A Rest Home

A Report by the

Health and Disability Commissioner

(Case 05HDC06957)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer (deceased)
Ms B	Complainant/Mrs A's daughter
Ms C	Complainant/Mrs A's daughter
Ms D	Complainant/Mrs A's daughter
Ms E	Complainant/Mrs A's granddaughter
Mrs F	Provider/Registered nurse and manager
Ms G	Charge Nurse
A rest home and hospital	Provider/Rest home
A rest home company	Provider/Rest home company
Dr H	General practitioner
Dr I	General practitioner
Dr J	House officer
Dr K	General practitioner
Dr L	Orthopaedic registrar

Complaint

On 16 May 2005, the Commissioner received a complaint from Ms B (on behalf of her family) about the services provided by a rest home to her late mother. The following issues were identified for investigation:

- *The appropriateness of the care the rest home provided to Mrs A from December 2004 to January 2005. In particular, the management of:*
  - *Mrs A's neck fracture*
  - *Mrs A's nutrition and fluid intake.*

Ms B also complained about other matters, including the communication between her family and staff at the rest home, and the presence of cats and ants, which I have discussed in a separate section of my report.

An investigation was commenced on 11 August 2005.

The investigation has taken 18 months. The need to clarify information from several parties and obtain additional expert advice delayed the process.

Information reviewed

Information from:
- Ms B
- Ms C
- Ms D
- Ms E
- The rest home, including:
  - The policies and procedures that applied at the time of Mrs A's admission
  - A report from HealthCERT dated June 2005.

Mrs A's:
- Clinical records from the district health board
- Nursing records from the rest home
- Medical records from Drs H and I

The following responses to my provisional opinion were received:
- Dr H, on 27 October 2006
- Ms B, on 30 October 2006 and 5 December 2006
- An auditing agency, on 6 November 2006
- The rest home's solicitors, on 6, 13 and 22 November 2006
- Gina Lomax (on behalf of HealthCERT, Ministry of Health) on 15 November 2006.

Independent expert advice was obtained from Ms Lesley Spence, a registered nurse with extensive rest home experience.

Information gathered during investigation

Background

Mrs A, aged 88, had hypertension and dementia. She lived with her daughter, Ms C and assisted with household tasks such as cooking. Mrs A's two other daughters, Ms B and Ms D, lived nearby. In 1991, while Mrs A was living overseas, she appointed Ms B as her enduring power of attorney. Mrs A signed the document whilst overseas pursuant to Section 175A of the Property Law Act 1974. (Ms B's enduring power of attorney is discussed further below.)

Fall in November 2004

On the night of 11 November 2004, Mrs A fell at home. She tripped on the carpet and landed on her head and upper body. An ambulance was called to assess Mrs A. Ambulance staff noted that she did not have any chest pain or suffer any loss of consciousness from the fall. As there was no cause for concern, they assisted Mrs A back to bed.

Admission to a public hospital

The following morning, on 12 November 2004, Mrs A developed neck and back pain. Her fall and symptoms were reported to Dr K, her general practitioner. He visited her at home to examine her and advised hospital referral. Mrs A was taken by ambulance to the Emergency Department at a public hospital where she was admitted. Following an initial nursing assessment, she was given a temporary neck collar. Later that day, a CT scan was taken of Mrs A's cervical spine. The radiologist reported fractures along the C1 and C2 area of her cervical spine, and severe degenerative disease causing the narrowing of Mrs A's spinal canal.

As it was apparent that Mrs A would remain in hospital for some time, Ms B needed to ensure that she was appropriately authorised under New Zealand law to continue acting on her mother's behalf. She instructed her solicitor to review the enduring power of attorney document signed 13 years earlier in an overseas country, and prepare the equivalent document under Part IX of the Protection of Personal and Property Rights Act 1988. Later that day, while visiting her mother in hospital, Ms B and Mrs A executed the documents giving Ms B enduring power of attorney in relation to Mrs A's property, personal care and welfare. Dr K witnessed the execution. Thereafter, Ms B informed the public hospital that she was Mrs A's next of kin. However, she did not provide the hospital with signed copies of the enduring power of attorney as the hospital did not request such evidence.

On 13 November, Mrs A was reviewed by an orthopaedic and spinal surgeon. He confirmed that she had sustained a severe neck injury and observed that she was neurologically intact. In light of Mrs A's age, the orthopaedic and spinal surgeon advised treating her conservatively (without surgery). A Philadelphia collar[1] was ordered to assist with mobilising.

Over the next few weeks, Mrs A remained as an inpatient under the care of the orthopaedic and spinal surgeon and his orthopaedic team. She was reviewed regularly by a speech language therapist in response to her difficulties with swallowing, and a puréed diet was recommended. Mrs A was also seen by a dietitian on 26 November and 3 December 2004, and her weight was recorded as 50.1kg and 47.1kg respectively. In light of Mrs A's weight loss of 3kg within a week, the dietitian advised nursing staff to closely monitor Mrs A's weight and food intake.

[1] A Philadelphia collar is a hard collar designed to support and immobilise the neck.

On 6 December 2004, a Support Needs Re-assessment was conducted, which identified Mrs A as having "very high" needs. Mrs A was noted to be "eating better but not enough", and again a puréed diet was recommended, in line with the advice from the speech language therapist and dietitian. After her condition stabilised, a meeting was held with Mrs A's family to discuss her long-term need for geriatric nursing at a private hospital.

Following the meeting, Ms D made enquiries with a rest home. During her visit, she was shown a room with small kitchen facilities and ranch sliders opening out to the courtyard. Ms D discussed this with her family. As the rest home was located close to all three of Mrs A's daughters, they agreed to transfer her there.

Discharge from the public hospital

On 6 December 2004, Mrs A's condition was stable enough for transfer to the rest home. That day, a discharge letter was issued by Dr J, an older people's health house officer, to Dr K. The house officer recorded Mrs A's fracture as "Fracture C spine (C2, C3)". This differed from the radiology report of 12 November 2004. The discharge letter contained instructions for Mrs A's Philadelphia collar to be worn for three months. The house officer recommended monitoring Mrs A's skin integrity, as skin contact with the collar encouraged the development of pressure areas on her left cheek and the back of her neck. The discharge letter included the orthopaedic team's advice that Mrs A could mobilise as long as she wore her Philadelphia collar, but did not specify that it had to be worn on a 24-hour basis. The house officer recorded that Mrs A was "independent" in terms of feeding. An outpatient review was scheduled at the Orthopaedic Clinic of the public hospital on 29 December 2004.

However, Mrs A remained in the public hospital for another fortnight as the rest home did not have any beds available.

On 20 December 2004, Mrs A was discharged from the public hospital. Shortly before the discharge, a nurse from the public hospital telephoned the rest home to discuss Mrs A's transfer. The rest home staff were informed that Mrs A was frail, and two staff members were required to handle her. A discharge letter, a nursing transfer summary and a support needs re-assessment were issued by the public hospital as part of the discharge procedures.[2] The nursing transfer summary accompanied Mrs A upon her admission to the rest home, and the discharge letter was received several days after Mrs A's admission.

The nursing transfer summary from the public hospital noted that there were existing pressure areas on Mrs A's left cheek and the back of her neck as a result of the Philadelphia collar. It was suggested that these areas should remain under review. Mrs A

[2] HealthCERT, Ministry of Health has commented adversely on the public hospital's discharge planning — see the "Responses to provisional opinion" section of the report.

was described as requiring assistance with grooming, dressing, transfers and toileting. In terms of mobilisation, Mrs A was noted to require close supervision, as she had chronic dementia and was at an increased risk of falls. Mrs A was recorded as needing a Purée -3 diet with thickened Complan[3] 125ml, four times a day, and required assistance with feeding and taking medications. The nursing transfer summary also stated that Mrs A required "full assistance with all cares" as she did not "initiate any activities despite encouragement". However, this differed from the house officer's account, which stated that Mrs A was "independent" in relation to her feeding.

The discharge letter from the public hospital contained a list of Mrs A's medications and noted that Ms C was her next of kin,[4] which differed from the information Ms B provided to the hospital.

The rest home

The rest home is a 61-bed geriatric facility. It is owned by a rest home company. The rest home company is certified to provide rest home and private hospital care — medical and geriatric services (discussed below). References to the rest home in this opinion include the rest home company

Mrs F is a Director of the rest home company. She is a registered nurse and the manager of the rest home, and attends on site daily. Ms G is the charge nurse. The rest home also employs several other nurses and caregivers.

The rest home has an arrangement with general practitioners Drs H and I to provide care to all its residents. However, residents may elect to be seen by other general practitioners at their own cost. All residents are assessed by a registered nurse on the day of admission, and examined by a doctor within two days. Thereafter, residents undergo a medical review every three months or earlier if the resident becomes unwell. The rest home also has an arrangement with a consultant dietitian, who makes routine visits once every three months (on the third Monday of January, March, May and November) to review each resident's file, and discuss the resident's nutritional needs with a registered nurse. However, there was no routine visit in January 2005 as the consultant dietitian was on leave (discussed below). Residents are weighed on admission, and thereafter on a monthly basis. Weight loss is closely monitored by the rest home staff, and a dietitian is consulted when a resident's weight loss is over 3kgs.

[3] Liquid nutritional supplement.

[4] Staff at the public hospital were aware that Mrs A had been living with Ms C up until her admission to hospital in November 2004.

Certification audit

In 2003, the rest home converted several existing blocks to hospital facilities, and sought approval from HealthCERT, Ministry of Health to include private hospital care to its existing rest home services. As part of HealthCERT's assessment of the rest home's application, it engaged an auditing agency (the agency) to conduct an audit of the rest home. The agency's process comprised three audit visits between November 2003 and October 2005. During the provisional audit on 28 November 2003, the auditing agency assessed all of the rest home's policies and procedures, along with its staffing levels and qualifications, against Part 6 of the Health and Disability Sector Standards, and confirmed that it satisfied the criteria for providing private hospital care. Four months later, in March 2004, the rest home signed the Contract for Aged Residential Care with the Ministry of Health. The Contract for Aged Residential Care includes a requirement that facilities develop and document certain policies, including policies relating to "clinical procedures relevant to the needs identified in the individual Subsidised Resident's Care Plan".[5] A month after signing the contract, a second full audit was completed on 14 April 2004. During this visit, the agency's auditors sighted policies relating to care planning, and a sample of residents' files, and confirmed that the rest home had in place appropriate systems, policies and procedures including that of its care planning. On 21 October 2005, a surveillance audit was conducted. Again, the auditors viewed a sample of residents' files, and randomly selected "Care planning" as the standard to check. The residents' files evidenced compliance in areas including short- and long-term care planning and care plan reviews, and there were no concerns identified during this audit. In line with the audit process, the agency reported its findings from each of the three audits to HealthCERT.

Policies

The rest home was asked to provide copies of the policies and procedures that were in place at the time of the events giving rise to this complaint. The rest home provided copies of its policies on:

- Wound management;
- Pain management;
- Nutritional needs;
- Communication with family members;
- Liaising with general practitioners;
- Referrals to other health practitioners.

[5] Clause D5.4(b).

In response to my provisional opinion, the rest home provided copies of its policies on:

- Care planning;
- Care plan evaluation;
- Cats.

The rest home's care planning policy[6] requires nursing staff to prepare a long-term and short-term care plan for each resident. The long-term care plan is updated once every three months, and records all aspects of a resident's daily care such as nutrition and hydration requirements, sleep patterns, wound management, pain management, mobilisation and utilisation of specialist assessments. In addition, a short-term care plan is used in conjunction with the long-term care plan whenever there are temporary changes to a resident's care from illness or change in routine. The short-term care plan is developed within 24 hours of change, and updated throughout that period of change. The rest home maintains both types of plan, and records them using "[a computer programme]". Although the rest home's nurse manager and registered nurses are the only staff authorised to prepare and update care plans, caregiving staff have access to these documents to guide them in their care of the residents. In addition, the rest home prepares an activity care plan for each resident, which is reviewed annually or more frequently if the resident's condition changes.

The rest home also uses "[the computer programme]" to record a resident's medication and progress notes. On admission, details of a resident's medication are entered into the system to generate a medication list, which is checked by the doctor during the resident's first medical review following admission. Thereafter, any new medication added to the list is individually checked and signed by the doctor on a monthly basis. The rest home clarified that a resident's daily progress notes are not handwritten, but typed straight into the computer programme. A dietary assessment sheet is maintained for each resident detailing his/her dietary requirements and meal plan. The original copy is kept in a folder in the kitchen of the hospital, and a copy is kept on the computer. In addition, typed guidelines for all special diets, fluids and nutritional supplements are maintained on the wall in the kitchen. Formerly, the rest home kept a single wound care report for all residents, but since the complaint from Mrs A's family, it has introduced individual wound care reports for each resident.

Mrs A's admission

On the afternoon of 20 December 2004, Mrs A was transferred by ambulance to the hospital section of the rest home and accommodated in a room with an en suite bathroom. Her care was directed at all times by the on-duty registered nurse. At the time of her mother's admission, Ms B advised the rest home that she held an enduring power of attorney in respect of Mrs A.

[6] This policy was effective from 6 May 2003 and was reviewed in May 2005.

The rest home was asked to provide all of its nursing care plans for Mrs A as part of this investigation. Mrs F advised that, other than the care plans that were written on 13 and 15 January 2005 (discussed below), there were no other nursing care plans prepared for Mrs A. This was confirmed by Ms G. Ms G commented that the nursing transfer summary from the public hospital dated 20 December 2004 was "quite adequate in the meantime" to guide the rest home staff in caring for Mrs A.

At the time of her admission, Mrs A wore the Philadelphia collar to immobilise her head and neck. The rest home staff confirmed that Mrs A had existing pressure areas on her left cheek and the back of her neck, which had been induced by the Philadelphia collar. Ms G advised that the collar was hard and ill-fitting, and protruded an inch or two out from Mrs A's chin (it covered Mrs A's mandible (lower jaw)).

During dinner, Mrs A's first meal at the rest home, staff observed in the progress notes that she could "feed herself partly" but managed "small amounts only". On 21 December Mrs A's family visited and assisted with her feeding. Mrs A's family advised that they indicated to the rest home staff that they were willing to assist with her feeding on an ongoing basis, and visited almost daily during meal times. During these visits, they observed that Mrs A was frequently left to feed herself. Mrs A's family were concerned that if they did not assist with feeding her, "staff would not give her the attention she required".

Mrs F clarified that the rest home residents are encouraged to feed themselves where possible, and highlighted the inconsistent feeding instructions between the nursing transfer summary and the public hospital's discharge letter. The ill-fitting collar also contributed to Mrs A's feeding problems as she had difficulty swallowing, and tended to keep food in her mouth. In accordance with the public hospital's nursing transfer summary, Mrs A was mainly provided with moulied meals to facilitate swallowing, and given thickened Complan four times a day. In addition to her small intake of food, staff described Mrs A as "always thirsty". Mrs A's progress notes of 20–31 December 2004 include several entries where she had requested fluids. The notes also record that Mrs A experienced frequent headaches in the evenings. Along with administering the prescribed 1g dose of Pamol elixir (paracetamol in liquid form) four times daily between 21 December 2004 and 21 January 2005, Mrs A was given nine additional doses of paracetamol.

On admission, the rest home generated Mrs A's medication list based on the information recorded in the nursing transfer summary. As nursing staff were uncertain at that point whether Mrs A was agreeable to receiving care from the rest home house doctors, the medication list named Dr K as Mrs A's doctor.

On 22 December 2004, Mrs A had her first review with Dr H, who did not advise any change to her care. He checked and signed her medication list. Mrs A's weight on admission was recorded at 44kg, which the rest home considered to be very low. A

caregiver also documented in the progress notes that Mrs A was "allergic to [the] feline family". (Her aversion to cats is discussed further in the report.)

Although Mrs A's daily care included wearing a Philadelphia collar at all times, the rest home noted in its response to this investigation that this was not specified in the public hospital's discharge letter. Mrs A was very uncomfortable in the collar, and asked daily if she could take it off. Being summer, Mrs A perspired considerably from wearing the collar. The pressure areas on Mrs A's neck required frequent cleaning and, to do this dressing, the staff would remove her Philadelphia collar while keeping her neck and head immobilised.

Ms G explained that on the occasions when the Philadelphia collar was removed for cleaning, a registered nurse was present to hold Mrs A's head and neck in place, and she was given a suitable temporary collar to wear. The progress notes of 22 December 2004 state "took collar off for shower", while on 25 December 2004, it is recorded "… neck mucky and neck brace removed. Neck cleaned with n/saline and Duoderm dressing applied. Brace replaced and the old one washed." On 27 December 2004, Mrs F recorded her instructions to staff in the progress notes to "check Duoderm around [the] back of [Mrs A's] neck where collar rubbed skin off [on a daily basis]. Ensure Duoderm not leaking. Report and change if it is."

Orthopaedic review

Several days before Mrs A's review at the Orthopaedic Clinic (on 29 December 2004), her family contacted the rest home to confirm her transport arrangements by ambulance. They recalled that there was confusion amongst staff about the actual date of this appointment. Since it had been scheduled over the Christmas–New Year holidays, staff assumed that the Clinic would be closed. As a result, an ambulance was not arranged until "the last minute causing distress to [Mrs A] who ended up going to hospital on her own". Mrs A's family travelled separately to the public hospital.

Mrs A was seen by Dr L, an orthopaedic registrar. He ordered a repeat CT scan of Mrs A's cervical spine, which showed no deterioration in its alignment although there was significant displacement in the C1 and C2 area from the aligned injury. On examination, Dr L noted that Mrs A was "neurologically intact with no apparent motor or sensory deficit". His follow-up plan included scheduling another review in a month's time, during which repeat CT scans would be carried out to assess the extent of healing. Dr L considered it probable that Mrs A would need a Philadelphia collar beyond the recommended three-month timeframe.

During the review, Mrs A's family informed Dr L that they had seen several occasions where the rest home staff removed the front part of their mother's collar to encourage self-feeding. In his report (written on 29 December 2004 and sent on 31 December 2004) to the rest home, Dr L clarified that Mrs A needed to wear her Philadelphia collar at all times as she had an unstable neck injury. He commented that a soft collar was "entirely

inappropriate". In relation to adjusting the collar for cleaning and dressing the pressure areas, Dr L highlighted the importance of holding Mrs A's neck still while she lay flat on her back. He also advised transporting Mrs A by ambulance for all future clinic appointments.

In response to this investigation, the rest home confirmed that "the written instructions contained within the orthopaedic clinic letter of 29 December 2004 were incorporated into Mrs A's care plans and into the daily nursing summary". These instructions were entered in the progress notes on 29 December 2004 and, subsequently, in a nursing care plan dated 15 January 2005 (discussed below). Following the orthopaedic review, nursing staff also contacted the Orthopaedic Clinic for specialist advice on the ongoing pain and discomfort Mrs A was experiencing from the Philadelphia collar rubbing against her skin. However, the date of this discussion is unknown, as it was not documented in Mrs A's progress notes. The Orthopaedic Clinic agreed to provide another collar, which was despatched to the rest home premises on 7 January 2005. To reduce the friction between Mrs A's neck and the collar, the Orthopaedic Clinic's charge nurse advised the rest home staff to file down prominent points on the collar.

After the orthopaedic review, Ms D returned to the rest home to spend some time with her mother. She found Mrs A "sitting in the dining room with her collar off" and "trying to feed herself". Ms D informed the nurse on duty that her mother had to wear her collar at all times "as her neck could snap completely if she moved it without support". On 29 December, an entry was made in the progress notes stating "informed by ortho team that Mrs A must wear neck collar at all times, even at meal times". Ms D queried why Mrs A needed to feed herself, as her family were available to assist. Staff explained that as far as possible, all residents are encouraged to feed themselves. In relation to Mrs A, staff clarified that they assisted with her feeding whenever she required help.

Stroke on 31 December 2004

Around lunchtime on 31 December 2004, Ms D returned to visit her mother. She found Mrs A seated in the dining room "with [her] collar half off again". It was explained to Ms D that the rest home had recently had a change of staff, who were not informed of the instructions regarding Mrs A's Philadelphia collar.

After lunch, a staff member assisted Mrs A back to her room. Ms D recalled that the staff "walked [her mother] quite quickly" and she had to "hold onto the shoulders of the staff member" as her walker could not be located. In contrast, Ms G explained that two caregivers always walked Mrs A, and she was mostly mobilised by the physiotherapist. As Mrs A was short in stature, she had difficulty reaching the caregivers' shoulders. Ms D disagrees that caregiving staff regularly assisted her mother to mobilise, and her sister, Ms C, reported only two occasions when she saw her mother mobilise with assistance from a physiotherapist. On this occasion, before reaching her room, Mrs A suffered a stroke, which left her feeling "paralysed down the left side". Ms G contacted a doctor to review Mrs A.

Ms D used the telephone allocated for residents and visitors to contact her sisters and employer. She wanted to explain her absence from work that afternoon, but was unsuccessful in reaching her employer, who has an 0800 telephone number. According to Ms D, she then requested the use of the rest home office telephone and was told that it could not connect to 0800 telephone numbers. Ms D then drove home to contact her employer. In contrast, the rest home were unaware of Ms D's request to use the office telephone, and stated that they would have acceded to it if it had been made.

Dr H came to see Mrs A shortly after 3pm. He observed that she had left-sided partial weakness including facial weakness and slurred speech. Dr H recorded his diagnosis of TIA (transient ischaemic attack — a small temporary stroke) and queried whether Mrs A had suffered a CVA (cerebrovascular accident — a stroke). Following this, Mrs A became predominantly immobile.

Care in January 2005

For most of January 2005, Mrs A's care was provided by the rest home. Her family visited on a daily basis and brought meals occasionally.

The rest home advised me that it has an arrangement with a local dietitian, who reviews the residents once every three months. However, there was no visit in January 2005 as the dietitian was on leave. Mrs A was therefore not seen by a dietitian during her stay at the rest home.

On 3 January 2005, Dr H reviewed Mrs A. He noted some improvement in her left facial and left arm weakness, and marked improvement in her left leg. He considered it probable that Mrs A had suffered a CVA on 31 December 2004. During Dr H's visit on 5 January 2005, he noted that there was improvement in Mrs A's left arm and leg, but she was still experiencing difficulty walking despite assistance from caregivers. On 7 January 2005, Dr H observed that Mrs A could weight bear but had difficulty using her left leg and arm. He referred her for physiotherapy.

On 10 January 2005, Mrs A was seen by a physiotherapist, who gave her a short walking exercise. Mrs A required assistance and prompting to complete the exercise. The physiotherapist observed that Mrs A had left-sided weakness and reduced mobility. A follow-up assessment was scheduled for a week later. In addition, the physiotherapist advised the rest home to have two caregivers present when mobilising Mrs A.

In relation to the Philadelphia collar, Mrs F instructed her staff on 3 January 2005 in the progress notes to keep Mrs A in her collar "24 hours a day". On 10 January 2005, Mrs F emphasised that staff had to ensure that Mrs A was "wear[ing her] Philadelphia collar "AT ALL TIMES. If taking off for cares, [she] must be lying flat on [her] back with a nurse holding her neck so there is NO movement of the neck during adjustment."

In early January 2005, Mrs A developed a small pressure area "the size of a 5 cent piece" on the right side of her buttock. (The pressure areas on her left cheek and neck continued to be a problem.) Barrier cream was applied and the sacral pressure area was dressed with Duoderm. Mrs A was turned regularly in bed. On 12 January 2005, Mrs A was seen by Dr I, who prescribed flucloxacillin syrup (an antibiotic). Although he charted the antibiotic on Mrs A's medication list, Dr I did not document this consultation in the treatment notes. In addition to administering the antibiotic, Mrs F instructed staff in the progress notes to apply a wet dressing daily and to use a donut (rubber ring) to relieve pressure on Mrs A's sacrum. However, this was not used constantly because Mrs A complained that it was uncomfortable.

A care plan was written for Mrs A on 13 January 2005. It recorded that Mrs A had an "infected red area back of neck where the Philadelphia collar has rubbed area raw". The plan was "to treat the infection" and the intervention was recorded as "swabbed and fluclox started".

On 15 January 2005, Mrs A's sacral pressure area was noted to be "breaking down" and Ungvita (healing and protective cream for broken skin) was applied. The following day, the area was dressed as it had "broken down". A further nursing care plan was written, noting that Mrs A was to wear the Philadelphia collar 24 hours a day and not a soft collar. It also gave instructions on holding Mrs A's neck in place during adjustments, and encouraging mobility. I have received no information to indicate that a Braden scale assessment[7] was carried out during the six weeks that Mrs A resided at the rest home.

From early January 2005, Mrs A had difficulty falling asleep at night. Mrs F instructed staff, via the progress notes, to monitor Mrs A's routine. On 14 January, Mrs A was seen by Dr I, who prescribed temazepam 10mg (a sedative). Initially, it helped Mrs A to settle to sleep but, several days later, she woke up during the night seeking attention.

On 17 January 2005, Mrs A attended a review session with the physiotherapist. She completed a 10-metre walking exercise assisted by two caregivers. The physiotherapist observed "some sensory loss" and increased weakness in Mrs A's left hand, and queried whether there had been an "extension of right-sided cardiovascular accident". The physiotherapist recorded in her notes: "? Extension of (R) CVA due to increased weakness (L) hand. Some sensory loss/neglect. Plan: active wrist & finger movements." A follow-up review was scheduled a week later. Ms B confirmed that her mother's left hand remained clenched from around this date and "it could never be re-opened". Between 17 and 18 January 2005, Mrs A's legs were observed to be very swollen. A doctor was not called to

[7] A Braden scale assessment is used to assess a patient's risk of developing pressure ulcers.

examine her. On 18 January 2005, Mrs A was weighed again. Her weight was recorded as 41kg (a loss of 3kg from her weight of 44kg on admission one month earlier).

During Ms C's visit on the afternoon of 18 January, she observed that her mother "was not very well and was slurring her words". She asked whether her mother had suffered another stroke and was told that Mrs A "did this when she was tired". The rest home disagreed that Mrs A suffered a second stroke around 17–18 January 2005. In response to Ms A's query about a second stroke, Mrs A was reviewed by two registered nurses at 3pm on 19 January 2005. They documented in her notes "? mild stroke at around 1500 hrs". They also recorded that Mrs A's "blood pressure and temperature [were] okay" and she was "focussing well on people, when [they talked] to her though she was not able to speak clearly". Although the nurses queried whether a mild stroke might have occurred, they did not consider a medical review necessary as her observations were normal. That evening, staff observed that Mrs A "was taking a while [to] swallow foods, and was holding it in her mouth". As she looked tired, staff washed her and put her to bed early. The broken areas around her sacrum were dressed and she settled to sleep after 8pm.

On 20 January 2005, the nurse on duty observed that Mrs A's neck brace was "causing skin abrasions". A dressing was applied and a swab taken. That evening, Mrs A "did not ea[t] much" and was "just drinking". She went to bed early as she felt unwell. The night nurse recorded that Mrs A was "not talking nor sucking her drink but blowing [it]". She was turned regularly during the night.

On 21 January 2005, Mrs A experienced difficulty swallowing and looked "miserable". Gauze dressings were applied to her pressure areas and Mrs A was given paracetamol. Staff contacted Dr I, and were advised to continue the existing care. In addition, he gave verbal orders to the nurse on duty to chart Sevredol 10mg (morphine) for the management of Mrs A's ongoing pain. She went to bed early that evening and woke up during the night. Mrs A had "a few sips of juice" and "looked uncomfortable but could not say anything". She was turned regularly in bed.

Between 22–25 January 2005, Mrs A continued having difficulty swallowing. The rest home advised that a fluid balance chart was commenced on 22 January 2005 to monitor Mrs A's fluid intake and output. However, a copy of the chart was not produced by the rest home as part of this investigation. Fluids were administered using a syringe. Mrs A's family also assisted with her fluid intake during their visits. Ms E recalled that "squirting fluids would often start a coughing fit" because of Mrs A's inability to swallow. Mrs A's cough worsened as she "was so thirsty". On one occasion, Ms E said she enquired about the possibility of using a "drip to get fluid into Mrs A" as her family had difficulties "getting enough into her". Ms E was informed that the rest home "would not do it because they did not want to prolong things". According to Ms E, "the staff did not appear concerned about this and offered no solution to the problem".

On the afternoon of 24 January 2005, Dr H saw Mrs A in relation to her limited fluid intake and the ongoing management of her Philadelphia collar. Ms G was present during the review. Ms C recorded in her diary notes that her mother was seen sometime between 1.15 and 3.15pm. There is no record in Dr H's notes that Mrs A had suffered a second stroke. Dr H ordered swabs and prescribed Ciproxin (an antibiotic) for the pressure areas on the back of Mrs A's neck. Ms G smelt ketones in Mrs A's breath and, believing that she was dehydrated, recommended to Dr H that he prescribe subcutaneous fluids. Dr H directed that subcutaneous fluids be administered at the rate of one litre every 12 hours. Although the rest home stocks subcutaneous fluids, it did not have a "giving set" (equipment for administering intravenous or subcutaneous fluids) on site at the time Mrs A required one. This was because all the sets in stock had been used, and Mrs F had not been informed. Ms G recorded the need to order a giving set in the progress notes and to "push fluids". As the giving sets had to be ordered in bulk, it was not possible to make a one-off order to the supplier. In addition, the supplier informed Ms G that it was unable to deliver a set immediately (within the same day the order was placed). Pending the delivery, staff and Mrs A's family continued administering fluids orally by syringe. Ice blocks were also given. In response to this complaint, Mrs F stated:

> "[The rest home] does have facilities to provide subcutaneous fluids to patients. On the date that [Mrs A] was prescribed subcutaneous fluid, [the rest home] unfortunately did not have in stock any 'giving set'. The 'giving set' was immediately ordered and available to the hospital within 48 hours. [Mrs A] had prior to the availability of the giving set, been transferred to [the public hospital] following a visit to the [orthopaedic clinic]."

Since this incident, the rest home has introduced an "Imprest" system to ensure that it maintains a sufficient quantity of all necessary equipment on site.

Further orthopaedic review

On the morning of 26 January 2005, Mrs A travelled by ambulance to attend her second review at the orthopaedic clinic. Dr L observed the development of pressure sores on Mrs A's neck. Mrs A's family informed him that her speech had "slurred progressively to a point where she [could] not articulate" although she was "able to respond to simple instructions". Dr L noted that Mrs A had developed a hemiparesis (loss or impairment of motor function) down the left side of her body and was unable to mobilise her left arm and leg. The X-ray taken of Mrs A's spine showed the same bone alignment as the X-ray of 29 December 2005. According to Dr L, the likely explanation for Mrs A's paralysis was the occurrence of another stroke sometime in January 2005 rather than spinal cord compression. In light of Mrs A's poor nutritional intake and difficulty with swallowing, Dr L decided to transfer her to the public hospital. Arrangements were made with the on-call medical registrar, who agreed to admit Mrs A.

Re-admission to the public hospital
On the afternoon of 26 January 2005, Mrs A was re-admitted to the public hospital for re-dehydration and medical review. Intravenous fluids were administered and mouth cares given. A chest X-ray on 27 January 2005 showed a normal heart size with no signs of pneumonia, pulmonary oedema (increased fluids in the lung resulting in severe disturbance of gas exchange) or pleural effusion (a collection of blood or fluids in the space between the lung coverings). Mrs A was also seen by a speech language therapist who noted that Mrs A had "severe communication + swallowing deficits".

Later that day, the medical registrar discussed Mrs A's prognosis with Ms C and Ms B. In light of Mrs A's deteriorating condition, her family decided against any resuscitation, aggressive management or nasogastric feeding, and requested comfort cares only. Mrs A's family were advised to find a hospice.

Transfer to a second rest home
On 4 February 2005, Mrs A was transferred from the public hospital to a second rest home where she died a short time later.

Other matters

Communication with family
In her complaint to my Office, Ms B was concerned that she had not been kept informed of her mother's condition by staff at the rest home, stating "there was absolutely no communication between senior staff and family about mum's condition". In response, the rest home stated that they did listen to Mrs A's family's concerns and, on a number of occasions, the charge nurse met with Mrs A's family to discuss their concerns. During the investigation, the rest home provided a copy of its policy entitled "Family Rights and Responsibilities". Clause 2 states: "with your family member's permission, you have the right to be informed about any aspect of their care".

Case Review Conference
Part of the rest home's policy on "Availability of Doctors & Urgent Assistance" includes scheduling a case review conference annually on the anniversary of the resident's admission or as required. The case review conference provides an opportunity for the resident, his or her support person, members of the rest home's care team and the resident's doctor to review the resident and address any concerns raised.

During Mrs A's six-week stay at the rest home, her family did not request a case review conference.

Ants
According to Mrs A's family, the room she was allocated differed from that shown to Ms B. It was smaller and did not look out to the courtyard. In addition, Mrs A's family found ants "climbing up the bedroom walls and over the sink area". They also discovered ants on Mrs A's bed and "over her lazyboy chair where she spent [the] majority of her time". During their visits, Mrs A's family had to bring their own insect spray to eradicate the ants.

In response, the rest home clarified that it maintains a vermin management plan with "[a pest control company]" whereby the pest control company fumigates the premises twice a year for ants and other pests. The plan was in place at the time of Mrs A's admission.

Kittens
Along with ants, Mrs A's family observed "several kittens roaming freely mainly in the lounge cum dining area". At times, they saw kittens "wander down corridors into patients' rooms including [that of Mrs A]". Mrs A's family said that she "had a great aversion to cats". Had they known in advance that the rest home kept kittens indoors, Mrs A's family would have chosen another nursing home for her.

In response, the rest home clarified that its cat policy has been in place for over nine years. The policy permits a resident to bring his/her cat on admission to the rest home, and stipulates a list of conditions for keeping the cat clean and healthy. However, on her admission, Mrs A and her family were not informed or given a copy of this policy. The rest home has since acknowledged that all its residents should be notified of the presence of any pets on the premises, and given the opportunity to decline being a resident on that basis.

Staff training
The rest home advised that its staff undergo regular in-service training on all aspects of residential care, and provided a list of the training courses held between November 2004 and October 2006. Topics covered during this period include residents' rights, regulations on professional boundaries, wound care, repair of major skin tear, pain management, depression, the general practitioner's role in palliative care, and the impact of death on family members.

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Ms Lesley Spence, a registered nurse:

> "I have been asked to provide a nursing opinion to the Commissioner on case number 05/06957.

I have read carefully the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Qualifications and Experience

I am a registered general and obstetric nurse (1963) and hold an Advanced Diploma of Nursing (1981) specializing in medical nursing.

Following graduation, I worked in an acute medical surgical hospital becoming a staff nurse in a medical ward and prior to being promoted to a nurse tutor position, was Sister-in-Charge of Christchurch Hospital on night duty (600 patients).

I taught General Nursing for 3 years (1966–1969) and then had a period raising a family during which time I worked part-time in a hospital for the aged.

In 1975, I was invited to teach in the then quite new Comprehensive Nursing programme at Christchurch Polytechnic where I was employed for 18 years.

During these years, I taught most comprehensive nursing courses but in the latter 5 years, I had the responsibility for postgraduate short courses which included courses in Gerontology (care of the aged). It was the importance of this knowledge that led me to accept the offer of a nurse manager's position in a large modern rest home caring for approximately 80 seniors. There I began to apply my learning to practice — I found it rewarding to be able to teach caregiving staff and see the benefits of their knowledge conveyed to the residents. I also developed skills in management which assisted in meeting the challenges of running a rest home.

From this rest home, I was invited by new employers to develop a 60-bed rest home, Middlepark Senior Care Centre, from the building plans up — this gave me the opportunity to modify design, plan appropriate furniture, furnishing and equipment, write the policies and procedures, employ, orientate and educate the staff and develop trusting relationships with the residents.

While challenging, this project was enormously satisfying as I was able to implement the nursing philosophies I believed in.

Since then, a further two rest homes, The Oaks Senior Care Centre (120 residents) and Palm Grove Senior Care Centre (110 residents) have been built to include long-term hospitals. Palm Grove was opened in December 2003.

I am a member of:

- New Zealand Nurses Organisation
- New Zealand Association of Gerontology
- Healthcare Providers NZ
- New Zealand Retirement Villages Association

I have recently facilitated a group of nurse managers to meet regularly in order to seek solutions to the serious shortage of registered nurses and caregivers in Canterbury.

I act as an advisor for:

- Christchurch Polytechnic Institute of Technology Post Graduate Courses for Nurses
- Health and Disability Commissioner

I regularly attend conferences and courses associated with the care of seniors in rest home and hospital facilities.

Palm Grove Senior Care Centre has been chosen by the Ministry of Health to provide education for Bachelor of Nursing students, Nurse Assistants and Return to Nursing courses for Registered Nurses who wish to return to the workforce.

Report on the appropriateness of the care [the rest home] & [Mrs F] provided to [Mrs A] from December 2004 to January 2005.

Background

On 12 November 2004, [Mrs A] (aged 88 years) fell at home and sustained a fracture to her cervical spine. She was admitted to [a public hospital] from 12 November and was transferred to the hospital section of [the rest home] on 20 December 2004 with instructions that her Philadelphia collar was to be worn at all times. [Mrs A] also had a history of Cerebral Vascular Accident (C.V.A.), hypertension, dementia, and incontinence.

On 31 December 2004, [Mrs A] suffered a minor stroke, and became predominantly immobile. There are conflicting accounts between the complainants and the rest home as to whether [Mrs A] suffered a second stroke on 18 January 2005.

On 24 January 2005, [Mrs A] was examined by a doctor in relation to the difficulties she was experiencing with her neck brace and fluid intake. Directions were given to [the rest home] to administer subcutaneous fluids. As a 'giving set' was unavailable on the hospital ward, one was ordered the same day.

On 26 January, [Mrs A's] cervical spine was reviewed at the orthopaedic outpatient clinic. As there were concerns with her general state of health including her dehydration, [Mrs A] was transferred to [the public hospital]. In light of her poor prognosis, she was transferred to a private hospital for comfort cares on 4 February 2005. [Mrs A died sometime later].

Note: Certification against the Health & Disability Sector standards was undertaken by [a designated auditing agency] under the Act and [the rest home] was certified on 13 May 2004 for a period of three years.

I have been asked by the Commissioner to provide a professional opinion of the care provided to [Mrs A] in December 2004 to January 2005 by [Mrs F and the rest home] as to whether this was of an appropriate standard.

Four issues of care are commented on:

1. The adequacy and appropriateness of the nursing care provided to [Mrs A] between 20 December 2004 and 26 January 2005; specifically relating to the management and care of her:

   (a) neck fracture
   (b) nutrition and fluid intake

2. The unavailability of a giving set at [the rest home] on 24 January 2005.

3. Whether appropriate referrals were made by [the rest home] for [Mrs A] to be assessed by a doctor in:
   (a) December 2004
   (b) January 2005

4. Was the documentation completed by nursing staff at [the rest home] of an adequate standard?

1(a) Management and care of neck fracture

[Mrs A] fell on the 11 November 2004 and sustained a C2 and C3 type neck fracture. She was admitted to [the public hospital] and the fracture treated conservatively with a Philadelphia collar.

Debate surrounds the issue about when staff at [the rest home] were told the Philadelphia collar must remain in place 24 hours per day.

In the discharge letter which was written on 6 December 2004 (curiously 14 days prior to discharge — there may have been delay in sending it because the family had some difficult finding a hospital bed), [Dr K] only states that [Mrs A] may mobilise as long as she has the collar on — nowhere does he state the collar must be on 24 hours per day.

It should be noted this letter was sent to [Mrs A's] previous G.P. — no copy was sent to [the rest home] although a copy is included in her notes — perhaps [Dr K] sent this on himself.

The nursing transfer summary sent on [Mrs A's] discharge does not indicate the Philadelphia collar is to remain in place 24 hours and only has superficial information about skin care. The transfer summary is not signed or dated but otherwise gives generally good information about other aspects of [Mrs A's] needs for nursing care.

Family on two occasions complained they had found staff (this was prior to the advice of 29 December 2004 where staff were told implicitly that the Philadelphia collar was to remain in place at all times) open the front of the collar. The staff may have done this to make feeding [Mrs A] easier and to facilitate her swallowing. It also meant that food did not collect inside the collar and made the meal a much more pleasant experience.

In hindsight, this was wrong as it compromised the protection of the cervical fracture but at the time was an understandable error by staff who were trying to facilitate a more comfortable and effective feeding arrangement for [Mrs A].

On 29 December 2004, [Mrs A] attended the orthopaedic clinic at [the public hospital] and it was at this time [the rest home] were advised by the orthopaedic team, probably by telephone, that [Mrs A] must wear the Philadelphia collar at all times. In addition, a letter was written by the orthopaedic clinic on 31 December 2004 to confirm this. A copy of this letter was not provided by [the rest home], but it was found in the [the public hospital] records and the information was recorded in the nursing progress notes on 29 December 2004, repeated on 5 January 2005 (although out of chronological order) and again on 10 January 2005.

The information is again written into the very brief nursing care plan on the 15 January 2005 some 26 days after admission.

[Mrs A] had complex nursing needs in relation to her unstable neck fracture, because of the necessary immobilisation by a Philadelphia collar. No nursing care plan was provided but it needed to fully address:

1. maintaining alignment of the fracture
2. supporting swallowing and feeding
3. prevention and treatment of pressure sores
4. prevention and treatment of pain
5. assisting with achieving sleep

While there are entries in the progress notes that deal with these issues, it is not possible to know the depth to which these major nursing needs were dealt with using the information provided.

1(b) Management of nutrition and fluid intake

The three family members who contributed to the formal complaint to the Health and Disability Commissioner expressed their concerns about her food and fluid intake.

They said staff had told them that [Mrs A] was to feed herself even though it was very difficult for her, and that staff were not feeding her sufficiently, yet were reluctant to have family help.

The family made significant efforts to be there at mealtimes and at times to bring food or liquids [Mrs A] could eat/drink e.g. ice sticks.

The first entry on admission day noted that [Mrs A] could feed herself partly — only small amounts. There are 12 other entries in the progress notes that record her ability to eat or drink and the family's contribution.

Using the progress notes only (in the absence of a care plan), there is evidence that staff did make efforts to feed [Mrs A].

Of note from 19 January 2005 when [Mrs A] may have had another stoke or Transient Ischaemic Attack (passing stroke), her ability to eat or drink became more compromised — she appeared to have much more difficulty swallowing and both the staff and family were having difficulty in maintaining her fluid intake.

On 22 January, a nurse commenced a fluid balance chart to monitor the fluid intake and output which would have good evidence about her fluid intake but a copy has not been provided nor was it mentioned again.

On 23 January, it took a family member one hour for a syringe full of fluid to be swallowed.

Fluid intake continued to be a problem until a nurse on 24 January 2005 suggested to [Dr H] that subcutaneous fluids could be helpful and [Dr H] agreed and charted 1 litre of normal saline over 12 hours. This was not given because there was no giving set — one was ordered but did not arrive until after [Mrs A] went for her orthopaedic outpatients' appointment and was later transferred to [the public hospital] for medical review and re-hydration some 36 hours later.

There is some mention of appropriate food being provided — pureed and Complan on 25 December 2004.

In the nursing transfer note from [the public hospital], the food requirements were described as a puree-3 diet and on her medication sheet, thickened Complan, 125ml, four times per day.

I am unable to ascertain from [the rest home's] notes whether this was provided. Feeding [Mrs A] was difficult because of the swallowing difficulties subsequent to her stroke and the position her head was held in by the Philadelphia collar.

Apart from on admission when her weight was 44kg, no comment has been made about monitoring [Mrs A's] weight or referral to a dietitian which should be done for a resident as nutritionally vulnerable as [Mrs A].

2. Unavailability of giving set at [the rest home]

On 24 January 2005, [Dr H] in consultation with a Registered Nurse [Ms G] ordered a litre of normal saline to be given to [Mrs A] over 12 hours.

There was no giving set available.

Using the diary notes of a family member, it appears the doctor saw [Mrs A] between 1.15 and 3.15pm. On 24 January 2005 which was a Monday, there is conflicting evidence as to the ordering of a giving set — in the solicitor's notes […] it is stated the giving set was ordered immediately. In the p.m. nursing notes, [Ms G, registered nurse] is asking for a set to be ordered. She also makes a comment to 'push fluids' which indicates her recognition of [Mrs A's] need for more hydration.

[In a city] it should be possible to obtain a giving set and the appropriate fluids by courier from the local medical supplier within a few hours.

Considering [Mrs A's] degree of dehydration (she smelt of ketones and had not been drinking adequately since 19 January when she may have had another TIA), the need for subcutaneous fluids should have been seen as a matter of urgency and a courier used to obtain the equipment.

As it turned out, [Mrs A] was without significant fluid for a further approximately 36 hours. In fact, it was not started until she was given intravenous fluids following her assessment at the Orthopaedic clinic at [the public hospital] and later on re-admission to [the public hospital] on 26 January 2005.

I can also find no evidence that [Mrs A's] health was to be treated conservatively i.e. active treatment to be withheld.

3(a) Doctors' referrals in December 2004 and January 2005

Five and a half weeks — 7 visits

From the doctors' notes the following visits to [Mrs A] were documented:

22 December 2004
The day after admission. Initial visit to admit [Mrs A] and confirm medical care — a note was made that [Mrs A's] cervical fracture was to be treated conservatively (no surgery) by stabilising with a Philadelphia collar.

31 December 2004
Called to see [Mrs A] because of left-sided weakness — made the provisional diagnosis of either a transient ischaemic attack (possible stroke) or left cerebral vascular accident (C.V.A., stroke on left side).

3 January 2005
Noted some improvement in left facial and left arm weakness but left leg most improved. His impression was that [Mrs A] had a C.V.A. and left hemiparesis — noted that [Mrs A] had a background of previous C.V.A. involving the same side, noted the cervical fracture probably still unstable.

5 January 2005
Notes improved strength in left arm and leg but still difficulty in walking with assistance.

7 January 2005
Noted [Mrs A] was doing some weight-bearing and made a physiotherapist referral.

12 January 2005
Nursing notes state seen by G.P. and commenced flucloxacillin for neck infection. This visit was not recorded but the medication was charted.

14 January 2005
Identified was not sleeping due to pain and charted temazapam to help.

24 January 2005
Between 1.15 and 3.15pm, identified major problems with neck brace causing rubbing and chaffing of the neck and an infected area of skin which was found to be pseudomonas.

Pain, discomfort and swallowing difficulties. Dehydrated — ketatonic breath and lethargic.

i. Ceproxin 500 B.D. ordered
ii. Subcutaneous fluids, 1 litre 12 hourly, normal saline ordered – review Wednesday.

Comment:
The doctor has recorded a gradual decline following one or two further cerebral vascular attacks (or transient ischaemic attacks) but has been responsive to the resident's signs and symptoms; e.g.

> *charting aspirin for C.V.A., Temazapam for sleeplessness, antibiotics for infections, Panadol elixir for pain, fluids for dehydration.*

The family have expressed their concern that a doctor was not called on the 19 January 2005 when [Mrs A] appeared to have either another transient ischaemic attack or cerebral vascular accident. Nurses noted her deterioration, but according to the family, they felt it was insignificant and did not justify calling the doctor.

Verbal orders were taken from another [Dr I] on 21 January 2005 for the treatment of [Mrs A's] pain — this was for Sevredol 10mg, one tablet rectally up to four times a day.[8]

The medication list was not provided by [the rest home][9] — a copy was found in the clinical records of [the public hospital].

[8] This addition to the medication list was signed by Dr H.

[9] In response to my provisional opinion, the rest home provided a copy of Mrs A's medication list, and medication administration sheet.

Documentation completed by nursing staff at [the rest home]

The following was provided (see attached):

- Progress notes from 20 December 2004 to 28 January 2005
- A nursing care plan written on 13 January 2005 and 15 January 2005, out of order — 24 and 26 days after admission.

This brief plan identifies [Mrs A's] needs as:

- Mobilizing with assistance
- Neck fracture sustained from fall
- Infected red area at the back of neck

Progress notes were written every day sometimes covering the three shifts. They identified both changes in [Mrs A's] condition and nursing instructions.

It is possible that the progress notes were hand written and typed later[10]. This could account for entries on 5 January, 6 January, 10 January, 14 January, 20 January, 23 January being out of order and an incorrect entry on the 26 January pm stating that [Mrs A] was managing sips of fluid when by this time she was in hospital.

The progress notes however give a fair overview of [Mrs A's] health problems and some nursing interventions. There are no comments made about interaction with [Mrs A's] family apart from the fact that they visited and assisted with her feeding.

[Mrs A] had a complex health history as identified in the support needs reassessment of 6 December 2004 from [the public hospital]. This required complies and thoughtful nursing.

On admission, a nursing care plan should have been written to address the following needs and problems:

- Care of the neck fracture and management of the Philadelphia collar
- Prevention and treatment of pressure sores
- Nutrition and hydration related to swallowing difficulties
- Pain and sleep
- Mobility, transferring and risk of falls
- Bowel and bladder
- Communication/deafness and dementia

[10] The rest home has since clarified that a resident's progress notes and other nursing records are entered straight onto the computer using the "[computer program]".

- Family relationship and support

The lack of a nursing care plan has made the assessment of the quality of nursing directed by the plan difficult.

Only a superficial overview can be gained by using the progress notes.

List of information provided:

- Copy of letter of complaint from [Ms B], dated 12 May 2005, with attached diary notes from sister, [Ms C] marked 'A' (Pages 1–5b).
- Copy of subsequent supporting letter (undated) from [Ms B], marked 'B' (Pages 6–8).
- Copy of subsequent supporting letter (undated) from [Ms E], marked 'C' (Pages 9–11).
- Copy of subsequent supporting letter from [Ms D], dated 13 June 2005, marked 'D' (Pages 12–14).
- Copy of notes of telephone discussion on 20 and 21 July 2005 between investigator and [Ms B], marked 'E' (Pages 15–18).
- Copy of HDC's notification letter of 11 August 2005 to [the rest home], marked 'F' (Pages 19–28).
- Copy of written response dated 9 September 2005 from [the solicitors] acting for [the rest home], marked 'G' (Pages 29–47).
- Copy of the Ministry of Health's investigation report regarding [the rest home], dated June 2005, marked 'H' (Pages 48–67).
- Copy of [Mrs A's clinical notes from the public hospital] for January/February 2005, marked 'I' (Pages 68–116).

Further aspects in the care of [Mrs A]

Pain Management
The nurses noted [Mrs A] was experiencing significant pain from admission onward for which she was treated with Panadol elixir until Sevredol was added on 21 January 2005.

Considering the number of doses recorded in the progress notes — sometimes with minimal effect, pro-active nurses could have managed the pain better i.e. by nursing measures; e.g. pressure relieving mattresses or requesting adding to or changing the existing medication.

Communication with the family
[Mrs A's] family implies they were willing to help and by their account, were present nearly every day — sometimes several times a day.

Their concern that staff did not listen to them or keep them informed is of concern.

One incident where a family member advised of an outpatient appointment, and was told that it would not occur because of a public holiday, and was later found wrong, should have prompted open apologies.

Another incident when a family member wished to use a telephone and found the residents' telephone was out of order, was forced to drive home because there was no willingness by staff to allow her to use another telephone. She had wanted to advise other family members that their mother was not well and the doctor was being called.

The Health and Disability Sector Standard 4.1.2. states that Service Delivery should be developed in partnership with the consumer and their family or other representatives as approval 'through an appropriate communication style'.

Wound Care
[Mrs A's] pressure sores were significant and challenging to prevent and treat. Many entries in the progress notes identified this.

A wound care plan should have been developed and expert advice obtained from a wound care specialist — often provided free from medical supply companies.

[Mrs A] also developed a pressure sore on her sacrum due to the complexity of nursing her. While this appeared (from progress notes only) to be well treated, other expert advice may have helped.

It is also highly possible that [Mrs A's] tissue breakdown was enhanced by her less than adequate nutrition. A dietitian could have assisted by providing appropriate feeding methods and products which stimulate healing.

Cats
While many rest homes have a cat, [the rest home] mention a family of cats. On 22 December 2004, [Ms G] records in the progress notes that [Mrs A] is 'allergic to the feline family'. If a rest home has a cat, it needs to be by consensus of all residents. Difficulties can arise later when new residents are admitted.

If a facility wishes to retain their cats, all prospective residents should be advised and thereby have the choice of admission or otherwise.

A pet policy for the management and care of pets is also required.[11]

[11] The rest home has since provided this Office with a copy of its policy on cats. However, on admission, Mrs A and her family were not informed of or given a copy of this policy.

Active Treatment
One nurse implied to [Mrs A's] daughter that she was not for Active Treatment. The nurse said 'they wouldn't put in a drip because they didn't want to prolong things.' Unless this is formally documented using approved forms, all residents should be cared for actively and Power of Attorney/Next of Kin consulted should treatment/nursing outcomes change.

Medication Charts
The doctor's medication chart was not provided but a copy was found in the [the public hospital's] clinical records.

The medication administration record maintained by nurses was also not provided and may have contained valuable insight into pain management.[12]

Ants
[In a city] where ants are a problem, it would seem essential that a long-term care hospital should have an insect management plan.[13]

Families should not have to provide insecticides to ensure a comfortable environment for their relative.

Nursing Care Planning
The nursing care of [Mrs A] required an in depth nursing care plan which directed all nursing staff in their daily care of her. Only a very superficial plan was provided dated 13 January 2005 and 15 January 2005.

I have liaised with the Health and Disability Commissioner's investigator about the omission of the nursing care plans and have been advised that there are no others.

The Health and Disability sector standards state clearly in Part 4 Service Delivery:

> *4.1.4 Service is documented to the level of detail required to demonstrate the needs of the consumer/kiritaki are met.*
>
> *4.1.5 Recorded at a frequency that is appropriate to the degree of risk associated with the normal delivery of the service and the*

[12] The rest home has since supplied a copy of Mrs A's medication list and medication administration chart.

[13] The rest home has since clarified that it has a contract with a pest control company to fumigate its premises twice a year.

particular needs of the consumer/kiritaki and reflects sector/professional documentation requirements when these exist.

4.3.1 Service delivery plans are individualised.

4.3.2 Service delivery plans describe the required support intervention required to achieve the desired outcomes or goals identified by the assessment process.

4.3.3 Service delivery plans demonstrate service integration.

I have serious concerns about the adequacy of the documentation at [the rest home] and would doubt that it would meet the requirements of certification.[14]

Summary Comments

1. Adequacy and appropriateness of the nursing care provided to [Mrs A] between 29 December to 26 January specifically to her:

Neck fracture

While family believed there were very clear instructions to [the rest home] about the Philadelphia collar remaining in place 24 hours per day, I could find no documentation requiring this until after the visit to the Orthopaedic outpatient department at [the public hospital] on 29 December 2004. A telephone call was apparently made and a letter was sent on 31 December 2004. Following this, clear entries were made in the progress notes and it appeared that staff complied with this.

Caring for an elderly person with dementia in a Philadelphia collar is complex and requires thoughtful nursing.

In the absence of a complete nursing care plan, it is difficult to assess the nursing skill used in caring for [Mrs A]. Once the stability of the fracture was achieved after 29 December 2004, significant other issues arose which I believe the nursing staff had serious difficulties coping with. The pressure sores and infections which developed, the pain and sleeplessness and the problems in feeding [Mrs A] were not well managed. Along with the cerebral events, this led to a downward health spiral.

I believe expert advice should have been sought early in her admission — more attention should have been paid to:

[14] The rest home and HealthCERT have since provided further information about the certification audits conducted. This aspect of Ms Spence's advice is discussed in the "Opinion" and "Other matters" section of my report.

Nutrition and fluid intake

Along with the difficulties in eating in a Philadelphia collar and the cerebral incidents, [Mrs A's] nutrition was seriously compromised. I could only find one entry in the nursing notes where a high calorie food was offered her in a form she could swallow, ie:

25 December 2004 — well able to feed herself and Complan with a straw

While food and fluids were offered, it appeared to be mostly orange juice and some pureed foods. A dietitian referral could have provided a better balanced high calorie supplement which may have assisted to maintain her health and improved her ability to heal. Advice could also have been sought for the swallowing difficulty.

I could find no entries which required [Mrs A] to be weighed following her admission weight of 44kg, important for a patient who is nutritionally compromised.

While recognising the difficulties in providing nutrition and hydration for [Mrs A], I believe the nursing did not meet current standards of care.

The unavailability of a giving set at [the rest home]

I can find no documented requirement in the Health & Disability Sector Standards or the District Health Board specifications which require a certified long-term care hospital to have subcutaneous infusion sets and appropriate fluids (normal saline) as stock, however I believe it would be best practice in most long-term care hospitals to ensure they were available as standard stock.

[In a large city], it should also be possible on a weekday to obtain a giving set within a few hours.

[Mrs A's] dehydration on the 24 January was serious — ketones could be smelt on her breath.

I consider 36 hours which elapsed without subcutaneous fluids being administered to be a serious breach of nursing standards even taking into account the sips of fluid that staff and family were able to administer.

Were appropriate referrals made by [the rest home] for [Mrs A] to be assessed by a doctor in December 2004?

The doctor visited twice — once to admit [Mrs A] on 22 December 2004 two days after admission and again on 31 December 2004 because of left-sided weakness.

These visits appear adequate, although nursing staff could have sought more advice on pain and sleep and pressure sore management.

January 2005
The doctor visited six times (one visit was not recorded) and a telephone referral was made for Sevredol.

A physiotherapist referral was also made.

Relatives were concerned that a doctor was not called on 19 January 2005 when it appeared [Mrs A] may have had another stroke. It is possible that she did but as there is very little that can be done, staff decided that it was not necessary to call the doctor.

Of concern [is that] on 17 January 2005, [Mrs A's] legs were found to be very swollen and this was noted again on 18 January — a doctor was not called to check and no further entries were made in regard to [Mrs A's] legs.

The cerebral incident occurred on 19 January but no referral was made to the doctor and he did not see her again until 24 January 2005 at which time the subcutaneous fluids were ordered.

[Mrs A's] condition appeared to deteriorate following this cerebral incident — her swallowing became increasingly difficult and it is likely her fluid intake was insufficient from this point.

It may have been appropriate for a doctor to be called on 19 January 2005; certainly if the family was distressed and requesting it, a referral should have been made. At this time, the swollen legs could also have been advised and fluid intake addressed.

A telephone referral was made on 21 January 2005 by a nurse requesting more pain relief and Sevredol was charted.

The omission in referral on or about 19 January 2005 is of moderate concern, otherwise [Mrs A] appeared to have adequate medical care.

Was the documentation completed by nursing staff at [the rest home] of an adequate standard?

Nursing documentation submitted consisted of:

- Progress notes — 20 December 2004 — 28 January 2005

- A nursing care plan:
  15th January 2005 — mobilising well with assistance
  15th January 2005 — neck fracture sustained from a fall
  13th January 2005 — Infected red area at back of kneck (spelling)

This plan was written 23 days after admission, and was very superficial in content.

It breached the Health & Disability Sector Standards Part 4 and therefore also the certification process.

Health and Disability Sector Standards

Standard 4.1 Service Provision Requirements

4.1.6 Service is documented to the level of detail required to demonstrate the needs of the consumer/kiritaki are met.

4.1.7 Recorded at a frequency that is appropriate to the degree of risk associated with the normal delivery of the service and the particular needs of the consumer/kiritaki and reflects sector/professional documentation requirements when these exist.

Standard 4.3 Planning

4.3.1 Service delivery plans are individualized.

4.3.2 Service delivery plans describe the required support intervention required to achieve the desired outcomes or goals identified by the assessment process .

4.3.3 Service delivery plans demonstrate service integration.

It would appear that the progress notes were used to direct the nursing care which is not its purpose.

I did check with the Health and Disability Commissioner's investigator as to whether more documentation existed — she did investigate whether there was more, and I was advised 'no'.

I believe that this serious lack of documentation provided by [Mrs F] at [the rest home] should be viewed with serious disapproval. It may also be necessary to ask questions of the Designated Auditing Authority as to how certification could be achieved with this serious lack of nursing records.

Reference:

Health & Disability Sector Standards NSZ 81341:2001."

Additional expert advice

Following receipt of further information from the rest home on 21 July 2006, Ms Spence was contacted for additional expert advice. On 18 August 2006, she provided the following advice:

"I have read fully your further brief and additional information provided by [the rest home] since my report of 6th December 2005.

These are my comments regarding each of the new items/policies/procedures you have provided.

My conclusions in the first report about [the public hospital] discharge letter written by [Dr J] remain the same — I suspect that the letter was not sent to the rest home directly perhaps because of a clerical slip up as it was written 14 days prior to [Mrs A's] discharge. It seems a fair explanation that there was a delay in finding [Mrs A] a hospital bed so the letter sat waiting. A copy of the letter did arrive but this may have been a copy from [the rest home] Doctor who would also have been sent the information.

Nursing Transfer Summary

There is nothing unusual in [Ms G's] comments that medical and nursing information comes in 'dribs and drabs'. While the goal from Public Hospitals is to provide all necessary medical and nursing information for the next provider on the day of admission, it is not unusual for one item to be delayed for a day or so.

The verbal handover from acute ward to receiving hospital would provide a safe guide for care. It would of course be necessary for [the rest home] to be sure they had an accurate account of medication so that it could be continued without interruption.

The nursing transfer summary provided by [the public hospital] was adequate to direct care although as I have noted previously it did not say the Philadelphia collar was to stay

on at all times. I note it did contain a list of medications and while this would be a guide, it should not have been the source from which [Mrs A's] medication was charted.

Date of discharge letter — see note previously

Verbal Handovers from Acute Hospital — see also above.
Verbal handovers would not necessarily be recorded in patient's notes.

The written nursing summary from Acute Hospital and SNL (support needs assessment level) provide the most important information on which a personalised care plan would be written.

The verbal handover provides an introduction to the new resident and allows rooms and equipment to be prepared.

Feeding Instructions
There were different feeding instructions — the doctor's letter (which arrived late) stated that [Mrs A] was independent in eating and the nursing transfer notes rightly described [Mrs A] as needing thickened Complan 4 x per day (identified on medication list), puree 3 diet, thickened fluids and to be assisted with feeding.

The nursing transfer notes gave clear instructions and would not have required further clarification from [the public hospital].

It would have very quickly become obvious to the staff that [Mrs A] could not manage solid food as she choked and had difficulty swallowing. Progress notes indicate efforts were made to give [Mrs A] appropriate food.

Philadelphia Collar
I believe [Ms G's] comments about the collar are important — it was obviously uncomfortable, ill-fitting, caused pressure sores and made it very difficult for [Mrs A] to eat. This collar was the major cause of her pain, discomfort and eating problems. Pro-active nursing could have ensured [Mrs A] to be referred back to [the public hospital] for a more comfortable solution to stabilizing her neck fracture — or other advice sought, perhaps through the doctor now responsible for her care.

Giving Set
The giving set should have been ordered on the day of [Dr H's] prescription. An $18 surcharge is not reason enough to delay the order.

The policies, procedures and related documents
The additional Policies & Procedures provided are of a good standard however the continued lack of a personalized care plan which would demonstrate use of the policies and procedures remains of serious concern.

e.g. Policy on the Care of Wounds — now obsolete but provided appropriate guidelines for [Mrs A's] wound care.

e.g. Maintaining an Intact Skin — procedures for care of skin — this is useful information but there is no evidence that this was implemented even though there is a statement made that the treatment is to be detailed on the resident's treatment sheet.

e.g. Predicting Pressure Ulcer Sore Risk — describes use of Braden scale but there is no evidence it was used for [Mrs A].

e.g. Skin Management (RCNZ) — another useful policy document complementary to the 'Maintaining an Intact Skin'.

e.g. Pain Management — Both policy and procedures included provided useful information for pain management.

e.g. Resident Nutrition — procedures for feeding and a letter of commitment from a dietitian for 4 visits per year. Unfortunately [Mrs A] was not in residence when the dietitian visited and a referral was not made to her. Very good referral criteria was outlined.

Communication with Family Members — the Health & Disability Code of Rights were identified and good information given as to how these would be implemented. While [the rest home] staff felt they had appropriate relationships with [Mrs A's] daughters, the two daughters gave examples of inappropriate and thoughtless staff relationships.

e.g. Guidelines for the need to contact the On Call administrator/liaising with GP's. Clear guidelines were provided for staff.

Weight Chart
[Mrs A] was weighed shortly after admission;

22nd December 2005	44 kgs
18th January 2006	41 kgs

A loss of 3kgs in less than 4 weeks. A 3kg loss should prompt referral to either or both the dietitian and/or doctor.

Summary

Policies and Procedures
Although some of the above are now obsolete, all contained appropriate and useable guidelines for staff. However, because of the lack of a nursing care plan and the brief

progress notes, it is not possible to know how much of this information was implemented.

Nutrition
The lack of attention to [Mrs A's] weight loss is of concern — an early referral to the dietitian and/or a multidisciplinary discussion as to how to manage successful feeding for a person with swallowing problems wearing a Philadelphia collar would have helped.

Philadelphia Collar
This collar created enormous discomfort for [Mrs A] and real nursing difficulties for [the rest home] staff which they tried to overcome. While they were remiss by removing the collar early in [Mrs A's] admission, it was understandable that this happened when a resident was choking or uncomfortable. The pressure sores it caused must also have been constantly painful and a sensitive nurse would have difficulty continuing its use.

I believe [the rest home] staff did their best in this regard. I am not in any way undervaluing the need for this collar to stabilize the fracture but feel referral back to [the public hospital's out patients department] or another specialty should have been sought.[15]

Balancing the comfort needs of this frail elderly woman against the stabilization of the fracture has been the issue of greatest concern. Using a multidisciplinary approach may have come up with a creative solution. I believe [the rest home] did make concerted efforts to manage the collar but needed more expertise to succeed.

It is interesting to note that following [Mrs A's] return to [the public hospital] and prior to transfer to the next private hospital, a soft collar was prescribed.

Braden scale
The Braden scale is useful for predicting a person's susceptibility to pressure sores; however [Mrs A] already had a pressure sore and [the public hospital] had given suggestions for treating it.

A wound care plan with regular evaluations of the healing process would have been more useful.

A small break in the skin on the right buttock appeared to be treated with appropriate dressings.

Care plans

[15] In response to my provisional opinion, the rest home advised that it contacted the Orthopaedic Clinic for clarification and specialist advice following Mrs A's appointment on 29 December 2004.

As indicated in the previous report, the lack of a care plan is of serious concern. There is no way of assessing the quality of [Mrs A's] care without professional nursing documentation. A personalised care plan demonstrates that staff have written information on which to base their care.

Fluid intake

There were significant nursing and medical challenges to ensuring sufficient fluid intake, however in regards to [Mrs A's] congestive heart failure, the doctor at [the public hospital] had advised she could have free fluids and [Dr H] made no comment in his notes that they should be restricted.

The challenges to her hydration arose because of difficulty with swallowing and the uncomfortable Philadelphia collar.

When [Mrs A] became dehydrated to the point that ketones could be smelt on her breath, [Ms G] was proactive — advised the Doctor and suggested sub-cutaneous fluids which were prescribed. Unfortunately, [the rest home] was not able to provide the giving set although they had I.V. fluids suitable for sub-cutaneous infusions in stock.

Where [the rest home] was remiss was in not accessing a giving set within a reasonably short time frame. [In a large city], on a week day this should not be difficult.

Two days' delay was unacceptable. It is pleasing to note that [the rest home] will now have giving sets readily available.

Doctors' visits

In the previous report, I noted the doctors' visits, and they appear adequate to deal with the health problems arising. [Mrs A] had a history of T.I.A. (transient ischemic attacks) and it is not always necessary to call a doctor if the symptoms subside within a few hours. [Ms G] also said it was not established whether [Mrs A] had a second stroke or T.I.A. although she did note in the progress notes in the morning that she would ask [Dr H] to check. There were no pm RN notes describing [Mrs A's] condition and the doctor was not called. When seen by [Dr H] on 3rd January 2006, [Mrs A] was much improved.

Mobilising within [the rest home]

Only three entries were made in the progress notes about mobilisation; one recording the physiotherapist's request to walk [Mrs A] once each shift to the toilet. With no care plan it is not possible to know whether this was done during the periods when [Mrs A] was well enough to do so.

Case Review

No case review was held during the relatively short period [Mrs A] was at [the rest home]. In light of the daughters' lack of confidence in the staff it could have been a useful way to build trust, however; in a 20 bed unit when families visit regularly, if nurses have the right professional motivation, it is very easy to keep families informed and to discuss with them any issues which might occur.

Other Comments
In regard to the family's unstated unhappiness about the care at [the rest home], some thoughts arise:

- Did staff make an effort to communicate warmly to the family which would have encouraged them to discuss and therefore resolve any issues?

- The family did express concerns about staff attitudes in their formal complaint to the Health & Disability Commissioner — why did they feel they could not express these to [the rest home]?

- Useful statements are made in the policy relation to Assessing medical service (00150) which had they been implemented, the outcome for [Mrs A's] family may have been quite different.

While these additional comments do not markedly change the conclusions of my original report, they may add some further information from which the Commissioner may be able to draw some conclusions."

Further expert advice
On 27 September 2006, a staff member from my Office called Ms Spence to ask for further advice about nursing care plans:

"Ms Spence advised that a rest home should have the following documents for each resident:

- Assessment documentation;
- A nursing care plan;
- Progress notes that are completed up to three times a day.

Ms Spence explained that a nursing care plan must be prepared for each patient when they arrive at a rest home. It is a detailed exercise which allows the rest home to consider and plan for the clinical requirements and holistic needs of each person. The care plan sets the foundation for that person's care and guides the staff in providing day-to-day treatment, ensuring that there is continuity of care. Ms Spence described this assessment and planning process as being fundamental to good nursing care.

Ms Spence advised that it is a requirement under the Health and Disability Sector Standards for rest homes to have service delivery plans. She advised that as of 1 October 2003, rest homes were required to have these policies in place to meet certification requirements. Ms Spence was surprised that [the rest home] achieved certification without this policy as auditors usually require a very high standard for nursing care plans.

Ms Spence was asked who is responsible for ensuring that nursing care plans are prepared — the rest home management or individual providers. Ms Spence advised that the rest home should have a written policy providing the staff with direction on how to carry out nursing care plans. However, every nurse that is educated through the Comprehensive Programme or a Bachelor of Nursing would know that a nursing care plan is a fundamental requirement when a patient is admitted for care. Ms Spence advised that it is usually the job of the principal nurse or the nurse manager in a rest home to check that nursing care plans are being used and updated for each resident, so rest homes should also have audit or check up systems in place. In summary, Ms Spence advised that usually it is the responsibility of the nurse manager to ensure that there was a policy in place and that it was being followed.

Ms Spence was asked to address the issue of the nursing transfer summary that was issued from the public hospital as Ms Spence had indicated in her further advice that the nursing transfer summary was "adequate to direct care".

Ms Spence advised that the nursing transfer summary is only one reference document that is referred to when a rest home is preparing a nursing care plan. A rest home should consider the medical transfer summary, the nursing transfer, the self needs assessment and any other documents from the hospital. The rest home should then interview the patient and use all of these documents to prepare a separate nursing care plan. Ms Spence advised that the nursing transfer summary was adequate for the purposes for which it was prepared but it should not have been relied on in substitution for a nursing care plan.

Ms Spence noted that Mrs A had no nursing care plan until January 2005, and considered the January care plan superficial and inadequate.

Ms Spence was asked whether, in her view, the lack of a nursing care plan was linked to the errors that occurred in Mrs A's care. Ms Spence advised that most registered nurses would be able to provide care even without a nursing care plan but caregivers would require a nursing care plan for direction."

Responses to provisional opinion

Responses to my provisional opinion were received from the following parties:

Ms B
Ms B provided clarification on the following aspects of her mother's care:
- Medical history
- Nutrition and fluid intake
- Mobilisation
- Events following Mrs A's "second stroke" in January 2005.

In addition, Ms B supplied this Office with copies of the enduring power of attorney documents she and Mrs A executed in 1991 and November 2004.

The rest home
In response to my provisional opinion, the rest home supplied copies of Mrs A's:
- Medication list
- Medication signing sheet
- Diet assessment.

As noted above, the rest home also supplied copies of its policies on care planning and cats.

In addition, the rest home provided clarification on the following aspects of its care:
- Documentation
- Care plan
- Medication sheet and pain relief
- Wound management
- Communication
- Dietary needs
- Weight loss and monitoring
- Staff training
- Pest control
- Cat policy.

In relation to the comments in my provisional opinion about referring Mrs A to a doctor, the rest home commented:

> "On 17 January, [Mrs A] was seen by a physiotherapist who commented as follows: '? extension of (R) CVA due to increased weakness (L) hand, some sensory loss/neglect. … It is clear that the physio at this review did not consider that it was necessary to call for a medical review.

[Mrs A] was also assessed by two registered nurses at 1500 hours on 19 January 2005. … Whilst the nurses queried whether a mild stroke had taken place, all observations were otherwise normal and the nurses clearly did not consider a medical review was necessary at that time.

On 24 January, [Mrs A] was seen by [Dr H]. He commented in his clinical notes as follows: 'pain, discomfort swallowing difficulty, dehydrated [ketonic] breath, lethargic and ordered antibiotics, subcutaneous and review Wednesday'. Clearly at this time, [Dr H] did not consider there to have been any cerebral incident … as no mention of such was made in [Dr H's] notes.

In the circumstances, we are of the view that [the rest home] acted appropriately in response to any suggested cerebral incident around 17–18 January 2005. The indications in our view were not sufficient or serious enough to require medical review, particularly when [Mrs A] was due to be seen by [Dr H] on 24 January in any event."

Dr H

Dr H clarified the rest home's procedure concerning the review and checking of a resident's medication list by the house doctor, and signing subsequent additions to the list.

HealthCERT — Ministry of Health

In response to my advisor's concerns, the Ministry of Health was invited to comment specifically on the adequacy of the audit carried out by the auditing agency. Ms Gina Lomax, Quality and Safety Manager, HealthCERT, provided the following response:

"Auditing of care planning

In light of your expert advisor's comments regarding the adequacy of the certification audits in regard to 'nursing care plans and related polices', HealthCERT has undertaken a further review of audit reports and supporting evidence supplied to the Ministry of Health by [the auditing agency] at the time the audit [was] undertaken for the provider to be certified to provide hospital care — geriatric and medical services.

…

In the evaluation of the audit report and supporting evidence submitted for this provider, the Ministry of Health concurred with [the auditing agency] that Health and Disability Sector Standard 4.3 Planning, was met and that each of the three criteria related to this standard were fully attained. To achieve full attainment, there must be evidence that there is a relevant policy or procedure documented and evidence of its implementation.

…

Adequacy of discharge planning

> Based on a review of the discharge documentation and other information available to staff at [the rest home] on the day of [Mrs A's admission], and interviews with the nurse manager and registered nurse, HealthCERT is of the opinion that the documented and communicated discharge planning for the resident by [the public hospital] was minimal given the complex nature of her required care. Health and Disability Standard 4.8 Exit, Discharge or Transfer requires providers to facilitate a planned exit, discharge or transfer of consumers that is documented, communicated and effectively implemented. During the Ministry of Health's onsite inspection, the detail of information provided to [the rest home] was considered minimal. The registered nurse interviewed confirmed that additional information had to be sought by telephone.
>
> Status of resident
> HealthCERT concurs with your expert's advice that whilst not ideal, 'most registered nurses would be able to provide care even without a nursing care plan'. … A registered nurse is required to be on duty at all times in a hospital. This was verified at certification audits (criterion 2.7.2) and during HealthCERT's inspection.
>
> Requirements for recording of residents' progress
> There is some variance between your expert advisor's requirements for the frequency of routine progress note entries, and those observed to be the current industry practice. In the hospital settings, these vary from a minimum of daily to once each shift, the most common being each shift. … In the case of [Mrs A], HealthCERT sighted progress notes [that] had been entered at least daily and in some instances, on multiple occasions throughout the 24-hour period when indicated by an event or observation.

Statement on registered nurses' knowledge

Ms Lomax queried the expert's comment that 'every nurse that is educated through the Comprehensive Programme or a Bachelor of Nursing would know that a nursing care plan is fundamental'. She stated that there are many nurses who gained registration prior to the implementation of tertiary nursing programme, but have undertaken ongoing professional development and demonstrate adherence to contemporary nursing standards in their practice.[16]"

The Auditing Agency

The auditing agency outlined the process its auditors follow when conducting certification audits, and explained the tools/checklist used. The auditing agency commented:

> "[The auditing agency] do rigorously review nursing care plans and relevant polices and procedures. …

[16] Discussed in the "Opinion" section of my report.

Care planning policies/procedures and review of resident files evidenced compliance at the certification audit on 14 April 2004, and again at the surveillance audit on 21 October 2005. Issues identified with [Mrs A] during her time at the facility … were outside our auditing period. However, the systems regarding care planning processes remained the same prior to and following [Mrs A's] admission/discharge from the facility. …"

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

Relevant standards

Health and Disability Sector Standards NZS 8143:2001:

"**Service Provision Requirements**

Standard 4.1 Consumers/kiritaki receive timely, competent and appropriate service provision in order to meet their assessed needs, desired outcomes and goals.

Criteria The criteria required to achieve this outcome include the organisation ensuring each stage of service provision (assessment, planning, provision, evaluation, review and exit) is:

i. Documented to the level of detail required to demonstrate the needs of the consumer/kiritaki are met

ii. Recorded at a frequency that is appropriate to the degree of risk associated with the normal delivery of the service and the particular needs of the consumer/kiritaki, and reflects sector/professional documentation requirements where those exist.

Assessment

Standard 4.2 Consumers/kiritaki needs and support requirements are assessed in a comprehensive and timely manner.

Criteria The criteria required to achieve this outcome include the organisation ensuring:

4.2.2 The needs, outcomes and/or goals of consumers/kiritaki are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Planning

Standard 4.3 Service delivery plans are consumer/kiritaki focused, integrate services and promote continuity of service delivery.

Criteria The criteria required to achieve this outcome include the organisation ensuring:

4.3.1 Service delivery plans are individualised and up to date

4.3.2 Service delivery plans describe the required support/intervention required to achieve the desired outcomes or goals identified by the assessment process

4.3.3 Service delivery plans demonstrate service integration"

Opinion

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

Breach — The rest home

Overview

Mrs A's nursing needs were numerous because of her age, medical history and unstable neck fracture. I acknowledge that the rest home staff tried hard to respond to Mrs A's needs, despite the ongoing difficulties and challenges they faced nursing a resident with such complex requirements.

However, as a health care provider subject to the Code of Health and Disability Services Consumers' Rights (the Code), the rest home was required to provide services with reasonable care and skill (Right 4(1)) and in accordance with legal, professional, ethical and other relevant standards (Right 4(2)). Under Right 4(3) of the Code, Mrs A had the right to have services provided in a manner consistent with her needs. In my view, two aspects of the rest home's care of Mrs A breached the Code — namely the absence of detailed care plans, and the unavailability of a giving set on 24 January 2005. These are discussed below.

Care planning

My independent expert, Lesley Spence, advised that "caring for an elderly person with dementia in a Philadelphia collar is complex and requires thoughtful nursing". Accordingly, a rest home should have assessment documentation, a nursing care plan and progress notes for each resident. Ms Spence stated:

> "There is no way of assessing the quality of [Mrs A's] care without professional nursing documentation. A personalised care plan demonstrates that staff have written information on which to base their care."

Ms Spence explained that a care plan is fundamental to good nursing care. It is a detailed exercise that allows the rest home to consider and plan for the clinical requirements and holistic needs of each person. The care plan sets the foundation for that person's care and guides their day-to-day treatment, ensuring continuity of care.

The rest home provided copies of the documentation it held in relation to Mrs A. This included Mrs A's nursing progress notes, care plans dated 13 and 15 January 2005, clinical notes from attendances by general practitioners, and documentation from Mrs A's discharge from the public hospital on 6 December 2004. The discharge information included a nursing transfer summary, a support needs re-assessment and a discharge letter.

The rest home confirmed that it did not have any care plans for Mrs A, until the brief plans prepared on 13 and 15 January 2005. Ms G commented that the nursing transfer summary from the public hospital was "quite adequate in the meantime" to guide the rest home staff in caring for Mrs A.

However, the nursing transfer summary gave only brief information about Mrs A's pressure areas, mobilisation, feeding and daily cares. Ms Spence advised that, while the nursing transfer document was relevant as a reference document, it should not have been relied on in substitution for a detailed nursing care plan. Ms Spence advised that Mrs A's nursing care plan needed to address:

- care of the neck fracture and management of the Philadelphia collar
- prevention and treatment of pressure sores
- nutrition and hydration related to swallowing difficulties
- pain and sleep
- mobility, transferring and risk of falls
- bowel and bladder
- communication/deafness and dementia
- family relationship and support.

There are a number of entries from Mrs F in the progress notes where she has instructed the staff on Mrs A's cares. By mid-January Mrs A had developed a number of complications, and the nursing care plans were prepared on 13 and 15 January 2005. However, my advisor commented that these plans were "very superficial in content and the lack of an appropriate care plan is a serious concern".

The Health and Disability Sector Standards require "each stage of service provision (assessment, planning, provision, evaluation, review and exit)" to be "documented to the level of detail required to demonstrate the needs of the consumer/kiritaki are met". Standard 4.2 specifically requires that "consumers/kiritaki needs and support requirements are assessed in a comprehensive and timely manner" with criteria 4.2.2 stating that "the needs, outcomes and/or goals of consumers/kiritaki are identified via the assessment process and are documented to serve as the basis for service delivery planning".

In Opinion 02HDC15234, the Commissioner considered the care that was provided to an elderly man as his health deteriorated over a period of four months. In relation to care planning, the Commissioner stated:

> "While I accept that in itself, lack of documentation does not equate to lack of care, good nursing care is guided by clear, ongoing assessments and a plan of care. Nursing assessments and the care plan should be properly documented, available to all staff, and updated as a patient's needs change. I do not accept that verbal discussions on an 'ad hoc' basis are adequate."

In this case, it is clear that a detailed nursing care plan was not prepared for Mrs A when she was admitted to the rest home. Instead, staff were guided by the nursing transfer summary from the public hospital and instructions from the registered nurses in the daily progress notes. The first care plan was not completed until 13 January 2005, some 23 days after Mrs A's admission. I accept the advice of my expert that this was inappropriate and contrary to professional standards. Furthermore, I note that the absence of a detailed nursing care plan for Mrs A contravened the rest home policy, which required nursing staff to prepare a long-term care plan for each resident.

Mrs A developed a number of complications during her stay at the rest home. Without a detailed assessment of her needs and nursing requirements at the time of admission, staff were unable to adequately manage and respond to her condition as it deteriorated. While attempts were made to assess Mrs A's condition on 13 and 15 January 2005, these care plans were brief and inadequate. In my view, the lack of adequate assessment, planning and review of Mrs A's care amounts to a breach of Rights 4(1) and 4(2) of the Code.

Clinical care — Nutrition and fluid intake

Managing Mrs A's nutrition and fluid intake was challenging for the rest home staff. Mrs A had swallowing difficulties on admission to the rest home and being confined in a Philadelphia collar and suffering a stroke in late December 2004 resulted in further swallowing difficulties. Although the rest home adhered to the discharge instructions to administer Complan and a puréed diet, and the progress notes show that staff made efforts to feed Mrs A, my advisor commented that her nutrition was "seriously compromised".

On 22 December 2004, Mrs A was seen by Dr H, and her weight was recorded as 44kg. In response to my provisional opinion, the rest home noted that Mrs A's admission weight was low and she had been losing weight as an inpatient in the public hospital. Mrs A was weighed on admission according to the rest home's policy, and should have been seen by a dietitian. On 18 January 2005, Mrs A was weighed again. Her weight was recorded at 41kg (a loss of 3kg from her weight of 44kg on admission one month earlier).

The rest home has an arrangement with a local dietitian, who reviews the residents once every three months. However, there was no visit in January 2005 as the dietitian was on leave, and Mrs A was not seen by a dietitian during her stay at the rest home. In my opinion, this is not good enough.

As Mrs A was "nutritionally vulnerable", staff should have asked a dietitian to advise on appropriate feeding methods and ways to maintain a well-balanced high-calorie supplement as part of her care planning. When Mrs A developed pressure sores, a dietitian could also have recommended products that stimulate healing.

From 19 January 2005, Mrs A experienced increased difficulty with eating, drinking and swallowing. Her family and the rest home staff had difficulty maintaining her fluid intake. As a result, Mrs A became severely dehydrated. This was another occasion when it would have been prudent for staff to have consulted a dietitian.

While it was appropriate to commence a fluid balance chart on 22 January 2005 to monitor Mrs A's fluid intake and output, a copy of the chart was not provided to my Office during the investigation, nor was it mentioned again in the progress notes. In addition, there is nothing in the rest home's notes to indicate that active treatment was to be withheld from Mrs A. Accordingly, it was inappropriate for staff to imply that Mrs A was not for active treatment when a family member suggested using a drip to administer fluids.

Mrs A's low fluid intake remained a problem. On 24 January 2005, when it became apparent that she was dehydrated, Mrs G acted appropriately and organised for Dr H to review Mrs A. He agreed to her suggestion of subcutaneous fluids and charted one litre of normal saline over 12 hours. However, this was not administered as the rest home did not have a giving set available. Mrs F stated that she was unaware that the last giving set had been used. She placed an order for further giving sets, but they were not delivered until two days later, on the morning of 26 January 2005, which left Mrs A without significant fluid intake for a further 36 hours.

Despite conflicting evidence as to the time of the day the order was placed, my advisor commented that the rest home staff should have treated the matter as urgent given Mrs A's degree of dehydration. My expert, Ms Spence, advised that it would be best practice in such hospitals to ensure that this equipment was available as part of its standard stock. I agree with my advisor that, even if there were no giving sets in stock, it should have been possible to quickly obtain a giving set and the appropriate fluids in a large city, and that Mrs A's condition required prompt action. The failure to ensure that the rest home had a giving set, and the subsequent delay in obtaining one left Mrs A severely dehydrated. In my view, these aspects of Mrs A's clinical care were not well managed, and many of her difficulties could have been alleviated through more proactive individualised care. Accordingly, in my view, the rest home breached Rights 4(1) and 4(3) of the Code.

The rest home has since apologised for the sub-optimal care it provided to Mrs A in respect of the unavailability of a giving set. It has introduced a system to ensure that it maintains a sufficient quantity of all necessary equipment on site.

Adverse comment

Referral to a doctor
In a rest home environment, the registered nurse assumes the overall responsibility for the health and well-being of the residents. The registered nurse is usually the first health professional consulted when a resident's condition changes, and is the person ultimately responsible for determining whether a resident requires further assessment or a referral to a specialist.

Mrs A was seen by a doctor a total of eight times during the five and a half weeks she resided in the rest home. Dr H's first visit took place on 22 December 2004, two days after Mrs A's admission. He saw her again on 31 December 2004 in relation to her left-sided weakness following a stroke. Mrs A received care from Dr H on 3, 5, 7 and 24 January 2005 and from Dr I on 14 January 2005. In addition, Dr I gave verbal orders for Sevredol (morphine) when Ms G telephoned him on 21 January 2005 to discuss Mrs A's ongoing

pain and sleeping problems. (This aspect of Mrs A's care is also discussed below.) The progress notes state that Mrs A was also seen on 12 January by Dr I regarding her pressure sores, although Dr I did not document this consultation in his notes.

In my view, there were other occasions in January 2005 when it would have been prudent for the rest home to have requested a medical review of Mrs A. The first was when swelling was observed in Mrs A's legs on 17 January. My advisor was concerned that there was no indication in the rest home's progress notes that the swelling had been investigated. Secondly, on 18 January, Mrs A's family thought she suffered a second stroke as her speech was increasingly slurred, and her overall condition was on the decline.

The rest home has commented that the physiotherapist did not consider it necessary to call for a medical review on 17 January 2005. Nevertheless, it is clear from the physiotherapist's notes of 17 January 2005 that she thought Mrs A might have suffered a further cerebral incident. She documented her observations accordingly, following which the onus fell on the rest home's registered nurses to instigate a follow-up. The physiotherapist and the family's concerns were followed up when Mrs A was reviewed by two registered nurses on 19 January 2005. Once again, she was not referred to a doctor. The registered nurses did not consider a medical review necessary at that time, and there is no indication that they directed Dr H to investigate the possibility of a further cerebral incident when he reviewed Mrs A on 24 January 2005 in relation to her limited fluid intake and the ongoing management of her Philadelphia collar. Dr H did not comment on any cerebral incident in his clinical notes of 24 January 2005.

In my opinion, the rest home's decision not to refer Mrs A to a doctor between 17 and 19 January 2005 was sub-optimal given the swelling in her legs, and the query from the physiotherapist and Mrs A's family about the possibility of a further cerebral incident on 17 and 18 January 2005. However, I accept that there were mitigating factors, namely that apart from her slurred speech, the registered nurses noted that Mrs A's observations were otherwise normal during their review on 19 January 2005. My expert advised that it is not always necessary to call a doctor if the TIA or stroke symptoms subside within a few hours. Assuming that Mrs A had suffered a further cerebral incident between 17 and 18 January, it appears that her symptoms had subsided when she was reviewed a day later on 19 January by the registered nurses.

No breach — The rest home

Policies

As part of this investigation, the rest home was asked to provide copies of the policies and procedures that were in place at the time of Mrs A's admission. The rest home provided copies of its policies on:

- wound management
- pain management
- nutritional needs
- communication with family members
- liaising with general practitioners
- referrals to other health practitioners.

Ms Spence advised that the policies provided by the rest home were appropriate but "because of the lack of a nursing care plan and the brief progress notes, it is not possible to know how much of this information was implemented".

Ms Spence advised that a rest home should have a written policy providing the staff with direction on how to complete nursing care plans. In response to my provisional opinion, the rest home provided copies of its policies on care planning and care plan evaluation applicable at the time of Mrs A's admission. According to the former, a long-term care plan must be formulated for every resident following admission, and the care plan updated every three months, in conjunction with input from the resident and their family members. The latter states that a comprehensive evaluation of the care planning process shall be carried out annually or more frequently if variances in care are identified. Based on my review, I am satisfied that the rest home had adequate care planning policies in place when Mrs A was a resident. However, as commented above, the issue was that the rest home did not adhere to the policies by formulating a detailed care plan for Mrs A.

Clinical care — Management of neck fracture

On admission to the rest home, Mrs A wore her Philadelphia collar. However, Ms B was concerned that staff at the rest home did not follow the specialist's instructions for using the collar.

The public hospital's discharge plan was for Mrs A to remain in her collar 24 hours a day for three months. However, it appears that this was not clearly communicated, and there is debate about when such instructions were first conveyed to the rest home staff.

The Nursing Transfer Summary accompanying Mrs A on her admission did not contain any specific ongoing management instructions in relation to the Philadelphia collar except for the application of Daktarin to the pressure areas. My advisor, Lesley Spence, commented that these skin care instructions were "superficial". In addition, Dr K stated in his discharge letter that Mrs A could mobilise "as long as she [had] her collar on" without specifying that it had to be worn 24 hours a day. His letter was written on 6 December 2004, a fortnight before Mrs A's discharge from the public hospital, and issued to the rest home either during Mrs

A's discharge or several days thereafter. Given the circumstances, I accept that initially, staff at the rest home lacked clear instructions on the ongoing management of Mrs A's Philadelphia collar. Consequently, there were several occasions when Mrs A's family saw staff open the front of her collar during mealtimes to facilitate a more comfortable feeding arrangement. While it compromised the protection of Mrs A's cervical fracture, Ms Spence commented that it was an "understandable error" at the time.

During Mrs A's review at the Orthopaedic Clinic on 29 December 2004, Dr L clarified that she was required to wear her Philadelphia collar at all times. He confirmed his instructions in a letter dated 29 December, which was sent on 31 December 2004. Following the appointment, it is likely that the rest home staff telephoned the Orthopaedic Clinic for clarification and specialist advice, since Dr L's instructions were recorded in the rest home's progress notes that day, with repeat entries on 5 and 10 January 2005. In addition, Dr L's instructions were incorporated in Mrs A's care plan dated 15 January 2005. Following Dr L's clarification on 29 December 2004, it appears that rest home staff attempted to comply with the hospital's instructions. I note that during the discussion with the Orthopaedic Clinic, the rest home staff requested a better fitting collar, which the Orthopaedic Clinic delivered to the rest home premises on 7 January 2005. I also note that following its receipt, the rest home staff were advised to file down prominent points on the collar to reduce the friction with Mrs A's neck.

On admission, Mrs A had pressure areas in her left cheek and neck. From the progress notes, it appears that these pressure areas were significant and challenging to treat. Ms Spence advised that, nevertheless, staff at the rest home should have developed a wound care plan, consulted a doctor and sought expert advice from a wound care specialist. A Braden scale assessment would also have assisted with planning care. In response, The rest home explained that at the time of Mrs A's admission, it maintained a single wound care record for all residents, but it has since improved its system of documentation by introducing an individual wound care report for each resident. In addition, the rest home confirmed that its staff are very familiar with wound care products and had attended in-house training on wound care in June 2004.

It is clear that the collar created enormous discomfort for Mrs A and real nursing difficulties for the rest home staff as they had to balance the comfort needs of this frail elderly woman against the stabilisation of the fracture. My advisor stated:

> "I believe [the rest home] staff did their best in this regard. I am not in any way undervaluing the need for this collar to stabilize the fracture but feel referral back to [the hospital outpatients' department] or another specialty should have been sought."

From my review of the rest home's response, I am satisfied that it took all possible steps to address the difficulties involved in managing Mrs A's neck fracture, including seeking specialist advice from the Orthopaedic Clinic and requesting a better fitting collar. I am also

satisfied with the rest home's efforts to manage Mrs A's pressure areas, and the decision to implement individual wound care reports for each resident.

Clinical care — pain and sleep
From admission, Mrs A experienced significant ongoing pain. She was given Pamol (liquid paracetamol) four times a day throughout her stay, in addition to paracetamol. When Mrs A complained of headaches, she was given nine extra doses of paracetamol overnight. In total, Mrs A received 152 doses of paracetamol, as confirmed by the rest home's medication signing sheet.

From early January 2005, Mrs A had difficulty falling asleep at night. Mrs F instructed staff to monitor Mrs A's routine. On 14 January, Mrs A was seen by Dr I who prescribed temazepam 10mg (a sedative). Initially, it helped Mrs A to settle to sleep but several days later, she woke up during the night and called for attention until the following morning. In response to Mrs A's sleep problems and ongoing pain from wearing the Philadelphia collar, the rest home sought advice from Dr I. On 21 January, he gave verbal orders for staff to administer Sevredol (morphine) rectally to Mrs A up to four times a day.

I acknowledge that Mrs A had ongoing problems with sleep and pain, which were challenging to manage, and I am satisfied with the rest home care in this regard. I am also satisfied that the rest home took appropriate measures by seeking medical advice, and requesting the prescription of additional medication to address Mrs A's pain and sleep problems.

Staff training
In her complaint to my Office, Ms B was concerned that the staff at the rest home were not sufficiently trained or skilled in dealing with her mother's needs and in providing the level of care she required. From reviewing the rest home's in-house training schedule between November 2004 and October 2006, I am satisfied that staff received appropriate ongoing training on a comprehensive range of nursing cares including those discussed above. I also acknowledge Ms Lomax's comment that many nurses were trained and registered before the introduction of a tertiary nursing qualification, but have undertaken ongoing professional development and demonstrate adherence to contemporary nursing standards in their practice.

Other matters

Communication with family
Ms B was also concerned that she had not been kept informed of her mother's condition by staff at the rest home. The rest home has provided a copy of its policy entitled "Family Rights and Responsibilities". Clause 2 states: "with your family member's permission, you have the right to be informed about any aspect of their care".

The rights in the Code are based on the direct relationship between a consumer, a provider, the delivery of health and disability services, and the rights that arise out of that relationship. Code rights do not automatically extend to support people and family members. The rest home policy for involving family members is therefore appropriate.

There are, however, certain situations where support people or family members can become involved in the consumer/provider relationship. If, for example, a consumer has diminished capacity to give consent, because of age or impairment, a family member, caregiver or support person may need to give consent as the consumer's legal representative. In such cases, the legal representative is entitled to enforce the Code rights on behalf of the consumer.

Ms B has supplied this Office with evidence that on 12 November 2004, she was appointed her mother's enduring power of attorney in relation to all aspects of Mrs A's personal care and welfare. The enduring power of attorney document that Ms B executed authorises the attorney to act on the donor's behalf in relation to the donor's personal care and welfare generally if the donor becomes mentally incapable. In light of Mrs A's dementia, Ms B was authorised to make decisions regarding her mother's health care from 12 November 2004. The enduring power of attorney was therefore operating when Mrs A transferred to the rest home, and the rest home have confirmed that Ms B held an enduring power of attorney in respect of her mother. Correspondingly, under the Code, there was an obligation on the rest

home to maintain ongoing communication with Ms B, including providing her with information and regular updates on her mother's progress.

In response to the comments in my provisional opinion about communication, the rest home commented:

> "[Its staff were] concerned for [Mrs A's] care and did listen to concerns voiced in this regard. [Mrs A's] family were present most days and assisted in her care, and the Charge Nurse did speak with the family on a number occasions regarding concerns."

I acknowledge that maintaining communication with a resident's family is an ongoing challenge for busy nursing homes. However, effective communication is a crucial and ongoing part of good nursing care. In my view, there were instances when it would have been helpful and reassuring for Mrs A and her family if the rest home staff had provided clearer information about her care and progress. I note that the rest home made efforts to maintain ongoing communication, including arranging several meetings between its charge nurse and Mrs A's family to discuss their concerns.

Further policies

My advisor highlighted the need for the rest home to have an insect management plan to deal with ants, and also a pet policy, given that some residents may be allergic to cats (as in the case of Mrs A). In response, the rest home supplied a copy of its policy on cats, and confirmed that it maintains a vermin management plan with the pest control company. Although I am satisfied with these measures, it would have been prudent if the rest home had told Mrs A and her family about the cat policy and given them a copy of it. I note that the rest home has since acknowledged that all its residents should be notified of the presence of pets on the premises, and given the opportunity to decline being a resident on that basis.

Discharge Planning Summary

As noted above, there were two discrepancies in Mrs A's discharge planning documents from the public hospital. First, her neck fracture was reported as a "C1 and C2" fracture by the radiologist, but recorded as a "C2 and C3" fracture in the discharge letter of 6 December 2004. Secondly, the discharge letter stated that Mrs A was independent with her feeding, whereas the nursing transfer summary stated that she required assistance with all aspects of her care. Although the former was not material to my opinion, the latter may have contributed to Mrs A receiving inconsistent care from the rest home in relation to her feeding regime. Furthermore, the Ministry of Health has commented that the discharge planning information from the public hospital was "minimal given the complex nature of [Mrs A's] required care". I have drawn this matter to the attention of the District Health Board.

Audit in 2004
Under the Health and Disability Services (Safety) Act 2001, rest homes and hospitals must be certified by an auditing agency designated by the Director-General of Health. The purpose of the audit is to review the facilities, premises and systems used by a rest home and to consider whether these comply with the Health and Disability Sector Standards. The auditing and certification process is an important mechanism for ensuring consistency and quality of services for elder care throughout New Zealand.

Ms Spence advised that part of the audit involves an examination of the systems and policies used by a rest home and hospital to provide care. She commented that nursing care plans and related policies are usually rigorously reviewed during an audit, and was surprised that these issues were not identified in June 2004. In response to my provisional opinion, HealthCERT provided information about the audits the auditing agency conducted at the rest home in November 2003, April 2004 and November 2005. There were no concerns identified by the auditing agency during these audits. From reviewing the information provided, I am satisfied that the rest home was adequately audited.

Actions taken

In response to my provisional opinion, the rest home provided the following:

- A written apology to Mrs A's family for its breaches of the Code.
- Copies of its written policies in relation to care planning and care plan evaluation.
- A schedule of in-house staff training between November 2004 and October 2006.
- A Report of the independent audits undertaken by the auditing agency.

The rest home has also changed its record-keeping in relation to wound management, and introduced a system to ensure that it maintains a sufficient quantity of all necessary equipment on site. I am satisfied with the actions taken to date by the rest home.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Ministry of Health Licensing Office, and the District Health Board.

- A copy of this report, with details identifying the parties removed, will be sent to the Gerontology Section of the New Zealand Nurses Organisation, the New Zealand Association of Gerontology, and HealthCare Providers NZ.