working in the rest-home wing only from time to time. She stated: 'A lot of the time I got worried that I would get something wrong, or miss something.'

[2] An underactive thyroid gland.
[3] A disease of the heart characterised by irregular and often rapid heartbeat.
[4] Chatswood refers to its service as a 'rest home'.

15. Ms B told HDC that during the afternoon shift, the first medication round was at 4pm, and she would then help with setting the table for dinner and help residents with toileting and assist some to the dinner table. She said that she did a second medication round between 5pm and 6pm, and then the next medication round started at around 8.45pm and could take up to an hour, and she had to try to complete it before the residents fell asleep. After that she would write notes, answer bells and do checks of residents.

Events 2019–2020

16. It is recorded in the adverse events register that Mrs A had six reported falls between 2019 and 2020. Mrs A's long-term care plan, dated 21 August 2019, identifies that she had a history of falls and notes that she was on diuretics and wore a pad for protection, but was able to take herself to the toilet. Staff were to ensure that a low walking frame was always within reach. The plan notes that staff should respond to the sensor mat or call bell quickly, as Mrs A could be impulsive when mobilising. However, the care home told HDC that Mrs A had not been identified or assessed as a high falls risk, as she had not fallen twice within any one month, which is the care home's formula/trigger for identifying residents at risk of falls and putting in place additional measures to manage them.

17. The care home said that its Clinical Manager monitors the adverse events log and works immediately with staff to put in place measures to prevent residents from further falls if they have fallen twice within 30–31 days. However, prior to 21 Month5 Mrs A had not fallen within that time frame. The care home stated that Mrs A was assessed as being relatively independent from a mobility perspective and could and had exited the toilet safely on many occasions without staff supervision or assistance.

18. On 18 Month1 a notation on the long-term care plan states that Mrs A was to be supervised with toileting at night. The long-term care plan was not reviewed between Month1 and Month5 but an entry on 4 Month2 notes that Mrs A had been up several times during the night.

Events on 21 Month5

First fall

19. On 21 Month5 Mrs A had an unwitnessed fall at around 2.21am. The adverse events log states that a caregiver found Mrs A sitting on the floor when he was doing a round. The registered nurse attended and assessed Mrs A. The adverse events log states that no injuries were noted and that Mrs A said that she had not hit her head. She had the usual range of movement in her upper and lower extremities. Her vital signs were taken and were normal. The nurse recorded in the progress notes: '[Mrs A was] assisted by two staff to stand up and transfer to bed. Able to walk with assistance. Denies any pain or dizziness.' A hoist was not used.

Short-term care plan

20. A nurse created a handwritten short-term care plan at 10am on 21 Month5. It states that Mrs A was at high risk of falls related to her short-term memory loss and lack of insight into her safety. The interventions in the short-term care plan were to supervise Mrs A at all times when she was mobilising, keep her walking frame within reach, and respond to the call bell

as soon as possible. The short-term care plan states: '[A]ssist [Mrs A] with toileting needs every two hours or as needed. Do not leave her unattended until she is safely back on her chair or bed.' It also states that the sensor mat should be in place and working at all times. There is no reference in the progress notes to the existence of a short-term care plan. The short-term care plan was placed on Mrs A's file but there is no evidence of an alert being distributed to staff. The care home told HDC that the two falls that occurred on 21 Month5 were dealt with as per the care home policy and staff instructions. This included keeping a close watch on Mrs A and the development of a short-term care plan following the first fall and watching Mrs A for any injuries and reduced mobility.

21. Ms B said that on the evening of 21 Month5, she was the team leader, and she worked a 3pm to 11.30pm shift. Another caregiver worked 3pm to 11.15pm and a second caregiver worked 4pm to 7pm. Consequently, after 7pm there was only Ms B and one other caregiver on duty. The care home told HDC that 31 beds in the rest-home wing were occupied at that time. Ms B told HDC that the caregivers divided the resident cares between them. Ms B said that she had met Mrs A previously when she had worked in the rest-home wing and, when she had first met Mrs A, she was quite mobile. Ms B said that Mrs A had deteriorated, but she could respond when spoken to and used a walking frame to mobilise.

22. Regarding Mrs A's care plan, Ms B said that each resident had a folder, which was located in the nurses' station. She stated that staff did not have time to read the folders and relied on the staff from earlier shifts to highlight anything that needed to be done. In response to the provisional opinion, she said that the short-term care plan was prepared by the registered nurse in the hospital wing.

23. At the beginning of the shift there was a verbal handover from the staff on the previous shift. There is no record of what information was provided about Mrs A. Ms B stated that the handover was from the caregiver from the previous shift, not the registered nurse. She said that the handover was quick and took from 3–3.15pm. She said that it was difficult to recall everything from handover, as there was always a large amount of information given in a short time about many residents and there were always several residents who had high needs and were not independent, so the focus was on triaging those who needed the most help. She said that it was particularly difficult because she was not working in the rest-home wing all the time and did not know all the details — such as the extent of Mrs A's deterioration. Ms B stated:

> 'I cannot remember even being told that a short-term care plan had been put in place for [Mrs A] that morning. It was only after the accident [the second fall] that an RN [registered nurse] told me that [Mrs A] had had a number of falls, and they were thinking of moving her to the hospital side. I did not know that she had become that bad when I went in to cover that shift, and if I had known that, I would not have left her.'

Second fall

24. Ms B stated that at around 9.30pm she was completing the final medication round and was about to administer the medication to the last resident. She said that normally while she

was doing this, the other caregiver[5] would answer any call bells that rang. However, Ms B said that she heard a call bell or sensor mat activated in Mrs A's room and this went on for some time. Ms B stated that as she was only two rooms away, and the other caregiver, Ms D, was busy at the end of the hall assisting other residents, she went into Mrs A's room to see what she needed.

25. HDC asked the care home what the expectation would be if the team leader was doing the medication round and the other caregiver was already attending to a resident. The care home responded that its expectations of staff who work in the rest-home wing are that the team leader should contact the registered nurse working in the hospital wing and ask for additional staff assistance if required. Ms B said that the registered nurse in the hospital wing was also very busy and often when they asked for assistance, the nurse would instruct them to take the resident's vital signs and say that she would come when she could.

26. Ms B noted that staff had a five-minute window[6] in which to answer call bells. She said that when she entered the room, Mrs A was sitting on the side of the bed with her feet on the floor on the sensor mat. Mrs A told her that she wanted to go to the toilet, so she assisted Mrs A to the toilet, sat her down, and put her walking frame in front of her. Ms B said that she told Mrs A that she would give her some privacy and would be back in a few minutes to check on her and help her back to bed. Ms B stated that Mrs A seemed fine and responded coherently, so she thought that Mrs A understood, and went back to give the other resident her medication. In response to the provisional opinion, Ms B said that it was her usual practice and part of her routine to remind residents where the bell was and to tell them to use it if they needed assistance, and she believes that she would have reminded Mrs A about the bell.

27. Ms B said:

> 'I thought [Mrs A] was safe as she was sitting on the toilet with her frame in front of her, and I thought that she understood that I would only be gone a few minutes. I never like to leave medications unattended, as I always worry that other residents may take them, and as I knew it would only take a few minutes to get that one final medication, I quickly went to do that.'

28. In response to the provisional opinion, Ms B said that despite the care home's expectations, staff did not always have time to stay with residents when they were in the toilet, as staff were too busy and there were often competing needs to be met.

29. The care home told HDC that its management team were 'disappointed' that Ms B chose to continue with the medication round after assisting Mrs A to the toilet, rather than wait for her to complete her toileting. The care home said:

[5] By this stage the second caregiver who worked 4–7pm was no longer present, so Ms B and Ms D were the only staff in the wing.
[6] See below — that is not a requirement in the call bell policy. The policy states that staff must respond to call bells 'promptly'.

> 'The short-term care plan had been developed only that morning by staff to emphasise that [Mrs A] required supervision by staff. This is regarded as normal protocol following an incident of note.'

30. The care home told HDC that Ms B had worked in a senior capacity for several years, and there had not been any issues with her competence, decision-making process, or actions prior to this event.

31. Another resident, whose room was next to Mrs A's room, said that she heard a 'thud' from Mrs A's room and, as Mrs A had fallen the previous night,[7] the resident thought she should ring her call bell to let the carers know. The resident said that practically straight away, Mrs A began calling out very loudly and 'two carers came immediately'.

32. Ms D told the care home that she did not hear Mrs A calling out. Ms B said that while she was beside the other resident's bed with the blister pack open to administer the resident's medication, Ms D came in and said that Mrs A had fallen. Ms B said that she told Ms D to return to Mrs A and to stay with her, and that she would come as soon as she had finished giving the medication. Ms B stated that she believes she attended to Mrs A within two or three minutes.

33. Ms B said that when she entered the room, Mrs A was sitting on the floor with her legs in front of her and her back against the recliner chair opposite the toilet door. The walking frame was off to one side near the hand basin. Ms B stated:

> 'We considered getting the hoist, but [Mrs A] was crying and kept asking us over and over to get her off the floor. I tried to comfort her, but she just kept saying to get her off the floor. I wanted to make her as comfortable as possible, so we gently lifted her up on to the chair. I then rang the registered nurse in the hospital and asked her to come. I took the vital signs and they were mainly normal.'

34. Ms D said that she mentioned the hoist to Ms B, but Ms B decided to lift Mrs A onto the chair.

35. Ms B noted that the care home had a policy of no lifting or manual handling of residents. She said that paragraph 10 of the hoist training checklist states: '[C]an identify that a hoist or lifting device MUST be used for any resident who is on the floor, and unable to get up with minimal assistance' (emphasis in original). She said that her only explanation for not using the hoist was that Mrs A was very uncomfortable and repeatedly asked them to get her off the floor. Ms B stated that she has thought about why they did not stop and get the hoist, and she thinks that in part it was because Mrs A was a very small woman, and they felt able to lift her quite easily and gently from the floor onto the chair. In response to the provisional opinion, Ms B said that the hoist was kept in the hospital wing, which meant that Mrs A would have had to remain on the floor while the hoist was retrieved by her or Ms D. Ms B stated: 'I believe that I let my concern for her immediate relief and comfort override what the policy generally required.' In response to the provisional opinion, the care home

[7] This appears to be a reference to the fall in the early hours of that morning.

agreed that a hoist was not kept in the rest-home wing but stated that one was available within approximately 40 metres of the rest-home wing. The care home said that the hoist was easily accessed by way of a covered passageway into the hospital wing, and that staff were aware of its availability there. The care home stated that Ms B could easily have called for the hoist to be brought to her from the hospital wing when she rang for the registered nurse to come to assess Mrs A, and that Ms B was carrying a phone with her, as part of her role of team leader. The care home further noted that staff may have to walk a distance to access a hoist even in the hospital wing when hoists are stored and not in use.

36. The care home said that its manual handling training and policies clearly articulate that residents are not to be lifted following any fall or event until the registered nurse on duty has assessed the resident fully and is cognisant of any injuries. The care home said that its staff are reminded of this protocol at staff meetings and as part of their health and safety inductions. It stated that a registered nurse is rostered onto the hospital wing 24 hours per day and the hospital nurse always makes any acute incident response their priority and attends the scene quickly.

37. In response to the provisional opinion, the care home told HDC that all staff are educated and trained to call a registered nurse immediately if a resident falls, so that immediate overview and assessment can occur prior to the resident being assisted following the fall. The care home said that Ms B did not follow the care home policy or protocols in this instance. She was considered an experienced carer and was acting as team leader, and she was well aware of the actions required to ensure residents' safety, especially after anyone fell in the rest home.

38. Ms B took Mrs A's vital signs and recorded that they were normal and that there were no signs of swelling or redness. She contacted a nurse, who reviewed Mrs A and noted that she had pain in the right upper outer area of her thigh and in her right wrist. The nurse rang the ambulance service and instructed Ms B to inform Mrs A's family.

39. The ambulance arrived around 10.15pm, and Mrs A's daughter, Mrs C, accompanied her to the hospital.

40. The care home stated that Mrs A's call bell was checked the morning after the incident and found to be working satisfactorily.

Incident report

41. Ms B wrote an incident report in the adverse events log. It describes the incident as: 'Found [Mrs A] sitting on the floor leaning on her right hand-side with her bottom against the lazy boy. Noticed walking frame by her bedroom hand basin.' The report indicates that it was a major incident.

42. Ms B said that at that time she did not know how detailed the description should be, so she just wrote what she saw when she entered the room. She said that she could not remember having had any training on what to write in an incident report and was just shown where the form was in the computer system. She stated that she had never been told previously

that her reports were too brief. She said that it was only after the care home received a complaint that she was told that the incident report was incomplete, and that she should have written in detail everything that had happened before and after Mrs A's fall. Ms B said that she was told that she should even write things that did not seem relevant, which she did not know previously.

Subsequent events

43. Mrs A was taken by ambulance to the Emergency Department at the public hospital. She was found to have a shortened and externally rotated right leg and tenderness in her right wrist. X-rays showed fractures of the right neck of femur and the right distal radius (wrist).

44. It was decided that Mrs A's fractured neck of femur would be managed conservatively, rather than with surgery. She was provided with pain relief. It was noted that she was unlikely to survive the event, and there was a high risk of complications from her immobility.

45. Mrs A was placed on a palliative care pathway and, sadly, she died a few days later.

Care home's investigation

46. On 7 April 2020, the care home wrote to Mrs C with the findings from its investigation. The letter states that Mrs A was assisted to the toilet by the senior caregiver and told to ring the bell when she had finished using the toilet. The report states:

> 'When the staff member returned to check [Mrs A], she had already finished and exited the toilet and was in her bedroom space, albeit found on the floor beside her chair. This is documented clearly in her progress notes of that evening. We can confirm that she fell in her bedroom beside her hand basin and chair and not in the bathroom.'

47. The letter states that the staff member rang the emergency call bell immediately for the assistance of other rest-home staff, and the other evening caregiver arrived, and they decided to call the hospital registered nurse to assess Mrs A physically.

48. The care home told Mrs C that it had concluded that the actions by all staff had met the expected standards of clinical assessment, care delivery and practice. The care home stated:

> 'We have reviewed our Rest Home practices identifying if [Mrs A's] fall could have been averted, but with [Mrs A] choosing to exit the toilet without ringing the bell to seek staff's assistance and our staff busy with their respective tasks at that hour of the evening, this was sadly an unfortunate and unwitnessed fall/accident. The Senior Caregiver stated there was only 5–10 minutes gap between when she assisted [Mrs A] to the toilet and when she next went to check on her, with the intention of assisting her back into her bedroom. This would be an acceptable time frame to ensure [Mrs A] would have had sufficient time to complete her toilet routine.'

Further information from family

49. Mrs A's family said that they received three reports from the care home regarding the incident and had two meetings, but they were not happy with the result of these as they felt

that they had to chase management to investigate the incident fully, and there were inaccuracies and inconsistencies in the reports. For instance, the reports did not refer to the account of the resident in the next room and said that between 5–10 minutes after Mrs A had been settled on the toilet, the senior caregiver returned to check on her, as she had not heard any call bell from Mrs A. At that stage the caregiver found that Mrs A had fallen.

50. The care home's initial conclusion was that the staff had acted appropriately and followed its guidelines. Subsequently, after it was provided with the other resident's statement, the care home concluded that Ms B had acted inappropriately in leaving Mrs A unattended on the toilet.

Policies

51. The Call Bell Policy states:

> 'Staff will respond to the Call Bell promptly and deactivate the alarm sound from the Call Bell system to indicate the call has been answered.
>
> **To minimise the risk of falls, dependent Residents are not to be left unattended while in the shower or toilet.**
>
> **Use Call Bell to gain assistance from other staff.** In the event of requiring assistance, leave the Call Bell ringing and do not push the reset button. Staff are expected to respond and provide support immediately.'

52. The Medical Administration Policy states: 'Nurses and approved Caregivers must give their undivided attention to the medication administration process …'

53. The Medication Administration Procedure states: '**At no time are staff permitted to leave medication unattended where other Residents, staff or visitors have access.**' (Emphasis in original.)

54. The Falls Prevention Programme states:

> '2. In the event of a fall, each Resident must be assessed immediately for injury prior to moving and first aid given as required. Notify the Clinical Nurse Manager or Village Manager or on-call person if the Resident has sustained an injury requiring more advanced treatment/care or if the Resident's condition deteriorates. Gain the assistance of the ambulance service. (Ring 111 or 0800 262 665).
>
> 3. In the event of a fall, an Adverse Event form must be filled out before completion of that duty. The Clinical Nurse Manager or Village Manager will analyse the fall for potential causative factors and will review the management plan accordingly.
>
> …
>
> **<u>Instructions in the Event of a Fall:</u>**
>
> ***Witnessed Fall***
>
> 1 Head to toe examination for the presence of bruise or skin tear by Senior First Aid trained personnel

2 Ensure head of the Resident is supported
3 Ask the Resident to move arms and legs (verify normal range of movement), check for verbalisation of pain and check facial expressions for evidence of pain
4 Assist Resident in sitting position then standing with assistance (if appropriate)
5 Monitor for weight bearing, if has problem in weight bearing — inform RN (On Call)
6 Full set of physical observations
7 Neuro-obs performed and documented in cases where head has been hit (or may have been hit)

Unwitnessed Fall

1 Call emergency bell to seek assistance as soon as Resident is seen on floor
2 Observe the environment where resident is lying, what other things are around the Resident
3 Put a pillow under their head, remove furniture or mobility, aid airway
4 Follow the same set of instructions starting from number 1 of Witnessed Fall

Any Unwitnessed Fall should be considered for possibility of head injury — neuro-obs are a must.

Fall resulting in resident on floor while only one person on duty in area

If a resident has fallen to the floor at night when **only one caregiver is on duty,** seek assistance from a staff member in another area. If this support is not available —

Follow above guidelines for witnessed or unwitnessed fall and —

1. first examine to meet first aid needs,
2. notify on-call and,
3. if resident cannot be safely mobilized by on duty staff, then seek an ambulance assist will be requested for assessment and assist as deemed clinically necessary.

…'

Responses to provisional opinion

The family

55. Mrs C was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion. Mrs C said that as a family, they truly feel that the care home failed to provide Mrs A with the attention and care she required, and were negligent, which resulted in her death after the fall that Mrs A was unable to recover from.

56. Mrs C said that the care home not only failed Mrs A and her family, but also failed the caregivers by not providing sufficient training. Clearly staff were stretched and did not seem to be aware of the care home policies. However, this does not take away from the fact that the caregivers did make the wrong decisions, which directly caused Mrs A's fall, and they were also dishonest in their reporting.

Ms B

57. Ms B was provided with an opportunity to comment on the provisional opinion, and her comments have been incorporated throughout the report where relevant.

58. Ms B told HDC that it is still very upsetting to her when she thinks about what happened to Mrs A, and it is something that she will always carry with her. She blames herself for not going back to help Mrs A sooner, and said that if she had, the fall may not have happened or the consequences of the fall would not have been so severe. She is very sorry for her part in the incident and is also sorry for Mrs A's family, who must miss Mrs A very much.

59. Ms B said that she loved her job at the care home but is now questioning whether it is the right work for her. Her concern is that the responsibility and burden is too great when caring for so many people when there is not enough staff and time.

Chatswood Lifecare Ltd

60. The care home was provided with an opportunity to comment on the provisional opinion, and its comments have been incorporated throughout the report where relevant.

61. The care home told HDC that it disputes that the rest-home staff were not given access to equipment to manage Mrs A's fall. Regarding there being no hoist in the rest-home wing, the care home noted that generally rest-home residents are more independent than residents in the hospital wing, and hoists are expensive to purchase to sit idle in the rest home when mostly they are required for use in the hospital area.

62. The care home said that Ms B was an experienced level 4 team leader, and she had been a regular worker in the rest-home area and had worked there the previous week between 13 and 16 Month5 on an afternoon shift. The care home said that she was familiar with Mrs A's care and was rostered to work in the rest home on a regular basis.

63. The care home disagreed that residents in a rest home aged over 90 years are regarded as frail and should be supervised fully, and it said that this comment 'negates the rights and ability of [its] more mobile and independent rest home residents to remain physically independent'.

Opinion — Introduction

64. Mrs A was elderly and vulnerable. She and her family reasonably expected that she would receive care of an acceptable standard while she resided at the care home. I take this opportunity to express my condolences to Mrs A's family and acknowledge their frustration at having been told varying accounts of the events that occurred.

65. I have considered the evidence from Ms B, Ms D, and the resident next door to Mrs A. I find that it is more likely than not that the events occurred as follows. Ms B had attended handover at the beginning of her shift but was either not told or did not recall being told

about Mrs A's short-term care plan or her falls. Ms B was undertaking the medication round at around 9.30pm on 21 Month5. She was about to administer medication to the final patient when she heard either the call bell or the alarm from the sensor mat in Mrs A's room. The other caregiver, Ms D, was assisting another resident, and so Ms B left the medication and went to assist Mrs A.

66. Ms B assisted Mrs A to the toilet, sat her down and put her walking frame in front of her. Ms B told Mrs A that she would be back in a few minutes to check on her and help her return to bed. Ms B then went to give the final patient her medication.

67. Mrs A fell in her bedroom. The resident next door heard a thud and rang her call bell. The resident said that Mrs A began calling out and shortly thereafter two carers came to attend to Mrs A.

68. It appears that Ms D did not hear Mrs A calling out but responded to the call bell. At that time, Ms B was beside the final patient's bed with the blister pack open to administer the medication. Ms D told Ms B that Mrs A had fallen, and Ms B told Ms D to stay with Mrs A. Within two or three minutes, Ms B entered Mrs A's room and found her sitting on the floor with her legs in front of her and her back against the recliner chair opposite the toilet door.

69. Ms B and Ms D lifted Mrs A onto the chair. Ms B then took Mrs A's vital signs, which were normal, and contacted a nurse.

Opinion: Ms B

Attending to Mrs A during medication round — no breach

70. Ms B was interrupted during the medication round by an alarm from Mrs A's room. No other staff member was immediately available to respond. My independent clinical advisor, RN Dr Karole Hogarth, advised that it is expected that a resident would be provided with a safe environment and receive the care needed to ensure that they could mobilise and toilet with the assistance of staff as needed and as indicated in their care plan. Call bells should be answered promptly as per the call bell policy. Dr Hogarth did not express concern about Ms B's decision to answer Mrs A's alarm and assist her to the bathroom.

71. In my view, Ms B was in a difficult situation. The only other caregiver, Ms D, was not available to respond to Mrs A's alarm as she was assisting another resident. The medication administration policy states that Ms B was required to give her undivided attention to the medication administration process, and the medication administration procedure stated that 'at no time are staff permitted to leave medication unattended where other Residents, staff or visitors have access'. However, the call bell policy required that staff respond to call bells promptly. Mrs A's long-term care plan noted that staff should respond to her call bells quickly as she could be impulsive when mobilising.

72. The care home said that Ms B could have contacted the hospital wing to obtain additional staff. However, the time delay, even if quite short, would have been likely to have resulted in Mrs A attempting to go to the toilet on her own.

73. In my view, it was understandable that Ms B did not want to leave the medications unattended because of the risk to other residents. In the circumstances, although Ms B's actions were in breach of the facility's Medication Administration Procedure policy, I am not critical of her assisting Mrs A during the medication round because the call bell policy required staff to respond to a call bell promptly, Mrs A's long-term care plan required staff to respond to her call bell quickly, and the only other caregiver in the rest-home wing was busy assisting other residents.

Leaving Mrs A on the toilet — adverse comment

74. Ms B assisted Mrs A to the toilet, sat her down and put her walking frame in front of her. Ms B told Mrs A that she would be back in a few minutes to check on her and help her to return to bed. In response to the provisional opinion, Ms B said that she would have reminded Mrs A about the call bell. Ms B then returned to the medication trolley to complete the medication round.

75. A short-term care plan had been implemented on the morning of 21 Month5, because Mrs A had fallen earlier that morning. The short-term care plan states that Mrs A was at high risk of falls because of her short-term memory loss, and lack of insight into her safety. The plan states that Mrs A was to be supervised at all times when she was mobilising, her walking frame was to be kept within reach, and staff should respond to the call bells as soon as possible. The plan states: '[A]ssist [Mrs A] with toileting needs every two hours or as needed. Do not leave her unattended until she is safely back on her chair or bed.'

76. I note that the call bell policy states that dependent residents are not to be left unattended, while in the shower or toilet. However, it is unclear what is meant by 'dependent'. The care home stated that Mrs A was assessed as being relatively independent from a mobility perspective and could and had exited the toilet safely on many occasions without staff supervision or assistance. However, my independent clinical advisor, Dr Hogarth, considers that Mrs A was a dependent resident, so to leave her was in contravention of the call bell policy. In my view, the care home should have provided greater clarity as to the meaning of 'dependent residents' to support staff to provide appropriate care.

77. Dr Hogarth noted that Ms B did not prioritise Mrs A's safety and instead continued the medication round while Mrs A was in the bathroom. Dr Hogarth advised that in light of the short-term care plan, Mrs A should not have been left in the bathroom on her own.

78. I have accepted that Ms B was either not told or did not recall being told about Mrs A's short-term care plan. I also note that the short-term care plan is not referred to in the progress notes. Mrs A's long-term care plan states that she was able to take herself to the toilet, although a notation on 18 Month1 said that she should be supervised when toileting at night. However, these events occurred during the evening at around 9.40pm, rather than at night.

79. Dr Hogarth advised that it would be expected that during a handover discussion, a senior caregiver would ask appropriate questions and determine areas of most need, concern or where alertness was required on any given shift, which would include implementation of short-term care plans or changes of residents' status. She said that ideally, the information about Mrs A's requirements would have been conveyed to Ms B at handover, but it is the responsibility of the carer who is taking over to know what is required.

80. I acknowledge that the rest-home wing was not Ms B's usual area of work, and she was not aware that a short-term care plan for Mrs A had been put in place that morning before she started her shift. However, I also note that the care home said that Ms B did work in the rest-home area quite frequently. Although that information would have been in Mrs A's records (but not the progress notes), by Ms B's account, she did not have time to read the records sufficiently due to the amount of information that was given in a short amount of time. I also note that Ms B said that she did not know the extent of Mrs A's deterioration and recent falls. As stated above, Ms B was required not to leave the medication unattended, and she was aware of the risks that posed.

81. I accept Dr Hogarth's advice that as team leader, Ms B was responsible for informing herself about Mrs A's requirements. However, I also accept that it may have been difficult to retain verbal information at handover regarding 31 residents during a 15-minute verbal handover. In that situation, I consider that Ms B should have noted down any important information about the residents. I am also unable to make a finding that information about the short-care plan was actually handed over. I note that the registered nurse who prepared the short-term care plan was not the person who conducted the handover.

Failure to assess Mrs A adequately before moving her — adverse comment

82. When Ms B became aware that Mrs A was on the floor, Ms B took Mrs A's vital signs and recorded that they were normal and noted that there were no signs of swelling or redness. However, Ms B did not recognise that Mrs A had pain in her thigh and wrist. In my view, Ms B did not assess Mrs A for injuries adequately or use the hoist to move her. The care home's falls prevention programme states that in the event of a fall the resident must be assessed immediately for injury prior to moving, and first aid given. The instructions in the event of a fall include to assist the resident into the sitting position, then to assist the resident to stand (if appropriate).

83. I note that following the earlier fall at 2.21am, Mrs A was assessed by the registered nurse, then assisted by two staff to stand up and transfer to bed. She was not lifted by the hoist on that occasion.

84. Ms B was aware that the care home's expectation was that there would be no lifting or manual handling of residents, and that a hoist or lifting device was to be used for any resident who was on the floor and unable to get up with minimal assistance. I note that Ms B said in response to the provisional opinion that obtaining the hoist from the hospital wing would have caused a delay and the care home has accepted that a hoist was not kept in the rest-home wing (but rather in the hospital wing) and was located a short distance away. Ms

B said that Mrs A asked them repeatedly to get her off the floor, and as she was a very small woman, they felt able to lift her gently onto the chair.

85. Overall, although I am critical that Ms B did not comply with the care home's expectations regarding use of the hoist, I note that the falls prevention policy provided that in the event of a fall the resident should be asked to move their arms and legs and then be assisted to the sitting position then to standing with assistance (if appropriate), and the policy does not refer to the use of a hoist.

86. In my view, Ms B should not have moved Mrs A without assessing her for injuries adequately. However, I accept that Ms B was influenced by Mrs A's strong desire not to remain on the floor, and that Ms B wished to make Mrs A more comfortable. I also acknowledge that the hoist was not kept in the rest-home wing, which was also a factor that Ms B considered in making the decision to move Mrs A. However, I consider that Ms B should have explained to Mrs A the need to check her for injuries before moving her.

Opinion: Chatswood Lifecare Limited — breach

Reviews

87. Dr Hogarth advised that Mrs A should have been reviewed regularly and that reassessment of her mobility and falls risk alongside her general health and wellbeing should have been part of the review. The records indicate that there was a four-month gap between Month1 and Month5 without any documented review of the long-term care plan.

88. Dr Hogarth said that this gap between reviews would be unusual for a woman in her nineties who was known to require assistance, had a lack of insight into her own safety, had a sensor mat, and had trouble using the call bell. Three falls were noted during these four months, prior to the second fall on 21 Month5, with no injuries noted. Dr Hogarth advised that the limited reviews was a mild departure from accepted practice and care of Mrs A. Dr Hogarth said that this was due to the four-month gap between falls risk assessments despite the three documented falls during that period. She stated that although the falls policy required a review only if there had been three or more falls in a month, she considered that 'it would have been prudent given [Mrs A's] age and her lack of insight into her own safety to review her mobility'. I agree and consider that the care home should have reviewed Mrs A's mobility regularly because of her risk of falls.

Handover

89. On the morning of 21 Month5, a short-term care plan was put in place for Mrs A. However, there is no reference to the plan in the progress notes, and no evidence of an alert to staff. Although Ms B could have seen the plan if she had reviewed Mrs A's records, she said that this was not possible as she did not have time to review 31 files at the beginning of her shift, given the limited amount of time allocated to handover. Consequently, she was reliant on

the information given at handover. She does not recall being told about the short-term care plan, and the care home has provided no evidence that the information was handed over.

90. Dr Hogarth advised that some streamlining of the handover process would be advised to ensure that key requirements are captured, such as an overall question about who is most at risk on any given shift, and whether anything significant has occurred or new plans put in place to be aware of. I agree.

91. The Health and Disability Services (Core) Standards requires organisations, including care homes, to ensure that services are planned and coordinated to promote continuity in service delivery.[8] This includes adequate handover or briefing between shifts.[9] Ms B told HDC that she did not have time to review all patient files in the time allocated to handover, and she could not recall being told about Mrs A's short-term care plan. I consider that the care home should have had in place processes to facilitate a clear handover in which Mrs A's requirements and short-term care plan were clearly identified to staff in order for them to provide appropriate supervision and to plan accordingly.

Conflicting instructions

92. Dr Hogarth advised that all facilities should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide staff to achieve the objectives for the scenario (eg, falls management, manual handling) and it should provide a broad outline of the facility requirements and leave scope for some decision-making by staff. Dr Hogarth said that flow charts work well in this regard.

93. The policies gave conflicting instructions — such as the person conducting the medication round should not leave the medication unattended, call bells were to be responded to promptly, and dependent residents were not to be left unattended while in the shower or toilet. Given that only the team leader and one caregiver were on duty in the care home, it was predictable that the caregiver could at times be unavailable at the time the team leader was conducting the medication round.

94. The Health and Disability (Core) Standards require organisations to ensure that the day-to-day operation of the service is managed in an efficient and effective manner, to ensure timely, appropriate, and safe services to consumers.[10]

95. I consider that the care home's policies put Ms B in a difficult position. The medication administration policy and the call bell policy were not compatible, and it was not possible for her to adhere to both policies at the same time. The care home's policies should be consistent and clear and allow staff to deliver appropriate and safe services to its consumers.

96. I am also concerned that a hoist was not available in the rest-home wing and that staff had to locate a hoist in the hospital wing. I accept that this was only a short distance away (40 metres), but this was yet another example of the care home not providing Ms B with

[8] Health and Disability (Core) Standards NZS 8134.1.3:2008, Standard 3.3.4.
[9] Health and Disability (Core) Standards NZS 8134.1.3:2008, Guidance 3.3.4(a).
[10] Health and Disability (Core) Standards NZS 8134.1.2.2008, Standard 2.2.

adequate resources for her to provide caregiving services. I acknowledge that Ms B could have called for the hoist to be brought to her from the hospital when she rang for the registered nurse to come to assess Mrs A. However, I consider that the additional delay could have added to Mrs A's distress. I note that a hoist is now available in the care suites and is readily accessible in an emergency.

97. I acknowledge Dr Hogarth's comment that staffing levels are an ongoing issue in aged residential care, and that minimum staffing numbers need to reflect the requirements of the residents. In my view, if the expectation was that additional support would be provided by staff from the hospital wing, it may have been preferable to have had a staff member 'floating', who would attend the rest-home wing at the times of the medication rounds.

Conclusion

98. In my view, the care home failed to provide Ms B with the tools to enable her to provide adequate caregiving services to Mrs A. The care home did not ensure that Mrs A was reviewed sufficiently frequently given her frailty and deterioration, did not take adequate steps to ensure that Ms B was made aware of Mrs A's short-term care plan, and did not provide compatible policies. Accordingly, I find that the care home failed to provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Changes made

99. The care home told HDC that in response to Mrs C's complaint, it identified shortcomings in its investigation process (as the thoroughness and time frame were affected by its COVID-19 pandemic response) and an issue with staff honesty. The care home said that it has provided additional education and training to staff on Manual Handling and Open Disclosure, and it is now mandatory for staff to complete unit standards for better understanding of their responsibilities in managing residents with cognitive decline.

100. The care home said that it asked its Quality Management system provider to review its policy on Falls Prevention and Call Bells and to develop a flowchart for ease of reading.

101. The care home told HDC that in 2021 it completed a stage 5 build that included several brand-new care suites that linked the rest home and hospital wings together, and there is now a hoist in the care suites. The hoist is easily accessible to both areas (care suites and the old rest home). The care home said that it would take any rest-home staff member one to two minutes (at most) to access the hoist if required from the care suites. The care home stated that the rest home where this incident occurred is likely for demolition in the next year, as it is outdated.

102. Ms B said that English is her second language, and that while she believes she is competent in reading and speaking, it was not easy to get all the information written down in the time

allocated. She said that she now asks more questions about who is at most risk and what changes have occurred in residents' statuses, and she makes notes for each resident.

Recommendations

103. Ms B apologised in writing to Mrs A's family for the criticisms in this report. The apology will be sent to the family.

104. I recommend that within three weeks of the date of this report, Chatswood Lifecare Limited apologise in writing to Mrs A's family for the criticisms in this report. The apology is to be sent to HDC for forwarding.

105. I also recommend that within three months of the date of this report, Chatswood Lifecare Limited undertake the following:

a) Review its process for handover to ensure that incoming staff are adequately informed of key requirements and resident issues and, if there has been an incident within the last 48 hours, that follow-up of this is noted in the progress notes.

b) Put in place a system to provide support for caregivers in the rest-home wing during medication rounds.

c) Establish a programme of regular in-service training for staff on the assessment of falls risk, monitoring, maintaining mobility in the elderly and the importance of exercise for balance and strength, and accurate documentation regarding falls management.

d) Consider developing a flow chart of the process to manage a falls incident, including clarification that three falls in a month means three falls within a 30-day period.

e) Develop more comprehensive policies covering the review of falls risks and when use of a hoist is required.

106. Chatswood Lifecare Limited is to report to HDC on recommendations (a) to (e) above within six weeks of the date of this report.

Follow-up actions

107. A copy of this report with details identifying the parties removed, except Chatswood Lifecare Limited and the advisor on this case, will be sent to Te Whatu Ora, Te Tāhū Hauora|Health Quality & Safety Commission, and HealthCERT, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from registered nurse Dr Karole Hogarth:

'REFERENCE: C20HDC01617

COMPLAINT: [The care home]

1. Thank you for the request to provide clinical advice regarding the complaint from the family of [Mrs A] concerning the care delivered at [the care home] in [Month5].

In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1989.Upon registration I was appointed to a new graduate position at Waikato Hospital and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Waikato Hospital. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract, I moved to England and worked as an RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as an RN and casual as a RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enrol in a PhD which I did following a further year of travel where I worked as an RN for the Australia blood service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role 2 days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Nursing and Midwifery students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full-time position in the School of Nursing at Otago Polytechnic teaching sciences. My current role is Associate Professor and Head of Nursing. I am also a Justice of the Peace for New Zealand having completed the requirements for this role in 2016 and reaccreditation in 2018.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by [Ms B], [Ms D] and [the care home] was reasonable in the circumstances and why.

With particular comment on:

1. The adequacy of the falls risk assessment and management plans in place for [Mrs A];

2. The adequacy of the care provided to [Mrs A] on the evening of the 21st [Month5] prior to her fall. In the comment, please note specifically whether any aspects of the care departed from [care home] policies;
3. The adequacy of care provided to [Mrs A] by [Ms B] on the evening of the 21st [Month5] following her fall. In the comment, please note specifically whether any aspects of the care departed from [care home] policies;[1]
4. The adequacy of care provided to [Mrs A] by [Ms D] on the evening of the 21st [Month5] following her fall. In the comment, please note specifically whether any aspects of the care departed from [care home] policies;
5. The adequacy of [Ms B's] communication to [the care home];
6. The adequacy of the investigation carried out by [the care home] including communication with the family;
7. The adequacy of the Manual Handling and Transfer guideline;
8. The adequacy of the outdated "Fall Prevention Programme";
9. The adequacy of the updated "Fall Prevention Programme";
10. The adequacy of the "Call Bell Policy"; and
11. Any other matters in this case that warrant comment.

For each question I am asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
c. How would it be viewed by my peers?
d. Recommendations for improvement that may help prevent a similar occurrence in the future.

4. In preparing this report I have reviewed the following documentation:

1. Letter of complaint dated [2020].
2. [The care home's] response dated [2020].
3. Clinical records from [the care home] covering the period [Month5]
4. Training records for caregivers, [Ms B] and [Ms D]
5. Investigation notes from [the care home]
6. A copy of [the care home's] call bell policy
7. A copy of the "Falls Prevention Programme" dated [2019]and [2020]
8. A copy of [the care home's] Manual Handling and Transfer guideline

Note that the time of the incident in question was 2140 hours on the 21st of [Month5].

5. Background

On 21st [Month5] at 2140, [Mrs A] got out of bed to use the bathroom. The sensor mat on the floor alerted staff to her movement, and a caregiver, [Ms B] attended and assisted [Mrs A] to the toilet. [Ms B] left [Mrs A] on the toilet and returned to her other duties elsewhere. Approximately 10 minutes later, [Ms B] and her colleague, Caregiver [Ms D] heard [Mrs A] calling out. They attended and found [Mrs A] on the floor, having suffered a fall. [Ms B] and [Ms D] lifted [Mrs A] off the floor without the use of a hoist and placed her in an armchair. A Registered Nurse then undertook an assessment and called an ambulance to transfer [Mrs A] to hospital. Sadly, [Mrs A] died [a few days later] in hospital.

It appears that initially, [Ms B] and [Ms D] provided differing versions of events as to what occurred. [Ms B] advised that she was informed by [Ms D] that [Mrs A] had fallen. However, [Ms D] advised that both herself and [Ms B] heard [Mrs A] calling from her room and discovered [Mrs A] together.

My comments are confined to the care provided at [the care home].

6. The adequacy of the falls risk assessment and management plans in place for [Mrs A].

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

Falls risk assessment is part of a first assessment when a resident is admitted to a facility to ensure a baseline and to put strategies in place as necessary to ensure safety. This would be followed up during the InterRai assessment which should be completed within 1 month of admission. Reassessment of falls risk should occur regularly, if there is any change in the resident's condition and after any falls.

[Mrs A] had been a resident at [the care home] for three years so should have been well known to all staff. Regular reassessment of her mobility and falls risk alongside her general health and wellbeing would have been part of review.

Long-term care plan review	Falls documented
[2019]	[2019]
[2019]	[2019]
18 [Month1]	29 [Month1]
19 [Month5]	26 [Month4]
	21 [Month5]
	21 [Month5]

This indicates a four-month gap between [Month1] and [Month5] without any documented review (in the information I have been provided). This would be unusual for a woman in her 90s who was known to require assistance, had a lack of insight into her own safety, had a sensor mat, and had trouble using the call bell. There were three falls noted during these four months prior to the fall under investigation with no injuries noted.

A short-term care plan was put in place on the 21st [Month5] following her fall during the night. This clearly indicated that [Mrs A] should not be left in the toilet unattended and that she should be supervised at all times when mobilising.

I would like to note that following [Mrs A's] fall at 0221 hours on the night of the 21st of [Month5] that she was not lifted up with a hoist but by 2 staff as indicated in the adverse event log [number]. She was assessed by an RN.

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

From the information given I would consider that there is a mild to moderate departure from accepted practice and care of [Mrs A]. This is due to the four-month gap between falls risk assessments despite the three documented falls during the same period. Though this meets the requirement of the falls policy (1st [Month2]) which required a review if three or more falls in a month, it would have been prudent given [Mrs A's] age and her lack of insight into her own safety to review her mobility. The short-term care plan put in place on the morning of the 21st of [Month5] was a positive review though the implementation of this was not noted in her progress notes.

How would it be viewed by my peers?
I believe that my peers in practice and education would agree that there was a gap in the review of falls risk which does not meet the accepted standard of care.

c. Recommendations for improvement that may help to prevent a similar occurrence in the future.
Regular in-service for ENs and HCAs on the assessment of falls risk, monitoring, maintain mobility in the elderly and the importance of exercise for balance and strength. The importance of accurate documentation in regard to falls management is recommended.

While the Falls Prevention Programmes (policy) have detail, it would be very useful to have a flow chart of the process to manage a falls incident. Flow charts, as a visual reference can be placed in nursing staff areas. They are a quick access and much easier to follow than wordy policy documents. The three falls in a month could be misinterpreted to mean a calendar month, this should be clarified to state within a 30-day period.

7. The adequacy of the care provided to [Mrs A] on the evening of the 21st [Month5] prior to her fall. In the comment, please note specifically whether any aspects of the care departed from [the care home] policies.

a. What is the standard of care/accepted practice?
It is expected that all of the needs of the individual resident are met in accordance with their care plan and in consultation with the staff, GP, and family. Ideally this would be with as much autonomy and independence as possible. The role of staff in this is to support, provide resources and assist as needed and planned with cares. In the event of an incident staff need to respond according to policy and procedure to ensure that the safety and wellbeing of the resident and the staff involved is maintained.

It was noted on the morning shift that [Mrs A] had complained of pain in her foot (antiflame applied) and had been further checked for bruising and skin tears following her fall overnight and that she was to be monitored for any abnormalities. Prior to her fall at 2140hrs [Mrs A] had been assisted with her evening cares and was assisted to bed with the sensor mat in place. The progress notes state "no new concerns", it is not clear if her foot was rechecked.

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

From the information given I would consider that there is no departure from accepted practice and care of [Mrs A]. The nursing notes indicate that [Mrs A] received appropriate assistance with her cares and that she was settled in her room prior to the fall.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that the documented actions meet the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

It would be useful in the progress notes to ensure that if there has been an incident within the last 48 hours that follow-up of this is noted in the progress notes. This will show continuity of care as issues may arise over time e.g., bruising, immobility, increased pain.

8. The adequacy of care provided to [Mrs A] by [Ms B] on the evening of the 21st [Month5] following her fall. In the comment, please note specifically whether any aspects of the care departed from [care home] policies.

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

It is expected that a resident would be provided with a safe environment and receive the care they need to ensure they can mobilise and toilet with the assistance of staff as needed and as indicated in their care plan.

[Mrs A] was assisted to the bathroom following activation of the sensor mat in her room indicating that she was out of bed. She was then left alone in the bathroom in contravention to the short-term care plan implemented on the morning of the 21st [Month5] following her fall over the previous night. [Mrs A] was known to have difficulty using the call bell, and it was clearly stated that she should not be left unattended in the bathroom.

[Ms B] was the Team Leader on shift.

<u>Events of the evening of the 21st [Month5] — [Ms B]</u>

1. Answered sensor mat alarm and assisted to the bathroom
2. **Left [Mrs A] in the bathroom unattended in contravention to STCP and did not remind her to use the call bell**

3. Undertook medication dispensing
4. **Did not return to the bathroom in a timely manner — three–four minutes**
5. Responded to call bell from another resident as [Mrs A] was calling out
6. Found [Mrs A] on the floor of her bedroom
7. **Lifted [Mrs A] to the chair with assistance of [Ms D]**

The three areas of concern are those in bold above.

2. [Mrs A] should not have been left in the bathroom on her own as per the STOP[11] which was implemented in the morning of the 21st [Month5] following her fall overnight. This is in contravention to the Call Bell Policy point #7. The fall resulted in a serious injury to [Mrs A] and may have ultimately contributed to her death. It also put other residents and [Ms D] in a difficult situation where they were required to assist in an incident that should not have occurred.

4. It appears from the account provided that [Ms B] did not prioritise [Mrs A's] safety instead undertaking medications while [Mrs A] was in the bathroom. From the information given it did not appear that [Ms B] wanted to be drawn away from the medications despite knowing that [Mrs A] was in the bathroom and needed assistance.

7. [Ms B] lifted [Mrs A] into a chair with the assistance of [Ms D], it is unclear what assessment occurred prior to undertaking the lift, this occurred without a hoist against the conditions of the policy which states that assessment by an RN is required prior to moving a resident following a fall and with the use of a hoist. [Ms D] indicates that she did suggest using a hoist for the lift. In the progress notes [Ms B] does not note that [Mrs A] was lifted into a chair prior to assessment by the RN on duty.

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

From the information provided I would consider that there is a moderate to significant departure from the accepted standard of care. This is due to [Ms B] not following the STCP or the policies, failing to follow up with [Mrs A] in the bathroom in a timely manner after not following the STOP, prioritising aspects of care (medications) over a resident's safety, lifting [Mrs A] into a chair without assessment by an RN in contravention to the falls policy, providing thorough documentation of the incident in the nursing progress notes including actions taken.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that this incident and the way it was managed do not meet the accepted standard.

[11] STCP is the correct abbreviation for short term care plan.

d. Recommendations for improvement to prevent a similar occurrence in the future.
[Ms B] has undertaken further falls training, which is a positive step, this should be undertaken regularly by all staff to update on new falls prevention practices. It is also essential that the implementation of the falls policy is discussed as part of the training with relevant areas highlighted.

The communication around the implementation of a STOP needs to be clear to ensure that when measures are put in place they are implemented by staff on the following shifts, there also needs to be a time for review of the measures. This includes full documentation of the incident in the progress notes — there was a lack of detail, as well as the adverse events log.

A falls flow chart in nursing areas would be very useful to reinforce the process for management of an incident. A visual can be succinct with links to relevant areas of the policy as needed to follow up on.

9. The adequacy of care provided to [Mrs A] by [Ms D] on the evening of the 21st [Month5] following her fall. In the comment, please note specifically whether any aspects of the care departed from [care home] policies.

a. What is the standard of care/accepted practice?
It is expected that a resident would be provided with a safe environment and receive the care they need to ensure they can mobilise and toilet with the assistance of staff as needed and as indicated in their care plan. Call bells should be answered promptly as per the Call Bell policy.

[Ms D] responded with [Ms B] to the call bell of another resident who had heard [Mrs A] calling out, it is unclear what assessment of [Mrs A's] condition was carried out at this time. [Ms D] and [Ms B] lifted [Mrs A] without a hoist into a chair against the requirements of the policy which states that assessment by an RN is required prior to moving a resident following a fall. [Ms D] indicates that she did suggest using a hoist for the lift, she stated that this was not seen as necessary by [Ms B] who was the Team Leader.

From the information provided it appears that [Ms D] felt unable to question the practice of a senior caregiver and Team Leader. She knew that it was not accepted process to lift [Mrs A] without a hoist as she stated but did not continue to speak up to [Ms B] re this. It is unclear whether [Ms D] questioned the moving of [Mrs A] prior to assessment by the RN.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information provided I would consider that there is a mild departure from the accepted standard of care by [Ms D]. She was put into a difficult position by the Team Leader upon finding [Mrs A] on her bedroom floor.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the management of the incident does not meet the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.
It is essential the limitations and staff capability are realised in the case of incident management. It would be advised that there is some training for staff to build confidence in being able to question the decisions of others when practice that does not meet policy is witnessed.

10. The adequacy of [Ms B's] communication to [the care home].

a. What is the standard of care/accepted practice?
It would be expected that staff communicate with their facility in a timely manner in an open and honest [way] with two-way communication, [as] this is the key to understanding and resolving issues. Where there are concerns there should be follow up and acknowledgement in writing.

The summary of the meeting [in 2020] with [Ms B] indicated that there had been some reflection though no apology to the family. There is an unresolved discrepancy around the events of the 21st [Month5] which is where it is essential to accurately document all aspects of an event, this lack of information was noted by the clinical manager when questioned about the incident by the family. The letter written by [Mrs A's] neighbour as an impartial witness is possibly the most accurate.

It is important to note that there is a power imbalance with the facility as the employer and the management team as senior staff, this may be a barrier to [Ms B] communicating effectively. There is no mention in the file if English is [Ms B's] first language which may also have an impact.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information given I would consider that there is a mild departure from accepted practice in the communication by [Ms B] to [the care home]. [Ms B] has responded to the requests for discussion but did not apologise to the family for her role in the incident involving [Mrs A] on the 21st [Month5].

The depth of information in the progress notes of [Mrs A] in regard to the incident was brief and lacked the required detail and did not reflect the seriousness of the incident or the actions taken.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the communication does not meet the accepted standard of care, though there may be mitigating circumstances.

d. Recommendations for improvement to prevent a similar occurrence in the future.
Ensuring accurate documentation of incidents by the use of a template which can be followed for writing in the progress notes as the information here will differ from that in the adverse event log.

It is recommended that all communication has a follow-up in writing.

11. The adequacy of the investigation carried out by [the care home] including communication with the family.

a. What is the standard of care/accepted practice?
Where a complaint has been made or if there has been an incident resulting in serious injury it would be expected that a facility would undertake a thorough investigation. This would include gathering all of the information from the documentation, discussions or formal interviews with the staff involved, direct and timely communication with the family and advice from external sources where necessary. This should be facility driven and needs to reach a resolution that is satisfactory to the resident and/or their family.

From the family's perspective they have indicated that they feel as though they have not received the information or action they thought was needed and that responses were delayed.

It must be noted that this incident occurred days prior to New Zealand going into COVID-19 Lockdown. The workload, planning, and safety requirements of aged residential facilities at this time was huge as they had to ensure the wellbeing of all residents. The facility has acknowledged the delay in responding and did offer alternative opportunities to discuss their concerns, but it was agreed that this would wait until this could be undertaken in person.

An investigation was undertaken by the facility with the interviews of the staff involved. There have been changes implemented by the facility such as the update to the Falls Prevention Programme, the staff involved have been censured and have undergone further training.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information given I would consider that there is no departure from accepted practice in regard to the investigation and communication with the family. The facility made all efforts that they could at a very extraordinary time when aged residential care nationally was at its greatest risk. This incident would have been followed up in a much timelier manner had the facility not had to prioritise the safety of all residents in Lockdown.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the investigation and communication meet the accepted standard of care at that time.

d. Recommendations for improvement to prevent a similar occurrence in the future.
No recommendations, the facility have acknowledged the delay, there were compelling reasons why this occurred, and they have implemented some changes.

12. The adequacy of the Manual Handling and Transfer guideline.

a. What is the standard of care/accepted practice?
All facilities should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (e.g., falls management, manual handling) and it should provide a broad outline of the facility requirements and leave scope for some decision making by staff, flow charts work well. Guidelines can be included, and it should be clear who has responsibility for the care, treatment and follow up including documentation. Procedures can also be included as appendices to be used on a day-to-day basis in patient care.

The documents provided are named programmes but are essentially the policies and procedures in one document. As they are a combined document, they are quite wordy as they cover the procedural aspects of falls assessment and management. This may mean that staff are less likely to engage with the policies. The procedures are the part that staff need to hand on a daily basis, the overarching policy needs to guide and make clear the facility's stance, this is adequate in most aspects. The procedural parts do have clear areas of assessment, examples of tools to use and evaluation of resident responses.

The Manual Handling document is useful in that it is part visual with a range of useful images that can assist in the understanding of the requirements and processes.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information given I would consider that there is no departure from accepted practice. The manual handling policy is adequate.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the manual handling policy meets the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.
No recommendations.

13. The adequacy of the outdated "Fall Prevention Programme" dated [2019].

a. What is the standard of care/accepted practice?
All facilities should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (e.g., falls management, manual handling) and it should provide a broad outline of the facility requirements and leave scope for some decision making by staff, flow charts work well. Guidelines can be included, and it should be clear who has responsibility for the care,

treatment and follow up including documentation. Procedures can also be included as appendices to be used on a day-to-day basis in patient care.

The documents provided are named programmes but are essentially the policies and procedures in one document. As they are a combined document, they are quite wordy as they cover the procedural aspects of falls assessment and management. This may mean that staff are less likely to engage with the policies. The procedures are the part that staff need to hand on a daily basis, the overarching policy needs to guide and make clear the facility's stance, this is adequate in most aspects.

The policy is clear, and the procedures outlined. The procedural parts do have clear areas of assessment, examples of tools to use and evaluation of resident responses. As mentioned this is a wordy document and may prevent staff from fully engaging with the content.

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

From the information given I would consider that there is no departure from accepted practice. The falls policy meets the minimum required standard.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree with my assessment that the falls policy meets the minimum accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

See below.

14. The adequacy of the updated "Fall Prevention Programme" dated [2020].

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

All facilities should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (e.g., falls management, manual handling) and it should provide a broad outline of the facility requirements and leave scope for some decision making by staff, flow charts work well. Guidelines can be included, and it should be clear who has responsibility for the care, treatment and follow up including documentation. Procedures can also be included as appendices to be used on a day-to-day basis in patient care.

The changes implemented into this later version of the policy do provide clearer guidance for staff. I do think that the implementation of a flow chart into this document would also be very useful. This is a wordy policy and staff would have to be very familiar with it whereas a flow chart of incident management procedure would provide a visual especially for those with English as a second language. It would be less wieldy than the overall policy but could still provide links to the relevant parts of the policy for follow up and documentation purposes.

Reassessment six monthly of falls risk is a long time for the elderly and frail. The areas that have been strengthened in this document include the requirement that residents are not left in the bathrooms unattended. Some areas have been highlighted which is useful as it indicates the importance of the statements. There is no flow chart of incident management in this document.

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

From the information given I would consider that there is no departure from accepted practice.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree with my assessment that the revised Falls Prevention Procedure meets the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

As above I would recommend adding a flow chart to the Falls Prevention Procedure. The policy part and procedural part could be separated out for ease of use of the documents. It would make it more user friendly for the staff.

15. The adequacy of the Call Bell Policy.

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

All facilities should have robust policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (e.g., safety, falls management, manual handling) and it should provide a broad outline of the facility requirements and leave scope for some decision making by staff, flow charts work well. Guidelines can be included, and it should be clear who has responsibility for the care, treatment and follow up including documentation. Procedures can also be included as appendices to be used on a day-to-day basis in patient care.

The Call Bell policy is straightforward and succinct with enough detail to ensure that the safety of the residents is maintained.

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

From the information given I would consider that there is no departure from accepted practice, the call bell policy meets the required standard.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree with my assessment that the Call Bell policy meets the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

No recommendations.

Review completed by: Associate Professor Karole Hogarth JP, RN, BSc, PhD

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HDC REPORT — ADDENDUM

REFERENCE: 20HDC01617 SIMS

I have been asked to provide further comment on the above case following responses from [the care home] and [Ms B].

With particular comment on:

1. Whether the responses from [the care home] and [Ms B] change any aspects of your initial advice;
2. Whether there are any other matters in this case that you consider warrants comment; and
3. Any recommendations that you could think of for future improvements at [the care home].

1. Response from [the care home] and [Ms B]

Response from [the care home]
As identified in my original advice I agree that the policy for review of falls risk was followed. However it was noted that [Mrs A] was "old-old", increasingly frail, did not tend to use the call bell, and had a lack of insight into her own safety as evidenced by her returning to her room from the bathroom despite being told that the carer would return to assist on the day of her second fall.

It was also noted by [Ms B] that after the incident an RN had indicated that [Mrs A] had had a number of falls and that there was consideration of moving her to the hospital wing.

Following this response I would still consider that there is a mild departure from accepted practice in the review of [Mrs A]. The falls mat was in place, a short-term care plan had been initiated (though I cannot see this recorded in the nursing notes which would have been visible to incoming staff) and it was noted not to leave [Mrs A] unattended in the bathroom. Other measures to explore would have been hip protectors, and reassessment of safety, mobility and insight in general. This could have been in conjunction with family input.

Response from [Ms B]
[Ms B] has undertaken a great deal of reflection, it is obvious that she is remorseful and has learnt from this incident. It would be expected that there has been a change in her practice in response. I would expect her to be proactive in seeking ongoing education opportunities to grow her practice and to ensure that she regularly reviews policies and procedures. As she is now working for mainly independent people this is even more important as support may not be readily available. Having a written client summary as she does in her new role is very useful and can be added to on a daily basis. There is also learning obvious around the importance of fully documenting incidents which indicates that she has understood the impact and shows growth in her practice.

[Ms B] was asked to be a team leader when she did not feel she had the experience for this (Level 4 role description and leadership requirements). [Ms B] had also completed a number of NZQA approved education standards and the Diploma in Health Services Management (Level 7) (2017). The graduate profile of this course states:

"On completion of this qualification graduates will demonstrate knowledge, skills and understanding of the practices, theories and principles required to be effective managers in the health care sector or work in a professionally related field. They will also be equipped with the skills, attitudes and values required to be able to function as confident, independent and reflective professionals."

Given this qualification, years of experience as a caregiver and the fact that she was paid as a Level 4 caregiver [the care home] would rightly expect that [Ms B] would be able to take on the Team Leader responsibilities as part of her role.

Areas highlighted by [Ms B]:

- She was asked to cover in the rest home which was not her usual area of work though she had worked there previously.
- Had not been told (verbally) of the short-term care plan put in place on the day of the incident. Though this would have been in the notes this is an important change in condition to be noted by incoming staff.
- Did not know until afterwards that [Mrs A] had been deteriorating from her last time working in the rest home and had had a number of falls.

It would be expected that a senior caregiver would ask appropriate questions and determine areas of most need, concern or where alertness required on any given shift.

This would include implementation of short-term care plans or changes in status. The second and third bullet points above are therefore not reasons for not knowing [Mrs A's] current requirements. Ideally this information would have been conveyed at handover but it is the responsibility for the carer taking over to know what is required.

Some streamlining of the handover process would be advised to ensure key requirements are captured. E.g. An overall question about who is most at risk on any given shift, has there been anything significant or new plans in place to be aware of? This shows situational awareness and makes outgoing staff accountable for the information they are giving.

Regarding the second fall on the 21st [Month5] [Ms B] did not document whether she followed the "Instructions in the event of a fall" as per the policy. Transfer was undertaken against the requirements of the Falls Prevention Policy which requires assessment immediately and then moving with the hoist. [Ms B's] nursing notes for this shift are brief and the Adverse Event form was not completed at the time.

Following this response I would indicate that there is moderate departure from accepted practice. [Mrs A] was left in the bathroom unattended which resulted in a fall and injury, the timeline is not relevant to the incident, the main point is that she was left alone contravening the care plan.

2. Other matters to comment on

It should be noted that [Ms B] is a caregiver not a registered or enrolled nurse and is therefore working under direction and delegation of registered staff.

Staffing levels are an ongoing issue in aged residential care and minimum staffing numbers need to reflect the requirements of the residents.

3. Recommendations for improvement

If staff take on team leader roles they should be supported by adequate education re role of the team leader:

- thorough completion of documents e.g. Adverse Event forms
- following of policies including the implications if not adhered to

The review of clients who have recurrent falls, becoming more dependent or increasingly frail should trigger a review, waiting for InterRai assessment timing can mean that cues are not acted on and other injury preventative measures are not put in place in a timely manner.

Dr KJ Hogarth'