Oceania Care Company Limited

(trading as Middlepark Rest Home & Village)

Registered Nurse, Ms F

Registered Nurse, Ms G

Registered Nurse, Ms H

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00528)

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Executive summary

Background

1. This report is about the standard of care provided to Mrs B at Middlepark Rest Home & Village (Middlepark) by several individuals employed at the facility.

2. Mrs B had been a resident at Middlepark since January 2008. In 2011, Mrs B's health began to deteriorate; she developed a stomach bug and experienced vomiting and diarrhoea.

3. Two weeks later, a dipstick urinalysis test indicated that Mrs B was suffering from a urinary tract infection (UTI). However, a urine sample was not obtained to confirm this. Mrs B was started on a course of antibiotics, but not all health providers involved in her care were aware of this treatment.

4. Over the next few days, Mrs B had five falls and continued to deteriorate. Incident forms were filled out, but they contained incorrect information and were not appropriately signed off. Staff at Middlepark advised one another that Mrs B was for palliative care. No decision regarding palliative care had been made or discussed with Mrs B, the necessary health providers, or her family.

5. Although Mrs B's family were aware that Mrs B was on antibiotics for a suspected UTI, they were not advised of her further deterioration or any of her falls. A registered nurse called one of Mrs B's daughters and advised her that Mrs B was confused and weak, and not eating or drinking. Two of Mrs B's daughters arrived at Middlepark soon afterwards, and were advised that Mrs B was for "comfort cares".

6. The following day, at the request of Mrs B's daughters, Mrs B was admitted to hospital suffering from pain in her abdomen, and confusion. A urine test showed resistance to the antibiotic she had been prescribed at Middlepark. Mrs B was diagnosed with urosepsis caused by her UTI and, a short time later, she passed away.

7. Mrs B's family complained to HDC that their mother did not receive an appropriate standard of care at Middlepark over the last period of her life. They also complained that they were not kept fully informed of their mother's condition, and of the care she was being provided with.

Decision summary

8. The Deputy Health and Disability Commissioner (Deputy Commissioner) found that Oceania Care Company Limited (trading as Middlepark Rest Home & Village) (Oceania) failed to ensure that appropriate policies and procedures were implemented and followed by clinical and care staff at Middlepark. It is clear that staff failed to follow documentation and communication policies.

9. Those failures created a situation where individual staff at Middlepark had an incomplete and, consequently, inaccurate picture of Mrs B's clinical condition. This

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was compounded by failures by a number of staff to communicate Mrs B's condition to one another and to Mrs B's family.

10. These failures had serious consequences for Mrs B's clinical care, and meant that her UTI was not appropriately diagnosed or treated, and that her admission to hospital was unduly delayed. Oceania breached Rights 4(1)[1] and 4(5)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

11. The Clinical Leader, Registered Nurse (RN) RN F, failed to ensure that her clinical staff were providing appropriate care, and failed to assess Mrs B until after her third fall. RN F therefore breached Right 4(1) of the Code. RN F also breached professional standards by failing to accurately document the care provided to Mrs B. She therefore breached Right 4(2) of the Code.[3] RN F's failure to communicate effectively with other healthcare staff to coordinate Mrs B's care was in breach of Right 4(5) of the Code.

12. The Facility Manager, RN G, failed to organise for Mrs B to be admitted to hospital, and failed, as a manager, to ensure that Middlepark staff were complying with policies and procedures. This had serious consequences for the care provided to Mrs B. RN G therefore breached Right 4(1) of the Code. RN G's failure to communicate effectively with other healthcare staff to coordinate Mrs B's care was in breach of Right 4(5) of the Code.

13. Middlepark's weekend RN, RN H, failed to ensure that a clean urine sample was obtained from Mrs B after she diagnosed her UTI, and failed to ensure that the correct course of antibiotics was administered. RN H also failed to attend Middlepark to assess Mrs B, or advise that she be admitted to hospital, when this became appropriate. RN H therefore breached Right 4(1) of the Code. RN H also failed to adequately document the need for Mrs B to have a repeat urine test, and the antibiotics prescribed, in breach of professional standards. She therefore breached Right 4(2) of the Code. RN H's failure to communicate effectively with other healthcare staff to coordinate Mrs B's care was in breach of Right 4(5) of the Code.

Complaint and investigation

14. The Commissioner received a complaint from Mrs B's daughter, Mrs A, about the services provided to Mrs B at Middlepark Rest Home & Village (Middlepark). The following issues were identified for investigation:

[1] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[2] Right 4(5) of the Code states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[3] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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- *Whether Oceania Care Company Limited trading as Middlepark Rest Home & Village provided Mrs B with an appropriate standard of care in Month 1 and Month 2 2011.*
- *Whether Middlepark Rest Home & Village Clinical Leader, registered nurse RN F, provided Mrs B with an appropriate standard of care in Month 1 and Month 2 2011.*
- *Whether RN F adequately informed Mrs B or her family about her condition and treatment in Month 1 and Month 2 2011.*
- *Whether Middlepark Rest Home & Village Facility Manager, registered nurse RN G, provided Mrs B with an appropriate standard of care in Month 1 and Month 2 2011.*
- *Whether RN G adequately informed Mrs B or her family about her condition and treatment in Month 1 and Month 2 2011.*
- *Whether registered nurse RN H provided Mrs B with an appropriate standard of care in Month 1 and Month 2 2011.*

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

16. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer's daughter
Mrs C	Consumer's daughter
Mrs D	Consumer's daughter
Mrs E	Consumer's daughter
Oceania Care Company Ltd (trading as Middlepark Rest Home & Village)	Provider
RN F	Clinical Leader, registered nurse
RN G	Facility Manager, registered nurse
RN H	Registered nurse
Ms I	Quality Co-ordinator
EN J	Enrolled nurse
EN K	Enrolled nurse
Dr L	General practitioner
HCA N	Health care assistant
HCA M	Health care assistant
RN O	Agency registered nurse

17. Information from all of these parties was reviewed during the investigation.

18. Also mentioned in this report:

The DHB	Funder
The hospital	Public hospital
Ms P	Health care assistant

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Dr Q	General practitioner
Dr R	General practitioner
An accident and urgent medical centre	
A pharmacy	

19. Information from the DHB (on behalf of the hospital), an accident and urgent medical centre and a pharmacy was also reviewed during the investigation.

20. Independent expert advice was obtained from Registered Nurse Glenda Brady, and is attached as **Appendix A**.

Information gathered during investigation

Mrs B — overview

21. Mrs B had been a resident at Middlepark Rest Home & Village (Middlepark) since early 2008. In 2011 she was in her mid eighties. She had a number of health problems including depression, hypertension,[4] osteoarthritis,[5] thrombocytopenia,[6] postural hypotension,[7] Mrs B also had a history of UTIs while she was a resident at Middlepark. Prior to Mrs B moving to Middlepark she had broken her femur, and had undergone a spinal fusion and hip replacements (she therefore wore plastic hip protector inserts during the day, and used a walker to mobilise). Mrs B's family also informed HDC that prior to moving to Middlepark, Mrs B had experienced TIAs.[8]

22. Mrs B's Middlepark admission form listed her daughter, Mrs A, as the first point of contact. Mrs B's other daughters, Mrs D and Mrs C, were listed as the second and third contacts on the form.

December 2010 and January 2011 health concerns

23. Towards the end of December Mrs B became unwell, suffering from an ear infection, vomiting, diarrhoea, and a haematoma.[9] On 20 December 2010 Mrs B's GP, Dr L, conducted a routine assessment, noting in Mrs B's Medical Progress Notes that "things appear much the same", and that "cognitive decline appears to be continuing".

24. Mrs B lost weight during December and, on 29 December 2010, was referred to a dietitian for assessment. There are some incomplete Care Progress Notes during this period.[10]

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[4] High blood pressure.
[5] A non-inflammatory form of arthritis, where degenerative changes occur in affected joints.
[6] Low numbers of platelets in the blood, resulting in susceptibility to bruising from mild trauma, and prolonged bleeding after injury.
[7] Abnormally low blood pressure when standing up. Also known as orthostatic hypotension.
[8] Transient Ischemic Attacks are often referred to as "mini-strokes".
[9] Blood blister.
[10] No Care Progress Notes are recorded for the 3rd, 10th, 11th, 16–18th, 21st or 26th December.

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25. The last entry on Mrs B's Observation Chart was made on 9 January 2011. RN F could not explain why there were no entries recorded on Mrs B's chart after that date.

January and February 2011 — family meeting and care plan

26. On 13 January 2011, RN F assessed Mrs B in a range of health areas, including balance, falls risk, mobility, pressure sores, pain, and depression. RN F recorded the results in various risk assessment forms, for the purpose of updating Mrs B's care plan. RN F concluded from the results of these assessments that Mrs B was at high risk of falls and pressure sores. On the same day, RN F met with Mrs B's daughters.[11]

27. RN F advised HDC that at that meeting it was decided that Mrs B was to have a sensor mat[12] placed in her room, to help prevent falls. RN F advised HDC that staff had already put a sensor mat in Mrs B's room over the Christmas/New Year period, but it is unclear from the records whether the sensor mat was still in place at the time of the family meeting.

28. During the meeting, Mrs B's daughters expressed concern about Dr L's management of their mother's recent ear infection. On the Multi-Disciplinary Review — Communication with Family form, RN F recorded: "Concerns with GP over Christmas, family to let us know if wish to change GP." Mrs B's daughters signed this form on 13 January 2011.

29. Following the meeting, Mrs B's daughters understood that they would be contacted by Middlepark if their mother's health deteriorated further, if staff were unable to settle their mother, or if staff had any questions. Mrs C advised HDC that she expected Middlepark to notify the family immediately if Mrs B had a fall. In response to my provisional opinion, Mrs B's daughters advised that they left the care plan meeting with an "absolute assurance" that RN F would notify any of them of any change "what-so-ever" in relation to their mother's health.

30. On 8 February 2011, RN F completed a new Care Plan for Mrs B. RN F explained that there was a delay between the family meeting and the completion of the new Care Plan because she would have been "getting all the information together".

Middlepark Rest Home & Village

31. Middlepark is owned by Oceania Care Company Limited (Oceania), a subsidiary of Oceania Group (NZ) Limited.[13] Oceania is contracted by the district health board (the DHB) to provide rest home level care for up to 60 residents at Middlepark.

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[11] RN F said that the purpose of such meetings is to meet with families face to face to discuss the resident and any concerns they may have. Comments are obtained in advance of these meetings from the health professionals involved in the resident's care. In Mrs B's case, comments had been obtained in September 2010 from her Recreational Therapist, Key Caregiver, Physiotherapist, General Practitioner, and RN F.

[12] Sensor mats alert staff if a resident moves on or off the mat, and are usually placed next to a resident's bed so that staff know when a resident is attempting to self-mobilise.

[13] In Month 2 2011, Oceania Care Company Limited was registered under the name Oceania Care Company (No 1) Limited.

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RN G — Facility Manager

32. In September 2009, RN G was appointed Facility Manager at Middlepark, with overall responsibility for managing the facility.[14] At that time, RN G had five years' experience working in rest homes, both as an RN and as a facility manager.

33. RN G is no longer the Facility Manager at Middlepark.

RN F — Clinical Leader

34. In June 2010, RN F was appointed Clinical Leader at Middlepark, with overall responsibility for managing the clinical aspects of the facility.[15]

35. RN F advised HDC that, when she started at Middlepark, residents' files were "well out of date", and missing multidisciplinary documents, care plans, and GP reviews. RN F said that she worked 10–12 hour days getting the files ready for a Ministry of Health certification audit in September 2010.[16] This involved organising multidisciplinary meetings with family members and conducting nursing assessments.

36. At certain times between August 2010 and January 2011, when RN G was on leave, RN F had responsibility for both her own role and RN G's role. RN G was on leave on a number of occasions.[17] Likewise, RN G covered RN F's role when RN F was on leave in Month 1 and Month 2 2011.[18]

37. RN F is no longer working at Middlepark or for Oceania.

RN H — weekend RN

38. In August 2010, RN H began working at Middlepark as the weekend RN. She worked from 7am to 4pm on both Saturday and Sunday, and was on call from 5pm Friday until 7am Monday morning.

39. RN H is no longer working at Middlepark or for Oceania.

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[14] According to the Job Description for the role of Facility Manager, the key purpose of this role is to "contribute to the achievement of the key strategic goals outlined in the Oceania Group business plan through the site specific facility business plan, LIFE philosophy and methodology, and associated work programmes". The Facility Manager also has responsibility for the management of service delivery at their facility, including compliance with Oceania Group's systems, structures, processes, policies and prpocedures, and ensuring that all professional codes of practice, clinical standards, and contractual and legal obligations are complied with.

[15] According to the Job Description for the role of Clinical Leader, the key purpose of this role is "to provide sound clinical leadership to clinical and care staff, through the development, implementation and evaluation of care plans in accordance with contemporary clinical standards, Oceania Group quality standards and LIFE programme as well as funding requirements". The Clinical Leader is also required to ensure that "facility clinical and care staff comply with Oceania Group's systems, structures, processes, policies and procedures and role models compliant practices at all times" and to "promptly and effectively [address] any clinical issues raised and [discuss] these with residents' family members and medical personnel".

[16] According to information provided to HDC by the DHB, Middlepark achieved certification for two years as a result of this audit. The audit identified 22 criteria that were only "partially attained" and that required action. All of the required actions were signed off within nine months.

[17] Two weeks in August, two weeks in October, and seven weeks in December/January.

[18] 17–18 Month 1, and 7–8 Month 2 2011.

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Canterbury Earthquake — 22 February 2011

40. On 22 February 2011 a 6.3 magnitude earthquake struck Christchurch. At that time Oceania operated eight facilities in the Christchurch area. Two of these facilities were severely damaged in the earthquake.

41. Middlepark was not significantly affected by the earthquake, and so took in seven hospital-level residents from another Oceania facility following the earthquake. After approximately three weeks, four to five of those hospital-level residents were still at Middlepark, with the last leaving a few months later. RN G advised HDC that the hospital-level residents stayed at Middlepark longer than expected.

Effect on staffing at Middlepark

42. RN G and RN F both advised HDC that it was difficult to obtain sufficient staff cover following the earthquake, and they both worked considerable hours for the two weeks immediately following the earthquake.

43. Oceania allowed Middlepark to access local nursing agency staff in order to maintain sufficient numbers of RNs and health care assistants (HCAs).[19] Some Oceania staff from the two badly damaged Oceania facilities also went to work at Middlepark.

Effect on policies and procedures at Middlepark

44. Staff at Middlepark (existing, redeployed and agency) did not consistently follow internal processes and systems in the period immediately following the earthquake. As RN G noted to HDC, this resulted in lapses in:

- documentation;
- verbal reporting of concerns to the duty and on-call RNs;
- documenting communication with families; and
- reviewing whether issues identified for follow-up were actioned.

RN F's increased stress

45. RN F advised HDC that, following the earthquake, further responsibility fell on her shoulders, and she felt that she was not provided with enough support by Oceania.

46. In Month 1 2011, RN F took two days' leave due to family and work stress. RN F advised HDC that, toward the end of the month, she met with RN G to express her concern that something was "going to happen" if extra staff were not brought in. RN F told RN G that she would resign if she did not get further support; however, RN G convinced her to stay. RN F advised HDC that, overall,

> "[f]ollowing February 22 2011 I relied very heavily on senior care staff and the Enrolled Nurse discussing anomalies with me and from there I made an assessment of the resident with the information that I had. …

[19] Budgetary restrictions were removed for some months following the earthquake to facilitate this. Oceania advised HDC that, between 28 Month 1 and 10 Month 2 2011 five RNs and five HCAs from agencies worked at Middlepark.

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> [Middlepark] had staff who were traumatised and we had residents and families who were traumatised. We had inadequate equipment and space. We had hospital residents, who we didn't know, with complex needs that we were unaware of and had to find out. Added to all this we continued to experience lots of aftershocks. I believe that it was one of the worst times in my nursing career."

47. In response to my provisional opinion, RN G's representative advised that RN G does not recall the above meeting with RN F. He said that RN G does recall that RN F "…was under an immense amount of pressure during the earthquakes, as was [RN G], but they worked together to keep Middlepark running well".

Record-keeping

48. Information about residents at Middlepark was recorded in a variety of documents. Not all of these documents were located on a resident's file. The documents most relevant to Mrs B's care and treatment are discussed below.

Progress Notes

49. Each resident at Middlepark had both Medical Progress Notes and Care Progress Notes. Medical Progress Notes were completed by a resident's GP whenever the resident was examined. Care Progress Notes were the main record of the day-to-day care provided to residents by nursing staff (RNs and enrolled nurses (ENs)) and HCAs. Oceania's Progress Notes Policy (issued December 2009) states:[20]

> "Progress Notes are legal documents which reflect the day by day, shift by shift status of a resident. Progress notes are written by the staff member who looks after the resident and signed by that individual as an actual account of their care delivery and status on that shift."

50. The policy required entries in the Care Progress Notes to include any "changes in condition, including mental, physical, emotional or spiritual condition … any event (fall, skin tear, bruising) or concerns related to that individual, including any expressed concerns by family members … any additional medication given or commenced".

51. The policy required RNs to read back to the last RN entry when making a new entry, to ensure continuity of clinical oversight.

52. RN G told HDC that HCAs were expected to make an entry in a resident's Care Progress Notes once every 24 hours, or more frequently when there were changes in a resident's health status or an event occurred that required recording. RN G believed that usual practice at Middlepark was for the HCA on the morning shift to record that entry. RN G later said that Care Progress Notes were to be written for each eight-hour shift, or more frequently when there were changes in a resident's health status or an event required recording. Where an issue was recorded, it was expected that an RN would follow up with a further entry.

[20] This policy applied to Care Progress Notes.

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53. RN G told HDC that:

- it is the Clinical Leader or Clinical Manager's responsibility to ensure that Care Progress Notes are being used correctly, and to ensure that issues raised by HCAs are followed up by an RN;
- Oceania's Clinical Quality Manager (a regional role with oversight of a number of facilities) also checks Care Progress Notes when visiting a facility; and
- RNs are responsible for checking the Care Progress Notes of those residents identified as having had issues arise on the previous shift, and who are discussed at handover.

54. RN F told HDC that "[t]he agreement that RN G had with Healthcare Assistant staff was that resident's Care Progress Notes were to be written on their shower day, unless a change had taken place". RN F said that either she or an EN would check (on an informal basis) that Care Progress Notes were being appropriately recorded, particularly if she had not heard about a resident in a while. RN F said that she did not document when she checked the Care Progress Notes, and acknowledged that she probably should have done so.

Handover Sheets

55. Handover Sheets had a row for each resident, and columns for each shift (morning, afternoon, and night) so that each resident had three boxes next to his or her name (one for each shift). Staff would complete the Handover Sheet for those residents for whom they had been responsible, and provide the sheets to the oncoming shift at the handover briefing. Comments recorded on the Handover Sheets were succinct and flagged particular issues.

56. RN F told HDC that the normal practice was for staff to tick the relevant shift box next to a resident's name when no issues had arisen on that shift. If there was something other than a tick recorded in the column, the RN would refer to that resident's Care Progress Notes for a more detailed account of any issues raised.

Observation Charts

57. A resident's Observation Chart recorded and graphed the resident's history of temperature, pulse, and blood pressure. RN F told HDC that the ENs were responsible for taking these observations monthly and recording them on the resident's Observation Chart. RN F said she would check that the observations had been done at least once a month; however, she did not document these checks.

Weight Charts

58. A resident's Weight Chart recorded and graphed the resident's weight. Oceania's Nutrition and Hydration Policy set out that each resident should be weighed monthly, or more frequently if clinically indicated. EN K confirmed that she had been measuring Mrs B's weight monthly and recording this on her Weight Chart.

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Fluid Balance Charts, Food Intake Charts, and Bowel Charts

59. A resident's Fluid Balance Chart recorded the volume of fluid intake (both oral, subcutaneous and intravenous) and the volume of fluid output (for example, urine and vomit). The Fluid Balance Chart also recorded episodes of urinary incontinence.

60. A resident's Food Intake Chart recorded how much (expressed as a percentage) was eaten at each meal. Food Intake Charts were used to assess whether a resident should be referred to a dietitian.

61. Fluid Balance Charts and Food Intake Charts would be implemented only when concerns about nutrition or hydration were identified, following assessment by an RN or the resident's GP.

62. A resident's Bowel Chart recorded the date and time of a resident's bowel movements.

Care Plans

63. A resident's Person Centred Care Plan (Care Plan) was based on a "comprehensive clinical assessment", and recorded a resident's needs in areas including nutrition, communication, mobilisation, and personal hygiene. The Oceania Person Centred Care Planning Policy stated that the plan is used "… as the basis to discuss, define and document care strategies that are thorough, accurate, systematic and clear".

64. Goals were agreed between the resident, his or her family, and Oceania staff, and were recorded on the resident's Care Plan. The Care Plan also recorded the interventions and support necessary to reach those goals. Care Plans were reviewed and updated every six months.

65. Where changes in a resident's condition or goals occurred, a Short Term Person Centred Care Plan (Short Term Plan) was prepared. This recorded the changes and recommended new interventions to help the resident reach his or her goals. Where a Short Term Plan was in place, a note placed on the relevant section of the Care Plan directed staff to the Short Term Plan for the most up-to-date planning information.

Incident Reports

66. Incident Reports were filled out by staff when an "unwanted event" occurred, and recorded the time, place, and nature of the event. There was space on the report form for staff to record corrective action taken and preventative action recommended, and to assign follow-up tasks to staff. Incident Reports required sign-off by an RN.

EN/RN Communication Book

67. The EN/RN Communication Book was used to pass messages between the nursing staff on different shifts. It contained messages about particular residents, and about more general matters (for example, which RN was on call and reminders of tasks that required follow-up).

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Location of documents

68. According to RN G, a resident's clinical records and the EN/RN Communication Book were kept at the nurses' station.

69. According to RN F, Fluid Balance Charts, Food Intake Charts, and Bowel Charts (if they were being used) were kept in a folder in the resident's room.

Mid Month 1 and early Month 2 - Mrs B's stomach bug and deterioration

70. In the last two weeks of Month 1, Mrs B suffered from a stomach bug. She was kept in isolation for much of this period. During her illness she was seen by a doctor, placed under increased supervision (particularly in regard to nutrition and hydration) and prescribed extra medication, and laboratory tests were conducted. Mrs B's family advised HDC that they were not contacted by Middlepark during this period.

15 Month 1 2011

71. On 15 Month 1 2011 Mrs B had a routine visit from Dr L, who noted in her Medical Progress Notes that she was "well", showed a "slight" weight loss,[21] her blood pressure was 140/90mmHg, and her heart rate was 76 beats per minute.[22] Dr L reviewed Mrs B's medications and instructed staff to "continue current cares". No Care Progress Notes were recorded for this day or the next.

17 Month 1 2011

72. On 17 Month 1 2011 Mrs B became ill with vomiting and diarrhoea. This continued over the next few days, and the Care Progress Notes record that Mrs B had a sore stomach, was not eating or drinking properly, was confused, and was up and down to the toilet with diarrhoea. Mrs B was put in isolation over this period.

20 Month 1 2011

73. On 20 Month 1 2011 Mrs B was seen by an after-hours GP, Dr Q. Dr Q recorded in Mrs B's Medical Progress Notes that she had "gastro", and charted Enerlyte[23] (which Mrs B had been given occasionally in the previous days) and prochlorperazine.[24] He advised that fluids were to be encouraged and intravenous fluids started if her intake dropped below 1000ml. A stool sample was taken and sent to the laboratory. Mrs B was kept in isolation, and a Fluid Balance Chart was started. The intake volumes over the next three days were documented, but not the output volumes. The reason why output volumes were not measured was not documented.

21 Month 1 2011

74. On 21 Month 1 2011 Mrs B's Care Progress Notes recorded four episodes of loose bowel motions. The Handover Sheet noted that Mrs B was still "isolated". Dr L rang

[21] Mrs B's weight chart, provided with her clinical notes, shows her weight as 54.1kg on 9 January, and then her next weight as 49.5kg on 20 Month 1 2011. RN F provided HDC with another chart, which showed that Mrs B weighed 54.1kg on 5 January and 51.2kg on 9 Month 1 2011. It is not clear which chart Dr L saw.

[22] Normal measurements for the average healthy adult while resting are blood pressure below 130/80mmHg and pulse between 60–100 beats per minute.

[23] Treatment for diarrhoea and dehydration.

[24] Anti-nausea medication.

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Middlepark to request that loperamide[25] be charted for Mrs B. The first dose was given at 5pm. That evening, Mrs B's urine had a strong odour, which was noted as testing "positive" (no further details were included in Mrs B's notes). An entry in the Care Progress Notes instructed night staff to collect a further urine sample in the morning. A urine sample was not obtained.

75. On 21 Month 1 2011 a Food Intake Chart was commenced, but only dinner and supper entries were recorded that day. RN F advised HDC that she asked EN J to start the Food and Fluid Charts for Mrs B,[26] and to let RN F know if she felt that there was a decline or change in Mrs B's health. RN F also said that she asked EN J to inform Mrs B's family that Mrs B had a declining appetite, and that Middlepark was starting her on Food and Fluid Charts.

22 Month 1 2011

76. At 7am on 22 Month 1 2011, EN K found Mrs B lying on the floor after she had gone to the toilet. EN K checked Mrs B for injuries and noticed bruising on her buttocks. EN K completed an Incident Form, which was signed off by RN F the following day. Under "Follow Up Action" on the Incident Form, RN F wrote, "[T]o be seen by GP, check urine ? UTI." The Incident Form recorded that the manager, family, and GP had been notified of the fall (Mrs B's daughters deny that they were contacted).

77. At 11am Mrs B's Care Progress Notes record that staff had been trying to obtain a urine sample but had been unable to do so. Mrs B's Food Intake Chart records each meal for that day, with the exception of afternoon tea. It is unclear whether this was because she did not eat at that time, or if it was simply not recorded.

23 Month 1 2011

78. On 23 Month 1 2011 EN J sent a fax to Dr L with a copy of Mrs B's laboratory results from the stool sample taken on 20 Month 1. EN J's fax also queried a possible UTI and need for antibiotics, stated that Mrs B had had no further diarrhoea, and requested that Dr L review Mrs B in two days' time. At 1.22pm Dr L responded by fax and stated that, as Mrs B had "improved" (presumably in reference to her vomiting and diarrhoea), no further action was required. EN J documented in the Care Progress Notes that she had called Mrs B's daughter to update her on progress; however, none of Mrs B's daughters recall that this occurred.

79. That day there were no entries for lunch or afternoon tea in Mrs B's Food Intake Chart. It is unclear whether this was because she did not eat that afternoon, or if it was simply not recorded.

24 Month 1–1 Month 2 2011

80. On 24 Month 1 2011 RN F documented in Mrs B's Care Progress Notes and in the EN/RN Communication Book that a Food Intake Chart was to be completed for the next five days. On the same day, RN F also wrote a note in Mrs B's Care Plan instructing staff to refer to her Short Term Plan regarding her eating and drinking. The

[25] Medication that reduces symptoms of diarrhoea.
[26] As mentioned above, the Fluid Balance Chart had already been commenced on 20 Month 1 2011.

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Short Term Plan instructed staff to implement a Food Intake Chart for five days, and weekly weigh-ins for a month, and to consider referral to a dietitian. Under "evaluation" on the Short Term Plan, RN F wrote:

> "[Mrs B] had a tummy bug, is starting to eat more & appears to enjoy food. Referral to Dietitian for review of supplements. Weight down by 4+ kg in 1 month."

81. EN K, who had been recording Mrs B's monthly weight on her Weight Chart, told HDC that she was never told that Mrs B should be weighed weekly. Between 24 and 27 Month 1 2011, Mrs B's Food Intake Chart contains entries only for dinner and supper, and these are incomplete. No further entries were made in Mrs B's Food Intake Chart after this point.

82. Between 25 Month 1 and 1 Month 2 nothing was noted in Mrs B's Bowel Charts.[27] RN F said:

> "I do not know why the bowel charts for [Mrs B] were incomplete; this is something that I constantly followed up with staff. I do recall having difficulty with Care Staff filling out the bowel charts. I would try to educate and inform Care Staff as to the reasons why it was important they were completed and initiated different ways of getting this done but it continued to be an ongoing battle."

83. RN F said that when she identified that staff were not filling in the Bowel Charts correctly she asked that all the charts be placed in a folder. This allowed a staff member doing the drugs rounds in the evening to ask residents whether their bowels had moved (if nothing was written down). RN F would check the folder in the morning.

84. Between 26 Month 1 and 2 Month 2 2011 there are no Care Progress Notes recorded for Mrs B.[28]

85. On 29 Month 1 2011 RN F wrote in the EN/RN Communication Book:

> "Please ensure that if you put a resident into isolation because of vomiting and diarrhoea that family are notified. I assume that if someone becomes unwell during the weekend families have been contacted."

86. On 30 Month 1 2011 a note was made on Mrs B's Person Centred Care Plan, and a Short Term Care Plan was attached. This noted that Mrs B had not been having restful sleep, and offered suggestions to aid sleep. There is no record of the family being contacted about the issue. There is no reference to the change in Mrs B's Care Plan in her Care Progress Notes, Handover Sheets, or EN/RN Communication Book.

[27] There are similar gaps in Mrs B's bowel chart between 13 and 27 December 2010, 10 and 17 February 2011, and 5 and 13 Month 1 2011.

[28] There are a number of similar gaps in Mrs B's earlier progress notes, with periods of up to a week at a time with no notes made.

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87. Mrs A and Mrs D advised HDC that they did not recall being contacted by Middlepark staff in Month 1 2011 regarding their mother's declining health. Mrs C similarly advised HDC that the family were not contacted and informed of their mother's diarrhoea, placement in isolation, or occasions where a doctor had been called. However, RN F advised HDC that:

> "[t]he family had … been called on 23rd [Month 1] about [Mrs B's] decline in health and they took her out for an outing on Saturday 26th [Month 1] and again on 2nd [Month 2]. I am sure that staff would have spoken informally with the family on both these occasions advising them of how she had been over the previous week, as [Mrs B's] family always asked how she had been when they came to pick her up."

88. RN F also stated:

> "My involvement with the care provided to [Mrs B] was limited to discussion/conversations with [HCAs] and the [ENs] at handover and throughout the day. I was never asked to go and assess [Mrs B] and nor was I made aware that [Mrs B's] condition had deteriorated significantly between the dates of the 17 [Month 1] and 5th of [Month 2]."

89. RN G advised HDC that she was aware of Mrs B's change in health status over this period through discussions with RN F.

90. RN H advised HDC that Mrs B's health declined significantly during this period, and said that Mrs B had lost a lot of weight and appeared quite frail.

3 Month 2 2011 — Mrs B's UTI

91. RN H advised HDC that, on Sunday 3 Month 2 2011, Mrs B complained to her of urinary urgency and frequency. An HCA obtained a urine sample, which RN H tested with a "dipstick" urinalysis test.[29] The Care Progress Notes and EN/RN communication book record that the results of the test indicated that Mrs B had a UTI. RN H disposed of the sample, rather than sending it to the laboratory for testing. She told HDC that this was because the laboratory would not pick up specimens from Middlepark until Monday and that, even if she had placed the specimen in the refrigerator to be collected, the laboratory may have rejected it as being too old.[30]

92. RN H advised HDC that, after conducting the urinalysis, she contacted an accident and urgent medical centre and requested oral antibiotics for Mrs B. RN H told HDC that Mrs B was prescribed a three-day course of trimethoprim 300mg over the phone.[31] This was recorded in Mrs B's medicines chart. However, telephone consultation notes from the accident and urgent medical centre indicate that a six-day

[29] A dipstick is a chemically treated strip of paper used in the analysis of urine and other fluids.
[30] RN H informed HDC that urine samples are best analysed within four hours of collection.
[31] RN H believed the prescription was for four tablets: one to be given straight away, with the remaining three to be given one per night.

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course of antibiotics was prescribed,[32] and this is supported by the records of the dispensing pharmacy, which show that a six-day course was dispensed.[33]

93. RN H then called Mrs A, informed her about Mrs B's UTI, and asked her to collect the prescription from the pharmacy.

94. Mrs A advised HDC that, when she arrived at Middlepark that afternoon with the prescription, her mother was sitting in a chair in her room, dressed, and appeared reasonably well and was able to converse with her. Mrs B was given the first dose of trimethoprim at 3pm that day. RN H advised HDC that Mrs B was encouraged with fluids, looked stable, and was conversing logically and coherently.

Failure to obtain new urine specimen

95. RN H believes that, following her diagnosis of Mrs B's UTI and disposal of the original urine specimen on Sunday 3 Month 2, she left a note in the EN/RN Communication Book requesting that a fresh sample be obtained on Monday and sent to the laboratory. There is no such note in the EN/RN Communication Book.[34] Agency RN O,[35] who came on for the afternoon shift on Sunday, recalls being made aware that Mrs B had a UTI. He advised HDC that he was never asked to obtain a urine specimen. Accordingly, no further urine specimen was obtained or sent to the laboratory on Monday 4 Month 2. On this issue, RN F advised HDC:

> "Had I been aware of the antibiotics being prescribed over the weekend, of the urine infection and the lack of a specimen being sent off I would have requested a urine specimen be obtained and sent off urgently for testing on the Monday. It was routine practice for a specimen to be collected following completion of the antibiotics to ensure that the infection had cleared."

96. Dr L does not recall being informed of the UTI or the prescription for antibiotics by Middlepark staff. However, records provided by the accident and urgent medical centre show that, on 4 Month 2 2011, an electronic notification of Mrs B's prescription was sent to Dr L.

4–7 Month 2 2011 — Mrs B's three falls

97. Between 4 and 7 Month 2 2011 Mrs B had three falls. There is no evidence that the family were contacted about any of these incidents.

4 Month 2 2011 — first fall

98. At 4am on 4 Month 2 2011 Mrs B was found by HCA N sleeping on the floor. Mrs B could not recall what had happened, and did not report any pain.

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[32] The surgery records show "Trimethoprim 300mg Tab — 2 stat and then one daily — 7".

[33] The pharmacy records show that the prescription label they printed read "7 Trimethoprim Ta 300mg (TMP) Take TWO tablets AT ONCE, then take ONE tablet DAILY until finished."

[34] The relevant note, in its entirety, records: "[Mrs B] — nasty UTI leucocytes 3+ blood 3+ urgency + frequency. On Triprim now."

[35] RN O's first shift at Middlepark was on 5 Month 1 2011, with further shifts on 18 Month 1 and 2, 3, 8, 9, 10, 13, 14, 15, and 17 Month 2 2011.

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99. HCA N recorded details on an Incident Form. She also recorded a brief note on the Handover Sheet: "[F]ound sleeping on the fall [sic] at 4am unsure what happened." It is unclear whether HCA N was aware of Mrs B's UTI. On 5 Month 2 2011 RN F signed the Incident Form from this fall as "closed".

100. Under "Persons Notified" on the Incident Form, RN F recorded that the manager and doctor were notified of the fall, but that the family were not. RN F cannot recall whether she telephoned Dr L herself, and cannot explain why she did not contact the family.

101. Under "Follow Up Action" on the Incident Form, RN F wrote: "Discussion with family re hospital bed if indeed [Mrs B] fell out of bed. Assess over next 48 hrs and determine need for change of bed." The date for completion of this follow-up was recorded as 7 Month 2 2011. However, RN F did not start a Short Term Plan, write instructions in Mrs B's Care Plan, Care Progress Notes, or the EN/RN Communication Book regarding the planned preventative action or assessment, nor did she contact the family.

102. Also on 4 Month 2 2011, RN F wrote a reminder in the EN/RN Communication Book that "[a]ll residents that are vulnerable must be toileted a minimum of 2 hourly, [and] given fluids a minimum of 2 hourly". The note states that "vulnerable" residents were those in their rooms with diarrhoea, vomiting, or respiratory infection. RN F also wrote in this note that there was a "form" to complete in this regard, which RN F would check.

103. At 8pm on 4 Month 2 2011 Mrs B was administered her second dose of trimethoprim for her UTI.

5 Month 2 2011 — second fall

104. Shortly after midnight on 5 Month 2 2011, Mrs B shouted for help and a neighbouring resident rang the call bell. HCA N found Mrs B on the floor, and Mrs B told her that she had slipped off the bed. HCA N's assessment did not identify any injuries, and Mrs B did not report any pain. The HCAs plugged in a sensor mat[36] and told Mrs B to wait for assistance before getting up on her own.

105. HCA N recorded the above details on an Incident Form, and recorded in Mrs B's Care Progress Notes that Mrs B was still awake at 2am.

106. On 6 Month 2 2011 RN F signed the Incident Form for the second fall as "closed". RN F noted on the Incident Form that a sensor mat was now in place, that she planned to hold a multidisciplinary meeting "at [the] earliest possible time", and that she planned to contact the family by 8 Month 2 2011. RN F also noted on the Incident Form that Mrs B was currently on antibiotics for a UTI, and that a specimen should be obtained on 7 Month 2 2011 to check whether the infection had cleared. RN F did not document this instruction anywhere else. The Incident Form records that the manager and doctor were notified, but not the family.

[36] This suggests that a sensor mat was not already in place in Mrs B's room at this time.

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107. Despite her notes on the Incident Form, RN F advised HDC that she does not think she knew about Mrs B's UTI and antibiotics on 6 Month 2 2011.

108. In respect of the sensor mat that was put in place following this fall, RN F could not explain to HDC why this was necessary when records show that a sensor mat had been placed in Mrs B's room over the Christmas/New Year period. RN F explained that sometimes staff "would remove the sensor mats to give to another resident overnight or if there was someone else more urgent or someone else more acutely unwell", and that this is probably why a new one needed to be installed following Mrs B's fall in the early hours of 5 Month 2 2011.

109. At 8pm on 5 Month 2 2011 Mrs B was administered the third dose of trimethoprim for her UTI. No further doses were administered, despite the prescription being for six days. Further, despite RN F advising HDC that it was normal practice for a urine sample to be obtained following a course of antibiotics (to check whether the infection had cleared), this did not occur.

6 Month 2 2011 — third fall

110. On the morning of 6 Month 2 2011 Mrs B was noted to have poor mobility, confusion, and nausea.

111. HCA Ms P recorded on an Incident Form that, at 11.15am on 6 Month 2 2011, Mrs B had a fall on her way to the toilet. The Incident Form records that Mrs B had bruising to the left side of her face and back, and a small skin tear on her left ear, and that GP Dr R had examined Mrs B. Dr R, who was visiting other patients at the facility when she was called in to assess Mrs B, recorded in Mrs B's Medical Progress Notes that Mrs B appeared confused, and that her confusion had become worse in the previous seven days. Dr R's notes advised that Mrs B did not require an X-ray, and to contact Mrs B's usual GP, Dr L, if required.

112. RN F (who was present during Dr R's assessment of Mrs B) advised HDC that she asked EN J to call Dr L and to contact Mrs B's family, as she wanted to continue with Dr R on her round. EN J did not contact Dr L until the following morning. EN J did not provide HDC with any information about her discussion with RN F, stating that she could not remember the events. RN F also recalls asking staff to obtain a urine specimen because this was her normal procedure when someone who was prone to UTIs had a fall. RN F said she did not document that instruction because she was attending the doctor's round. RN F said that, after giving instructions to EN J, she continued with the doctor's round and "it just completely went out of my head". A urine sample was not obtained.

113. RN F advised HDC that, later in the afternoon of 6 Month 2 2011, she had a handover meeting with RN G because she was going on leave for two days. RN F recalls giving RN G a general handover, whereas RN G recalls that there was no handover. No handover was documented. RN F does not recall specifically discussing Mrs B with RN G at this handover; however, she advised HDC that RN G was already aware of Mrs B's fall that day. RN F told HDC that she would not have told RN G what instructions she had given staff for caring for Mrs B. RN G cannot recall whether she

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was aware of Mrs B's falls at the time, and does not recall being aware of Mrs B's UTI before 7 Month 2 2011.

114. That evening, Mrs C telephoned her mother, who sounded tired and sleepy.

115. On 6 Month 2 2011 a Fluid Balance Chart was again started and continued until 8 Month 2 2011. No urinary output volumes were recorded. The Fluid Balance Chart has gaps of several hours on the afternoon of 7 Month 2 2011, and nothing after 3.30pm on 8 Month 2 2011.

116. RN F signed the Incident Form for the third fall as "closed" on 8 Month 2 2011. RN F was not at work on 8 Month 2 2011, and explained to HDC that she had taken the Incident Form home to work on as it was the only way she could get paperwork completed. Under "Follow Up Action" on the Incident Form, RN F recorded that she planned to contact the family regarding the "falls" by 9 Month 2 2011, and to contact Dr L by 7 Month 2 2011 with a request that he assess Mrs B for infection. RN F also recorded under "Follow Up Action" that an HCA was to obtain a urine specimen, and that she intended to hold the multidisciplinary meeting by 15 Month 2 to discuss Mrs B's falls. The Incident Form also records that the manager and GP had been contacted, but that the family had not.

7 Month 2 2011 — Dr L's review

117. The Handover Sheet for 7 Month 2 2011 records that Mrs B refused her morning medication and appeared very confused.

118. Mrs B's Care Progress Notes record that EN J called Dr L that morning to request a review because of Mrs B's fall the previous day. RN G did not attend the morning handover but met with EN J sometime between 8am and 9.30am. RN G does not recall EN J mentioning Mrs B, and therefore was not aware of EN J's call to Dr L.

119. EN K was working the afternoon shift. She recalls being pleased to see that Mrs B was dressed and in the lounge, because she knew that the week previously Mrs B had been in her room and unwell. EN K's impression was that Mrs B was feeling better, which she relayed to Dr L when he came into Middlepark to review Mrs B. However, EN K recorded in Mrs B's Care Progress Notes that Mrs B was frail, did not want to eat her dinner, only drank 200mls of fluids, and vomited that evening.

120. At 7pm Dr L reviewed Mrs B. He noted in Mrs B's Medical Progress Notes that she was more confused and had lost weight. In the notes Dr L requested referral to a dietitian, routine blood tests, and a check of her urine. Dr L advised HDC that he ordered the tests because he wanted to ensure that Mrs B had not sustained any major injuries from the fall, and to assess any possible underlying causes for the fall. These tests were not carried out.

121. Dr L advised HDC that, at the time of this consultation, he was unaware of the antibiotics obtained from the 24-hour surgery on 3 Month 2 2011. Dr L advised HDC that, even if he had been aware that Mrs B had been taking antibiotics, his "management [of Mrs B] would not have changed". Dr L said that this was because

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Mrs B had been prescribed trimethoprim, which was an appropriate antibiotic for her UTI.

122. EN K does not recall specific details of her conversation with Dr L on 7 Month 2 2011. However, she recorded in the Care Progress Notes that Mrs B was to be reviewed by a dietitian and to have blood tests. It was not recorded in the Care Progress Notes that a urine sample was to be obtained. EN K recalls placing the laboratory request form completed by Dr L in the container at the nurse's station. Middlepark has not been able to locate a copy of the form, so it is unclear what tests were ordered (and, as stated, none were carried out).

Following Dr L's review

123. Mrs B vomited more than once that evening, and was noted to be very unsteady. Her temperature was 36.4°C. It is recorded that it was difficult to give Mrs B fluids as she could not use a straw.

124. At 11.45pm, the night shift HCAs, HCA M[37] and HCA N, received a handover from EN K. EN K advised HDC that she told the night staff to inform EN J in the morning of the need for Mrs B to be reviewed by a dietitian and to have blood tests. HCA M recalls being told that Mrs B had been seen by the GP that evening, and that she was fine and required only a blood test. HCA M also recalls EN K telling her that Mrs B had not been settled that evening and had been ringing the bell frequently to be toileted. HCA N recalls being told that Mrs B had been seen by the doctor, and that Middlepark was "awaiting results".

125. Mrs B's family were not contacted prior to or following Dr L's visit on 7 Month 2 2011. Mrs C tried to call Middlepark that evening, but no one answered the telephone.

8 Month 2 2011 — Mrs B's further falls

1am — fourth fall

126. HCA M recalls that, at 12.30am on 8 Month 2 2011, Mrs B appeared settled. However, at about 1am, HCA N heard a scream and found Mrs B on the floor near her bed. HCA M and HCA N assessed Mrs B and found no injuries. Mrs B told the HCAs that she had slid off the bed.

127. HCA N recorded the details of the fall on an Incident Form. She noted on the form that a sensor mat could not be located for use,[38] and that the HCAs had to check Mrs B every 15 minutes. HCA N also recorded on the form that, each time the HCAs checked her, they would find Mrs B half out of bed.

128. HCA M advised HDC that, during this time, Mrs B continued to ask to be toileted but was told to use her pad. When Mrs B continued to attempt to self-mobilise to use the toilet, the HCAs placed the urine bowl in her bed. HCA M advised HDC that, by this stage, Mrs B's urine was very dark and contaminated with faeces. HCA M recalls that

[37] HCA M was the duty leader for the night shift on 7, 8 and 9 Month 2 2011, and was responsible for making decisions and contacting the on-call RN.

[38] This suggests that the sensor mat installed in Mrs B's room following her fall on 5 Month 2 2011 was no longer in place.

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the urine was tested with a dipstick, and the result indicated a possible infection, but because the sample was contaminated it was discarded. HCA M told HDC that Mrs B was given fluids and 20ml of Panadol, after which she settled.

129. The Incident Form was not signed off by RN F or RN G, and did not record whether the manager, doctor, and/or family had been notified. HCA N recalls notifying the morning RN about the incident, "as usual".

4.30am — moved to wheelchair

130. HCA M advised HDC that, at approximately 4.30am, Mrs B started screaming, waking other residents. HCA N was the first to arrive and found Mrs B attempting to get out of bed and asking to be toileted. HCA N requested assistance from HCA M, but before she arrived Mrs B almost rolled out of bed. HCA N advised HDC that she reached across to prevent Mrs B from falling and, in doing so, injured her own back.

131. HCA M advised HDC that, once she arrived in Mrs B's room, she and HCA N were assisting Mrs B to the toilet when she slipped to the floor. HCA M advised HDC that Mrs B appeared distressed and was crying out that she wanted to go to the toilet. After toileting Mrs B, the HCAs placed her in a wheelchair and took her to the reception area, where they could observe her more closely while they continued with their other duties. HCA M advised HDC that Mrs B kept trying to slide out of the wheelchair. The HCAs reassured her, and she appeared to settle. HCA N said that they monitored Mrs B closely overnight as she was very restless. During the shift, fluids were provided via syringe. HCA N's impression was that all staff were aware of Mrs B's condition.

6am — fifth fall

132. At 6am Mrs B told staff that she was slipping out of the wheelchair. The HCAs left Mrs B to respond to a call bell and, when they returned, found Mrs B lying on the floor. Mrs B was checked for injuries and none were found. Mrs B was lifted into a recliner chair, and one HCA stayed with her for one-on-one supervision. HCA N filled out another Incident Form documenting the most recent fall. Again, this Incident Form was not signed off by RN F or RN G, and did not record whether the manager, doctor, or family had been notified. RN G was on call overnight but was not contacted.

8 Month 2 2011 — morning handover

133. At approximately 7am on 8 Month 2 2011 the night staff handed over to EN J. According to HCA M, EN J was informed of the night's events and that Mrs B had been seen by the GP the previous evening. HCA M advised HDC that she told EN J that she suspected Mrs B had a UTI, but that she had not been able to obtain a clean urine specimen. HCA M recalls asking EN J to obtain a fresh urine sample for testing. RN G advised HDC that EN J did not report any concerns about Mrs B to her that morning. EN J did not provide HDC with any information about this handover, stating that she could not remember the events.

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134. The comments recorded in the Handover Sheet state that Mrs B had been unsettled for the whole night. During the morning shift, Mrs B was noted to be having trouble standing upright and swallowing fluids. She was described as being very sleepy.

135. RN G recalls speaking to EN J that morning and following up on concerns about several other residents. RN G said that she later asked EN J why she had not reported Mrs B's decline to her at this time, and that EN J said that, on the morning of 8 Month 2 2011, Mrs B "seemed alright".

Palliative care

136. Later that day, RN G recalls EN J telling her that Mrs B was for palliative care (initially RN G advised that she was told this in the morning, however in response to my provisional opinion, RN G's representative said that RN G was told this before she reviewed Mrs B at 5pm, and later said that it happened at the time of the shift handover). RN G said that she did not check Mrs B's file to substantiate this, but would have expected there to have been a Short Term Plan, GP notes, and a discussion with the family documented if Mrs B had indeed been assessed for palliative care. Dr L confirmed to HDC that palliative care decisions would normally include medical assessments, and patient and family involvement. RN G said that she had not been surprised to hear that Mrs B was for palliative care, because she had been unwell for so long.

8 Month 2 2011 — afternoon handover

137. At 3.30pm RN G walked past Mrs B's door and looked in at her. RN G said that Mrs B was confused, pale, restless, and "not ok", but did not appear to be in pain. RN G advised HDC that she had last seen Mrs B a few days earlier, and her appearance had changed. RN G said that this was when she first became aware that Mrs B was acutely unwell.

138. RN G advised HDC that she had a handover meeting with RN O (who was on duty that afternoon and evening) prior to his shift starting. RN G said that she told RN O that Mrs B was looking unwell, that they might be looking at a hospital admission, and that he would need to contact Mrs B's family. RN G advised HDC that she did not direct RN O to send Mrs B to hospital, as she expected him to do his own full assessment of Mrs B before deciding how to proceed.

139. RN G advised HDC that she cannot recall whether she told RN O that Mrs B was for palliative care, but thinks that she may have. In response to my provisional opinion RN G's representative advised that "[RN G] regrets passing on [EN J's] comment without clarifying it through the resident's file notes. She probably would have done so had she remained on duty".

140. Following this handover meeting, RN G recalls taking Mrs B's observations, talking to RN O again, and writing in Mrs B's Care Progress Notes. At 5pm, RN G recorded in Mrs B's Care Progress Notes:

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> "Confused and unwell today. BP 80/60 pulse 96 Temp 36.4. Continue to provide comfort cares and encourage with fluids."[39]

141. In response to my provisional opinion RN G's representative advised that, "[h]ad [RN G] not been handing over to an RN…[she] would have finished her observations of [Mrs B] and sought hospital admission". However, the representative then went on to reiterate that "[i]t would not have been appropriate for [RN G] to instruct [RN O] to seek [Mrs B's] admission to hospital because she had not undertaken a full nursing assessment." RN G's representative explained that, at the time of handover "… [RN G] needed to finish her shift by doing things such as following up on documentation as is usual".

RN O

142. RN O's recollection of the handover on this shift differs from RN G's account. He recalls RN G telling him that Mrs B was a palliative care patient for comfort cares, that she was receiving analgesics for pain, and that her family was aware of her condition. RN O also recalls RN G telling him that Mrs B was confused and restless because of a UTI, that she had been yelling and shouting, and that she had been like that for a few days. RN O recalls asking RN G if he was allowed to transfer Mrs B to the hospital if she deteriorated, and was told to telephone the on-call RN about this. RN O also advised HDC that RN G did not ask him to perform a nursing assessment of Mrs B; however, he performed one anyway because of Mrs B's condition. Further, RN O recalls there being only one conversation with RN G on 8 Month 2 2011, not two.

143. RN G denies telling RN O that Mrs B's family were aware of her condition as, at that time, she had just learned of Mrs B's status herself. RN G also denies telling RN O about Mrs B yelling and shouting, and said that if she had been told about this she would have investigated. She also denies telling RN O about the UTI. In response to my provisional opinion, RN G's representative also stated that RN G did ask RN O to perform a nursing assessment, and referred to the fact that RN O did do so as proof that RN G had requested this. RN G's representative said that, in the absence of a request such as RN G's, RN O's assessment "…would not be standard practice in the case of a patient about whom no warnings had been given".

RN G and RN H

144. Over the weekend, RN H was on call between 5pm Friday afternoon and 7am Monday morning (even when she was not on shift). It was usual practice for a senior staff member to telephone RN H on Friday afternoon to let her know of any residents who were unwell, or of any changes that had occurred during the week. RN G telephoned RN H in the afternoon of 8 Month 2 2011 and informed her of Mrs B's condition. RN H advised HDC that RN G informed her that Mrs B had "gone downhill" and was for "palliative cares".

[39] RN O told HDC that he does not know who made these progress notes.

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8 Month 2 2011 — afternoon and evening care

RN O

145. RN O recalls that, following the handover from RN G, he visited Mrs B to introduce himself and "see how she was". He recalls that she was in bed with no signs of pain or agitation, but appeared confused, which was consistent with the information provided at handover.

146. RN O advised HDC that he then read Mrs B's notes, and that "the absence of palliative/comfort care in the [care] plan made me treat [Mrs B] as an elderly client with a UTI, even though I was handed over [Mrs B] as a comfort care client".

147. RN O advised HDC that, having read Mrs B's notes, he asked staff to keep Mrs B comfortable, change her position regularly, encourage fluid intake, and to let him know of any changes in her condition.

148. RN O recalls that, at 8pm, Mrs B refused to take her pain medication, but that at 10pm the medication was reoffered and accepted.

149. At 9pm, RN O noted in Mrs B's Care Progress Notes that she was very weak and not eating or drinking well. He also recorded that her blood pressure at 8pm was 90/60, her heart rate 84 beats per minute, and her temperature 36.5°C. Later in the evening it was noted that Mrs B was still weak and unwell, not eating or drinking much, was confused, and required two-hourly turns, and that fluids were to be encouraged.

Mrs A

150. At 9.30pm RN O telephoned Mrs A to let her know about Mrs B's condition. Mrs A advised HDC that, when he rang, RN O described it as a "follow up call" to inform her that Mrs B was still not eating and drinking, and remained confused. Mrs A told RN O that she did not know what he was referring to. Mrs A advised HDC that all she knew at that stage was that her mother had a UTI (as she had delivered her medication to Middlepark on 3 Month 2). Mrs A said that she had not been informed of any further deterioration of her mother's health since then.

151. Mrs A recalls that, during the conversation, RN O told her that they were keeping Mrs B comfortable, and that there was no need to come into Middlepark. Following the call, Mrs A contacted her sister, Mrs D, to discuss what she had been told.

152. Mrs D then attempted to call Middlepark, but no one answered the telephone. Mrs A and Mrs D decided to attend Middlepark to obtain further information about their mother. Mrs A advised HDC that it took them at least 15 minutes to gain access to Middlepark once they arrived, as they were unable to attract the attention of staff passing the entrance, and there continued to be no answer when they telephoned. Mrs A advised HDC that a staff member eventually saw them waving their arms and calling out.

153. Oceania was unable to advise HDC why the family's telephone calls were not answered.

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154. Mrs A advised HDC that, once they gained access to Middlepark, they met two staff sitting at a table in the nurses' room, and also spoke to an RN. Mrs A went on to advise that:

> "[a]fter a very brief conversation of attempting to ascertain the situation with mum we headed off down the corridor. On getting closer to mum's room we could hear loud groaning, moaning and someone calling out. On entering mum's room [my sister] and I both took one look at mum and burst into tears — we were shocked and so horrified with what we saw — how ill our mother was. '… what have they done to you Mum …?' was asked to mum in disbelief and shock.
>
> Mum was bruised on the face, in great pain, and looking seriously ill. We attempted to try and comfort mum and at the same time question the staff 'what the hell is going on here …?' Mum was requesting to go to the toilet."

155. Mrs A advised HDC that the RN told them that their mother was on palliative care. Mrs A and Mrs D questioned who had authorised this, as they had not been consulted. Mrs A advised HDC that, when they questioned why Mrs B was not in hospital, the RN explained that Mrs B was on "comfort cares" and that, because of this, there was nothing that the hospital would do.

156. Mrs D advised HDC that by this time her mother was barely able to communicate. Mrs D recalls the "nurse" using a harness belt to assist her mother to the toilet, which Mrs D considered added to her mother's distress. Mrs D also recalls that, when her mother asked to go to the toilet again, the "nurse" said they had just taken her, and it was her UTI making her want to go all the time. When the family insisted that Mrs B be allowed to go to the toilet again, the "nurse" left "in a huff".

157. With help from an HCA, Mrs D and Mrs A assisted Mrs B to the toilet, where they noticed that she passed blood in her urine. Mrs B was returned to bed, and the staff member left. A few minutes later, Mrs B again asked to go to the toilet. Mrs D and Mrs A again assisted their mother to the toilet, where more blood was passed in her urine. Mrs D and Mrs A then spoke to the HCA and to RN O, and insisted that their mother be transferred to hospital. RN O advised them that he would need to get approval.

158. RN O advised HDC that he recalls that Mrs B was "confused and restless" but had been fairly comfortable prior to her family arriving. He said that after he had provided her pain relief she appeared to be more comfortable, alert, and talking to her family. However, in response to my provisional opinion Mrs D advised that, at that time, her mother was "crying out in pain" and was in extreme discomfort.

RN O's telephone call with RN H

159. RN O advised HDC that he called RN H twice about Mrs B's condition, and to ask about transferring her to hospital. RN O recalls that RN H told him not to transfer Mrs B to hospital, and that she would contact the family the next day and arrange for Mrs B to be transferred to hospital if need be.

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160. RN H recalls that she received one call from RN O, at around 10.30pm, telling her that Mrs B was very unwell and that her family wanted to send her to hospital. RN H said she told RN O that they could not stop the family taking Mrs B to hospital if they wanted to, but that the hospital would not actively treat Mrs B given that she was dying and was for "comfort cares".

161. RN H advised HDC that, on this call, she asked whether Mrs B was in pain, and RN O told her that he had administered Mrs B's normal night-time medications, and that Mrs B was comfortable. RN H recalls telling RN O that she would be at work the next morning, would talk to Mrs B's family then, and would organise a GP visit to commence stronger pain relief.

162. RN H advised HDC:

> "I thought [Mrs B] could be kept just as comfortable at Middlepark as she would have been at the hospital and it would be nicer and peaceful for her to pass away at her home (Middlepark was her home). If I had not been misinformed by [RN G] [regarding palliative care], I would not have hesitated to send [Mrs B] to hospital when [RN O] had rang me up at 1030 pm on Friday night."

163. RN O advised HDC that he treated Mrs B's family with respect, listened to all their concerns, and answered their questions "to the best of [his] knowledge as a casual RN" during their presence on his shift that night. He said that he reassured the family that staff would keep observing Mrs B, and would inform him or RN H if there were any changes in Mrs B's condition. He said that after his discussions with the family they went back to Mrs B's room and stayed with her. At 11pm, RN O finished his shift. He said that he asked the HCAs to contact RN H if they noticed any deterioration in Mrs B's condition, and he recorded that instruction in Mrs B's Care Progress Notes.

Night shift

164. At 11.45pm, HCAs M and N commenced the night shift. HCA M said that when she arrived she could hear someone screaming, and she went to find out who it was.

165. HCA M advised HDC that she found Mrs B in bed, with her daughter by the bed and the door to her room open. HCA M said that Mrs B's daughter asked that her mother be transferred to hospital. HCA M explained that she had just arrived and would need to receive handover from the earlier shift's staff first.

166. HCA M recalls that, at handover, she and HCA N were told by the previous shift HCA that Mrs B was not well, had not been settled during the evening shift, and that she was for palliative and comfort cares. The Handover Sheet stated that Mrs B was very weak, that RN H was aware that the family would like Mrs B to go to hospital, and that a close eye should be kept on Mrs B overnight.

167. Shortly after handover, HCA M returned to Mrs B's room and informed Mrs B's daughter that they had been instructed not to send Mrs B to hospital, but to observe and monitor her.

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9 Month 2 2011 — Mrs B's hospital admission

Decision to send Mrs B to hospital

168. HCA M advised HDC that, at around 12.30am on 9 Month 2 2011, she and HCA N again went to check on Mrs B. Mrs B had not settled, appeared to be in pain, was holding her lower abdomen, and appeared confused. Mrs D, who was still present, again requested that her mother be transferred to hospital. HCAs M and N explained that the instructions were not to send her to hospital. The HCAs checked the medication charts to see whether Mrs B had been given or charted any pain relief, but nothing additional to her normal medications had been charted.

169. Mrs D recalls that one of the HCAs provided Mrs B with a cup of thick orange liquid, which she said contained pain relief. When her mother had difficulty swallowing the liquid, Mrs D asked for a syringe. While rearranging the furniture in Mrs B's room that night, Mrs D found a sensor mat screwed up behind a chair.

170. HCA N advised HDC that, at some point in the early hours of the morning, she went into Mrs B's room again. HCAs N and M both recall that, at that time, Mrs B was screaming and holding her stomach. HCA N recalls observing Mrs B for approximately five minutes while she spoke to Mrs D, and that, during that time, Mrs B was in pain and very uncomfortable. HCA N advised HDC that she asked whether Mrs D still wanted her mother sent to hospital, which Mrs D confirmed. HCA N advised HDC that she then called RN H to organise Mrs B's admission to hospital.

171. RN H recalls receiving a telephone call from one of the HCAs at around 3.00am to say that Mrs B's daughter was very upset and wanted her mother to be taken to hospital. RN H recalls advising the HCA to call an ambulance to take Mrs B to hospital. RN H advised HDC that she did not think that it was necessary for her to go into Middlepark at that time because, in the time it would have taken her to get to Middlepark, Mrs B would have already been taken to hospital. HCA N called the ambulance and recorded the following in Mrs B's Care Progress Notes:

> "Ambulance officers came in at 0300hrs and asked to see the patient's notes. Officer stated that she didn't understand why the resident was kept here for so long as she has been unwell and was not send [sic] to hospital during the day. Officer stated RN on duty should have send [sic] resident to hospital. [Mrs B] was accompanied to hospital by [her daughter]."

Admission to hospital

172. At 3.24am, Mrs B arrived at the hospital's Emergency Department (ED), where she was catheterised and given morphine. An ED Assessment and Progress Note (completed at 8.42am) sets out the following:

> "Diagnosed as UTI by GP approx 1 week ago
>
> Has got worse over time in the rest home, according to daughter
>
> Reduced mobility, reduced appetite, abdominal pain, falls
>
> According to daughter, because pt has not been eating, then antibiotics for UTI have been withheld.

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Presents to ED with daughter c/o abdominal pain, and is likely delirious secondary to UTI …"

173. A urine test taken in the Emergency Department at 6.10am showed resistance to a number of antibiotics including trimethoprim, the antibiotic that had been prescribed and (at least partially) administered at Middlepark. As no urine sample had been obtained earlier that week to check that Mrs B's UTI had cleared after treatment with trimethoprim, the fact that Mrs B was resistant had not been picked up by Middlepark staff.

174. At 8.46am on 9 Month 2 2011, Mrs B was admitted to a medical ward at the hospital. On 18 Month 2 2011, Mrs B passed away at the hospital, owing to urosepsis caused by her UTI.

Meeting with family following Mrs B's death

175. Following their mother's death, Mrs B's daughters requested a meeting with Middlepark staff, as they wished to understand what had happened during Mrs B's last week at Middlepark. Members of Mrs B's family, with the support of a health and disability advocate, met with RNs G and F.

176. At the meeting, Mrs B's family were provided with an investigation report, prepared by Middlepark, on the care their mother received between 3 and 9 Month 2 2011. The investigation report consisted of a brief outline of events from the perspective of several different members of staff. The report contained no findings or conclusions. At the meeting, RNs G and F apologised to the family for the apparent inadequacies and failings that led to their mother's death.

177. In respect of the meeting, Mrs A recalls the following:

> "At this meeting we asked if blood tests were taken or further urine sample was done during the week to ascertain and diagnose Mums [sic] condition further or if indeed the antibiotics (that I had obtained on the Sunday) had all been administered to Mum. Neither [RN G] nor [RN F] could answer about the medication or advise us if in fact the medication had been given at all. We also requested for them to check the actual medication (tablets). [RN F] and [RN G] checked for this particular medication record though it could not be located in Mums [sic] file …The medication itself had since been returned to the providing Pharmacy. [RN F] did though advise us that a urine sample that had been requested earlier in the week (Prior to [Dr L's] request for a further sample) had not been done."

178. Mrs A advised HDC that following Mrs B's death, the family also met with Dr L, who told them that he was aware of only one fall during Mrs B's last week at Middlepark (on 6 Month 2 2011), and had been unaware that she had been diagnosed with a UTI and provided with antibiotics on 3 Month 2 2011. Dr L further informed HDC that he was concerned that management decisions were made regarding palliative care without his, or other, medical input.

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Changes made following Mrs B's death

Oceania

179. Oceania advised HDC that it has made a number of changes to its practices following Mrs B's death, summarised as follows:

- Oceania now has an emergency response plan for its facilities in Christchurch, including emergency telephone links.
- Oceania has "consolidated [its] documentation to ensure that all information is communicated by the Registered Nurse/Senior Healthcare Assistant at handover".
- The nurse's diary has now been replaced with a shift handover booklet, which is reviewed by all staff at handover.
- In January 2012, the General Manager and Operations Manager roles were restructured, and the business, clinical, and quality roles were divided to ensure there is "more clinical oversight and governance".
- Oceania has employed three Clinical and Quality Managers across the country to "oversee and ensure all policies and processes are adhered to by all staff".
- The Clinical and Quality Manager for the South Island is based in Christchurch, enabling a "rapid response" in that region.
- Facility "health checks" are conducted four monthly to "ensure we maintain a high standard of care to all our residents".
- Middlepark now has good staff retention and minimal agency use.
- Oceania has implemented "a new and comprehensive orientation programme for care staff. Middlepark's annual training programme is extensive to ensure all staff are trained in all of clinical and care related topics".

Middlepark

180. RN G advised HDC that Middlepark has made a number of changes to its practices following Mrs B's death, summarised as follows:

- An additional 231 hours of RN support time were provided for the Clinical Leader between Month 2 and Month 4 2011, and this increased support is ongoing.
- When the Clinical Leader or Facility Manager is away, an additional morning RN is rostered to provide cover.
- The weekend RN position was extended to become a three day per week position, in order to facilitate a complete handover from weekend staff to weekday staff on a Monday. This position has since been extended again, and is now a five day per week position, including the weekend.
- The senior HCA rostered on a night shift must be someone who holds RN status in a country other than New Zealand. This is to ensure that there is always an experienced staff member present who is able to recognise the difference between long-term deterioration and an acute illness. This will help ensure that correct

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procedure is followed regarding notifying the on-call RN and documenting this appropriately.

- EN J was immediately provided with extra supervision.
- The way in which the Clinical Leader (or her substitute) reviews the various written records has changed to "ensure that the verbal handover from the Enrolled Nurse [is] well supported by a myriad of communication methods".
- Middlepark has provided additional staff training on palliative care, and on documentation and communication. Staff meetings were held to discuss the incident, identify what went wrong, and consider how to prevent a similar event occurring again.

RN F

181. RN F advised HDC that she has made a number of changes to her own practice following Mrs B's death, summarised as follows:

- RN F now ensures that all changes in a resident's condition, whether slight or significant, are documented on the Short Term Plan.
- She now ensures that every discussion she has with staff, or external health professionals, is documented.
- She has continued professional supervision, which she has now had for the last four years.
- She has examined her practice and considered what she would do to change outcomes in the future.
- She now follows up with families herself rather than delegating this task to others.

RN G

182. RN G advised HDC that she has made a number of changes to her own practice following Mrs B's death, quoted as follows:

> "Personally, as a registered nurse I ensure that I do not rely on verbal handovers. I take extra time now to review all methods of communication and always do a walk around in the mornings regardless of whether I'm practicing [sic] as a nurse or a manager. This is now part of my everyday routine. I continue to handover to Registered Nurses if I have concerns about residents and I document my observations in resident's notes. I do not work as a Registered Nurse unless that is the only role I am to hold at that time. I still use agency staff as a matter of necessity but actively work towards employing regular staff into vacant shifts in order to ensure a consistent use of systems."

RN H

183. RN H advised HDC of her regret about not speaking to Mrs B's family at 3am on 9 Month 2 2011, and also advised of changes to her own practice since Mrs B's death, quoted as follows:

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> "This incident has truly taught me the importance of effective communication (both with family members and staff) and accurate documentation in nursing practice. … Since this incident I have been very thorough and concise in my documentation and communication with [colleagues] as well as patients and their family members."

Response to provisional opinion

184. In the course of my investigation, the parties were provided with relevant sections of my provisional opinion for comment. These comments have been incorporated into the above facts, where appropriate. The following additional comments were also provided.

Mrs B's daughters

185. Overall Mrs B's daughters advised that they found the facts gathered of my provisional opinion "profoundly disturbing". Mrs D summarised their views as follows:

> "…we are all deeply shattered. Not only at the degree of inappropriate care but also what we consider was at times, a blatant lack of care, dignity, respect and compassion over an extended period of time and by differing persons. All of this culminated in mum passing away in a manner she should never ever have had to experience. No words will ever be able to convey the distress to us of seeing, hearing, reading and knowing mum did go through what she did."

Oceania

186. Oceania advised that, since the events in question, "many positive changes have occurred at Oceania and Middlepark in order to improve resident care". With reference to certification audits completed in August 2011 and March 2012 (where four and two partial attainments were awarded respectively), Oceania stated that:

> "…significant quality improvements have occurred following the receipt of the complaint [in 2011] and Oceania Care Company is confident that systems and processes have been changed and embedded into culture in order to meet the Code of Rights for individual residents."

187. Oceania went on to accept my provisional opinion, however stated that the effects of the earthquake had not been adequately taken into account. In particular, Oceania emphasised that hospital level residents had been transferred to Middlepark following the earthquake, and stated that "[t]his and the personal stressors on the staff at Middlepark contributed in some ways to the care provision deficits".

RN F

188. RN F's representative submitted that, "[RN F] is aware of the failings that occurred over this time and feels considerable remorse for any distress this caused [Mrs B] and her family." However RN F's representative submitted that, in the context of the

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earthquake, it is "unfair and unreasonable" for RN F to be found in breach of the Code.

RN G

189. RN G's representative submitted that "[RN G] sincerely regrets the death of [Mrs B] from urosepsis which followed a urinary track [sic] infection she first suffered while at Middlepark".

RN H

190. RN H provided a written apology for forwarding to Mrs B's family, and advised that:

> "Since this incident I have changed my practice immensely. I try my very best to be very precise and accurate at my documentation. I now never hesitate to communicate with family members of my patients. I also ensure they are kept updated and informed. I believe that because of this incident I communicate better with all staff, patients and their family members."

Relevant standards

Competencies for registered nurses[40]

191. "**Domain two: management of nursing care**

Competency 2.2
Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings. …

Competency 2.3
Ensures documentation is accurate and maintains confidentiality of information.

Indicator: Maintains clear, concise, timely, accurate and current health consumer records within a legal and ethical framework. …

Competency 2.6
Evaluates health consumer's progress toward expected outcomes in partnership with health consumers. …

Indicator: Evaluates the effectiveness of the health consumer's response to prescribed treatments, interventions and health education in collaboration with the health consumer and other health care team members. (Beginning registered nurses would seek guidance and advice from experienced registered nurses). …

Competencies for nurses involved in management:

…

[40] This document was first published by the Nursing Council of New Zealand in December 2007. It can be found at www.nursingcouncil.org.nz.

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Competency Promotes a quality practice environment that supports nurses' abilities to provide safe, effective and ethical nursing practice. …

Domain three: interpersonal relationships

…

Competency 3.3
Communicates effectively with health consumers and members of the health care team. …

Domain four: interprofessional healthcare and quality improvement

Competency 4.1
Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care. …

Indicator: Maintains and documents information necessary for continuity of care and recovery. …"

New Zealand Standard Health and Disability Services (Core) Standards NZS 8134.1:2008

192. "**Standard 2.2** **The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.**

…

Standard 2.4 **All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.** …

Criteria …

2.4.3: The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

2.4.4: Adverse, unplanned, and untoward events are addressed in an open manner through an open disclosure policy. …

Standard 2.9 **Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.** …

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Criteria …

2.9.9: All records are legible and the name and designation of the service provider is identifiable.

2.9.10: All records pertaining to individual consumer service delivery are integrated."

Opinion: Preliminary comments

193. I accept that the ongoing effects of the earthquake on 22 February 2011 provided considerable challenges to both providers and consumers in the weeks and months that followed the event. At Middlepark, the earthquake resulted in stresses and pressures on both systems and individual staff. However, I do not accept that these difficult circumstances justify the suboptimal care that Mrs B received at Middlepark in 2011. In my view, that care was the result of both systemic and individual failures that were not directly linked to the earthquake and its effects.

194. My main concerns are: the poor communication between healthcare staff (particularly regarding Mrs B receiving palliative care), and between staff and Mrs B's family; inadequate documentation of the care provided to Mrs B; and the delayed and inadequate treatment of Mrs B's UTI. Overall, I am of the view that Mrs B's condition was not appropriately responded to, resulting in her experiencing unnecessary and preventable distress. I accept the advice of my expert advisor, Ms Glenda Brady:

> "The standard of care deteriorated when this communication [regarding Mrs B's care and treatment] broke down — family not notified of change in health status, instructions from the Doctors not passed on or documented and staff not given clear instructions as to the care that was expected of them. I believe that during this period there was a moderate departure from acceptable standards."

195. The earthquake would have had an impact on Middlepark staff (particularly given the need for agency staff and the addition of hospital-level residents). However, as noted by Ms Brady, those circumstances meant that it was "even more important that documentation and communication between staff and shifts be of paramount importance". I agree with this view.

196. Overall, the standard of care Mrs B received at Middlepark in Month 1 and Month 2 2011 was suboptimal, and demonstrates the importance of systems and individuals working together to ensure that consumers receive seamless and safe services. I do not consider that this occurred in Mrs B's case.

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Opinion: Breach — Oceania Care Company Limited (trading as Middlepark Rest Home and Village)

Documentation

197. I am of the view that Mrs B's care and treatment in Month 1 and Month 2 2011 was inadequately documented. I consider that Oceania's failure to ensure that its documentation policies were appropriately implemented and followed at Middlepark created a fragmented documentation system that caused staff to have an incomplete and, consequently, inaccurate picture of Mrs B's clinical condition.

Care Progress Notes

198. Oceania's Progress Notes Policy requires all staff to fill in a patient's Care Progress Notes at the end of each shift, and RNs to read the last RN entry in a patient's Care Progress Notes when they make a new entry.

199. Despite that policy, RN G provided HDC with inconsistent accounts of the frequency with which HCAs were expected to fill in a patient's Care Progress Notes. RN G initially said that they should be recorded at least once every 24 hours, which was also RN F's understanding of the policy. However, RN G later clarified that Care Progress Notes should be recorded at least for each eight-hour shift.

200. I am of the view that Oceania's Progress Notes Policy clearly requires a patient's Care Progress Notes to be filled in at each eight-hour shift. I am concerned that Middlepark's nursing management staff did not understand or enforce this requirement.

201. Mrs B's Care Progress Notes were not completed in accordance with the policy during Month 1 and Month 2 2011. No Care Progress Notes were recorded for Mrs B between 15 and 16 Month 1, and 26 Month 1 and 2 Month 2 2011. These gaps are particularly concerning given Mrs B's variable health, and general decline, over this period.

202. Even when Care Progress Notes were filled in for each eight-hour shift, the information recorded was frequently deficient. Oceania's Progress Notes Policy requires staff to document any changes in condition, any adverse event, and any additional medication commenced or given. RN G said that RNs were expected to check the Care Progress Notes and follow up on these issues.

203. I note that the Care Progress Notes on 3 and 8 Month 2 2011 do not record that urine samples had been obtained but discarded, and do not record that further samples were necessary. In addition, the extensive Care Progress Notes of 8 Month 2 2011 do not explicitly acknowledge that Mrs B was suffering from a UTI (despite referring to her symptoms). Again, I am of the view that these deficiencies are particularly concerning given Mrs B's deteriorating condition.

204. These deficiencies meant that RNs were not alerted to issues that required their action. While I accept that various aspects of Mrs B's condition were recorded in other documentation, I agree with the following comment made by Ms Brady:

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> "Handover sheets and communication books are not a record of care — all patient information, interventions, and changes in medication should be documented in the Progress Notes. Important information can be lost if not recorded and this is the case here — some staff not aware of an antibiotic being commenced, request for a urine sample not passed on, information not given to [Mrs B's] GP about the commencement of an antibiotic for suspected Urinary Tract Infection (UTI), blood tests not organised in a timely fashion."

205. Overall, I am of the view that both management and staff at Middlepark did not understand what was required of them in documenting a patient's Care Progress Notes. It is clear that relevant information was often recorded in other documents. As a result, Mrs B's Care Progress Notes were incomplete. This led to oversights in clinical care, a lack of continuity of care, and, in Mrs B's case, a failure to monitor and evaluate.

Handover Sheets

206. I do not consider that Mrs B's Handover Sheets for the relevant time period adequately or consistently flagged the nature of Mrs B's condition to staff coming on duty. In particular, not all of Mrs B's falls were noted on Handover Sheets, nor was the fact that she was suffering from a UTI or that further urine sampling was necessary.

Other documentation

207. I note the following further insufficiencies in the documentation of Mrs B's condition:

- Entries in the EN/RN Communication Book lacked detail and specificity. For example, the entry on 24 Month 1 2011 informed staff that a Food Intake Chart had been commenced for Mrs B, but did not explain the context for this or the concerns about Mrs B's decline.
- Mrs B's temperature, pulse, and blood pressure were not recorded in Month 1 and Month 2 2011 on her Observation Chart, as required by her Care Plan.
- On two occasions a Fluid Balance Chart was kept for Mrs B.[41] While both Fluid Balance Charts recorded Mrs B's fluid input, neither recorded her output, and therefore do not provide an accurate picture of Mrs B's hydration levels.
- A Food Intake Chart was kept for Mrs B between 21 and 27 Month 1 2011. However, it does not record every meal, and therefore provides an incomplete picture of Mrs B's nutritional intake.
- Mrs B's bowel movements between 25 Month 1 and 1 Month 2 2011 were not recorded on her Bowel Chart. RN F advised HDC that she was aware that staff were not consistently filling out bowel charts at the time, and was "constantly" following this up with HCAs. While this issue was noted generally in the EN/RN Communication Book on 6 Month 2 2011, that communication would not have been read by HCAs.

[41] Between 20 and 22 Month 1; and between 6 and 8 Month 2 2011.

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208. I am of the view that much of the confusion about, and consequent inadequacies in, documentation were the result of the fragmented document system that had developed at Middlepark. Standards New Zealand Health and Disability Services (Core) Standards[42] require organisations to ensure that consumer information is "uniquely identifiable, accurately recorded, current, confidential, and accessible when required". I consider that Middlepark's documentation system did not meet this standard, particularly in its failure to have an integrated clinical record for Mrs B that was comprehensive and easily available to staff. These failures led to serious consequences for Mrs B's continuity of care, as clinical and care staff did not have a comprehensive understanding of Mrs B's clinical status or needs.

Communication between healthcare staff

209. Staff at Middlepark (including management staff) did not adequately communicate Mrs B's declining health condition to one another, or document those communications.

210. I accept Ms Brady's advice that the lack of communication amongst staff at Middlepark was a serious departure from expected standards.

Discussions at handover

211. Discussions at shift handover appear to have lacked structure, and have occurred on an ad-hoc basis, resulting in important information regarding Mrs B's care and treatment not being passed on. In this regard, I note the following:

- RN O advised HDC that he recalls being made aware that Mrs B had a UTI when he came on duty on 3 Month 2 2011, but does not recall being asked to obtain a urine specimen. RN F advised HDC that she was not made aware of Mrs B's UTI or the prescription for antibiotics, and Dr L does not recall being advised by Middlepark staff of Mrs B's UTI at this stage.
- RN F advised HDC that she asked staff to obtain a urine specimen from Mrs B on 6 Month 2 2011; however, no sample was ever obtained. It also seems that Mrs B's condition was not discussed between RNs F and G that day, despite the fact that RN F was about to go on leave for two days.
- EN J appears to have arranged Dr L's assessment of Mrs B on 7 Month 2 2011, but does not appear to have advised RN G of this, or of the reason why it was considered necessary. I also note that Middlepark staff do not appear to have advised Dr L, in the context of his assessment, that Mrs B had a UTI and was taking antibiotics. Ms Brady was specifically critical of this omission.
- HCA M advised HDC that at handover on 8 Month 2 2011 she informed EN J that she suspected Mrs B had a UTI, and recommended that a urine specimen be obtained. This did not occur. RN G told HDC that this information was never passed to her by EN J.
- Handover between RNs G and O on 8 Month 2 2011 appears to have been based on the incorrect information passed to RN G by EN J that Mrs B was for palliative

[42] NZS 8134.1:2008, Standard 2.9.

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care. It is unclear whether RN G informed RN O at this handover that Mrs B was suffering from a UTI.

Discussions regarding palliative care

212. RN G advised HDC that, on 8 Month 2 2011, EN J advised her that Mrs B was for palliative care. It is unclear whether EN J did in fact state this and, if so, on what basis. In any event, it was inappropriate for RN G to relay that information to other staff members without first seeking clarification by, at the very least, checking Mrs B's clinical records (which would have revealed that this information was incorrect).

213. RN O advised HDC that he did check Mrs B's notes and, in the absence of evidence that palliative care was appropriate, did not treat her as a palliative care patient. However, it is clear that the view that Mrs B was for palliative care delayed her hospital admission. On the issue of palliative care, Ms Brady advised me that:

> "[w]ith regards to the staff assuming that [Mrs B] was for Palliative Care — again a lack of communication — this should not be assumed — it should be a formal discussion with nursing staff, medical staff and family and interventions and ongoing cares documented".

Communication with family

214. Following the multidisciplinary meeting on 13 January 2011, Mrs B's daughters understood that they would be contacted if their mother's health deteriorated further. However, Mrs B's daughters do not recall Middlepark contacting them about, or informing them of:

- Mrs B's stomach bug in mid-Month 1 2011 (which caused vomiting and diarrhoea, and resulted in her being placed in isolation);
- Mrs B's falls on 4, 5, 6 and 8 Month 2 2011;
- Mrs B's medical assessment by Dr L, and vomiting on 7 Month 2 2011;
- the continued concerns that Mrs B had a UTI on 8 Month 2 2011; or
- Mrs B's general decline in Month 1 and Month 2 2011.

215. Mrs B's daughters also told HDC that they were never involved in a conversation about palliative care.

216. While it seems that various members of Middlepark's staff recognised the need to contact Mrs B's family throughout her deterioration (evidenced by notes to that effect in, for example, the Incident Reports), it does not appear that this ever occurred.

217. Further, when Mrs B's daughters were eventually informed of their mother's condition on the evening of 8 Month 2 2011, and attended Middlepark themselves, initially their view that Mrs B should be admitted to hospital was not appropriately considered or responded to.

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218. Ms Brady advised me that Middlepark's communication with Mrs B's family was "seriously inadequate", noting that:

> "… it is important to be communicating with families, keeping them up-to-date with changes in health status of their loved ones (which is inevitable in Aged Care), informing them of incidents and accidents — after all they have entrusted the care of their loved ones to us".

219. I consider that Oceania's communication with Mrs B's family did not meet the family's expectations, and it is clear that Mrs B's family was frustrated and distressed by Oceania's failings in this regard.

Clinical care and treatment

Action based on clinical records

220. Where appropriate record-keeping did occur in relation to Mrs B's care and treatment, appropriate action arising out of the information contained in those records was not consistently taken. These omissions contributed to failures to provide Mrs B with appropriate care and treatment, particularly with regard to her UTI. In particular, I note the following:

- The Care Progress Notes on 21 Month 1 2011 recorded that Mrs B was suffering from a suspected UTI. Despite those notes specifically requesting that a urine sample be obtained the next morning, this did not occur.[43]
- The Medical Progress Notes on 7 Month 2 2011 recorded Dr L's request for referral to a dietitian, and for blood tests and a urine specimen to be taken. None of these requests were actioned.
- The 22 Month 1 2011 Incident Report (completed by EN K and signed off by RN F) recorded that, as follow-up, Mrs B would be seen by a GP, and a urine sample would be taken. There is no evidence that these actions occurred. The Incident Form also recorded that the Manager, GP, and family had been notified but, again, there is no evidence that this happened.
- The 4 Month 2 2011 Incident Report recorded that, as follow-up, there would be a discussion with Mrs B's family regarding using a hospital bed and a 48-hour assessment to see whether this was necessary. There is no evidence that these actions occurred. The Incident Form also recorded that the Manager and GP had been notified; however, this does not appear to have happened.
- The 5 Month 2 2011 Incident Report recorded that, as follow-up, there would be a multidisciplinary meeting, the family would be contacted, and a urine specimen would be obtained. None of these recommendations were actioned.
- The 6 Month 2 2011 Incident Report recorded that, as follow-up, there would be a multidisciplinary meeting, the family would be contacted, a urine specimen would

[43] Attempts were made to obtain a specimen on 22 Month 1 2011, but were unsuccessful, and this was not followed up.

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be obtained, and Dr L would be contacted. Only the latter appears to have occurred.

- Neither of the Incident Reports dated 8 Month 2 2011 were signed off by an RN. Therefore, no preventative or follow-up action was recorded in regard to either incident.
- The interventions identified in Mrs B's Care Plan were not consistently implemented. For example, a sensor mat was not installed in Mrs B's room until after her second fall on 5 Month 2 2011. Following that, it seems that the sensor mat was removed from Mrs B's room because, after her fourth fall on 8 Month 2 2011, it could not be located. On 9 Month 2 2011 Mrs D found the sensor mat screwed up behind a chair in her mother's room.
- While Short Term Care Plans were attached to Mrs B's Care Plan on 24 and 30 Month 1 2011 (regarding the use of a Food Intake Chart, and recommending ways to aid Mrs B to sleep), those plans were not properly implemented.

UTI

221. I consider that there was a failure by staff to properly diagnose Mrs B's UTI. Although staff identified that Mrs B had symptoms of a UTI on 21 Month 1 2011, and although there was continuous reference to those symptoms in Mrs B's clinical records following that date, a clean urine sample was not obtained and sent for formal testing. Express requests for a clean urine sample to be obtained were recorded in Mrs B's clinical notes, were made verbally between staff, and were made by Mrs B's GP, but a clean urine sample was never obtained.

222. I also consider that, where staff did recognise that Mrs B had a UTI, her condition was not appropriately treated. I acknowledge that Mrs B was prescribed antibiotics following RN H's assessment on 3 Month 2 2011. However, I consider that the medication was not correctly administered. On the evidence provided to me by the medical centre that issued the prescription, and by the pharmacy that dispensed the medication, I find that it is more likely than not that Mrs B was provided with a six-day course of trimethoprim. RN H failed to record this accurately, instead noting in Mrs B's medication chart that the prescription was for three days. Mrs B therefore did not receive her full course of antibiotics.

223. Additionally, I consider that there was a failure to follow up on the treatment that was provided to Mrs B for her UTI. No urine sample was obtained and tested to ensure that the antibiotics had cleared the infection. As a result, Oceania staff were unaware that Mrs B was resistant to the particular antibiotic that had been prescribed. The treatment was therefore ineffective. As noted by Ms Brady:

> "It is simple to obtain a clean sample by catheter when samples are being contaminated by faeces …This is especially important to obtain for sensitivities to antibiotics — especially if the patient is not responding to current antibiotic treatment. [Mrs B's] deterioration in health status would have warranted this."

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224. I accept Ms Brady's advice that Mrs B's worsening condition should have alerted clinical staff to the fact that her infection was not responding to antibiotic treatment. A clean urine specimen should have been obtained and tested, so that effective treatment could be prescribed and commenced.

Pain management

225. Ms Brady advised me that Mrs B's pain from 3 Month 2 2011 was "not well controlled". In particular, she noted that it was inappropriate for Mrs B to be administered oral pain relief when she was not eating or drinking well, and was experiencing nausea and vomiting. In addition, statements provided to HDC by staff on duty on the night of 8–9 Month 2 show that Mrs B was given only her usual pain medication that evening, despite her obvious discomfort.

226. I am of the view that Mrs B was in significant pain by the time she was admitted to hospital on 9 Month 2 2011. It is clear from what Mrs B's daughters told HDC that this was very distressing for Mrs B and for her family.

Hospital admission

227. I have already noted that the unnecessary confusion regarding whether Mrs B was for palliative care delayed her admission to hospital. Overall, Ms Brady advised me that the delay regarding Mrs B's admission to hospital reflected a moderate departure from expected standards:

> "It is, I agree sometimes difficult to assess a patient who is elderly, however after reading the reports by the Caregivers and the Agency Registered Nurse I would not have hesitated to send [Mrs B] for assessment at the Public Hospital — even for peace of mind that I was doing all that is necessary for their wellbeing/ongoing care … I believe it would have been appropriate to have [Mrs B] assessed at the Public Hospital on the 8th of [Month 2] …"

228. I am of the view that, given Mrs B's deteriorating condition and obvious pain throughout the day on 8 Month 2, it would have been appropriate to admit Mrs B to hospital during the day. I consider that the delay in sending Mrs B to hospital was undue, caused unnecessary distress to Mrs B and her family, and delayed appropriate clinical treatment.

Summary

229. Rest home owners have an organisational duty of care to provide a safe healthcare environment for residents. As stated in a previous Opinion of this Office:[44]

> "This duty of care includes ensuring that staff work and communicate effectively together, ensuring that its policies and procedures are consistent with relevant standards, and ensuring that staff comply with the policies and procedures. The systems within which a team operates must function effectively in order to provide an appropriate standard of care to the residents."

[44] Opinion 10HDC00308 (29 June 2012).

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230. I consider that Oceania failed to ensure that its policies and procedures were appropriately implemented by clinical and care staff at Middlepark. Staff failed to follow organisational policies. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them.[45] As this Office has also previously stated, without staff compliance, policies become meaningless.[46]

231. The failures by Middlepark staff to follow policies led to a breakdown in communication between staff, which had a significant impact on the care Mrs B received. Oceania must bear responsibility for the failure by a number of Middlepark staff to provide services with reasonable care and skill, in breach of Right 4(1) of the Code. In particular, Middlepark staff:

- failed to appropriately diagnose, treat, and follow up on Mrs B's UTI between 3 Month 2 and her admission to hospital early on 9 Month 2 2011;
- failed to appropriately manage Mrs B's pain on 8 Month 2 2011; and
- failed to promptly organise Mrs B's admission to hospital on 8–9 Month 2 2011.

232. In my view, Oceania failed to provide Mrs B with appropriate care and treatment, in breach of Right 4(1) of the Code.

233. I consider that these systemic failures had serious negative consequences for the continuity of care provided to Mrs B, and Oceania therefore breached Right 4(5) of the Code.

Opinion: Breach — RN F

234. As Clinical Leader, RN F had overall responsibility for the care provided to residents at Middlepark. As part of her role, RN F was required to provide nursing care to residents, to supervise the care provided by other staff, to address any clinical concerns raised, and to ensure that Middlepark's clinical and care staff complied with processes, policies and procedures. In providing care as a registered nurse, she was required to comply with relevant professional standards.

Documentation

235. As I have already outlined, it is clear from the information gathered during the investigation that, in Mrs B's case, Middlepark staff did not complete all of the documentation they should have, and did not complete documentation to a sufficient standard. As Clinical Leader, RN F must take personal responsibility for the failures of her staff to keep appropriate clinical records for Mrs B. I am concerned that RN F demonstrated a lack of understanding about how often staff were required to make

[45] Opinion 10HDC00308 (29 June 2012).
[46] Opinion 09HDC01974 (21 June 2012).

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entries in the Care Progress Notes, which were the main record of care provided. Additionally, RN F acknowledged that she checked documentation (including Care Progress Notes) only on an informal basis, and did not document such checks. I consider that practice to be unacceptable for someone in a clinical management role. In response to my provisional opinion, RN F's representative submitted that:

> "[RN F] does not agree that she did not understand how often the staff were required to write in the progress notes. She confirms her previous comments that although the policy was that notes should be written every shift, [RN G] had instructed the [HCAs] that they did not need to do this but that notes ought to be written on "shower" days unless a change had taken place."

236. While the above submission demonstrates RN F's knowledge of both the policy and of RN G's approach (which was different from the policy), whatever RN F's understanding was, the staff for whom she was responsible failed to keep appropriate clinical records. I remain of the view that RN F must take personal responsibility for those failures. As a registered nurse, RN F was herself required to maintain clear, concise, timely, accurate, and current records.[47] I consider that RN F failed to meet this standard on many occasions. For example, I note that she did not document her request for a urine sample to be obtained on 6 Month 2 2011. In relation to Mrs B's falls, RN F signed off numerous Incident Forms that contained inaccurate information about who had been contacted about the fall, and she did not ensure that her recommendations and instructions had been actioned.

237. These documentation failures led to breakdowns in communication between staff about Mrs B's condition and about the care she required.

238. In response to my provisional opinion RN F's representative stated that it is "…not agreed that that breakdown of communication between staff about Mrs B's condition was the result of a documentation failure. RN F communicated her instructions verbally…"

239. In my view, regardless of whether instructions were given to staff verbally, as set out elsewhere in this opinion, RNs are still required to maintain adequate records. These records are a key method of communication between staff, and I remain of the opinion that the documentation failures in Mrs B's case led to communication breakdowns.

Clinical care and treatment

240. While I accept that, between 17 Month 1 and 5 Month 2, RN F was not informed of Mrs B's condition and decline (and therefore did not have the full clinical picture), I consider that the information available to RN F should have prompted her to undertake an assessment of Mrs B (during this period RN F only weighed Mrs B). In particular, I note that RN F was aware that Mrs B had been in isolation with a tummy bug (which had caused vomiting, diarrhoea and weight loss), that food and fluid charts had been commenced (at RN F's own request), that it was appropriate for Mrs B's family to be contacted (although this did not occur), and that Mrs B had had falls

[47] Competency 2.3, Competencies for registered nurses.

HDC

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on 22 Month 1, 4 Month 2 and 5 Month 2 2011. I consider that, on the basis of that information, RN F should have assessed Mrs B prior to 6 Month 2 2011.

241. As Clinical Leader, RN F also had responsibility for the clinical care provided to residents by Middlepark staff. I am of the view that she must take responsibility for the failures of a number of her staff to provide appropriate care to Mrs B.

Communication with other healthcare staff

242. RN F was required to communicate and collaborate with members of Mrs B's healthcare team to facilitate and coordinate her care.[48] This was a key aspect of her role as Clinical Leader at Middlepark, where she had a responsibility to coordinate the provision of appropriate care to residents and to supervise the quality of that care. It is clear that RN F did not adequately communicate her instructions to staff or follow up to ensure that they had been carried out. An example is RN F's failure to coordinate the follow-up actions required after Mrs B's fall on 6 Month 2. I consider that RN F's failures to effectively communicate and coordinate the care provided to Mrs B were in breach of Right 4(5) of the Code.

Summary

243. In my view, by failing to personally assess Mrs B prior to 6 Month 2 2011, and by failing to ensure that clinical staff were providing appropriate care to Mrs B, RN F failed to provide services with reasonable care and skill, and so breached Right 4(1) of the Code.

244. I also consider that RN F personally failed to accurately document the care provided to Mrs B. In doing so, RN F breached professional standards, and therefore breached Right 4(2) of the Code.

245. RN F's failure to effectively communicate with other healthcare staff to coordinate Mrs B's care was in breach of Right 4(5) of the Code.

Opinion: Breach — RN G

246. The Facility Manager, RN G, had overall responsibility for managing Middlepark. According to her job description, the key purpose of her role was to "provid[e] sound business and clinical leadership as well as ensuring the efficient, effective and sustainable long term and day-to-day management" of Middlepark. Her job description also required her to ensure that Middlepark staff complied with professional codes of practice, clinical standards, and contractual and legal obligations. Although responsibility for residents' clinical care rested with RN F, RN G took on that responsibility in RN F's absence (as was the case on 7 and 8 Month 2 2011). In providing care as a registered nurse, RN G was required to comply with relevant professional standards.

[48] Competency 4.1, Competencies for registered nurses.

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Documentation

247. I consider that, particularly in light of her management role, RN G must take personal responsibility for the failures of Middlepark staff to comply with professional standards and organisational policies when documenting the care provided to Mrs B. RN G herself demonstrated a lack of understanding of documentation requirements (for example, about how often staff were required to make entries in the Care Progress Notes), which I consider to be unacceptable given her role as Facility Manager.

248. There does not appear to have been sufficient oversight at Middlepark of compliance with documentation policies and standards. As Facility Manager, RN G should have identified that standards were not being met, and should have taken steps to lift the quality of documentation at Middlepark. I am of the view that RN G must take responsibility for the general lack of compliance with documentation standards at Middlepark.

Communication with other healthcare staff

249. I consider that RN G's failures to properly communicate with other healthcare staff on the afternoon of 8 Month 2 2011 led to Mrs B receiving inadequate care.

250. First, it was inappropriate for RN G to accept that Mrs B was for palliative care based solely on her conversation with EN J (assuming that the conversation did occur). Acting in her dual capacity as both Clinical Leader and Facility Manager at the time, RN G should have checked the relevant documentation before proceeding on the basis that Mrs B was for palliative care, and informing RNs O and H of that.

251. Secondly, it does not appear that, at handover that afternoon, RN G clearly informed RN O of her expectations (if any) regarding further assessment of Mrs B during that shift. In her response to my provisional opinion, RN G's representative submitted that the fact that RN O did review Mrs B during that shift proved that RN G informed RN O of her expectations in terms of further assessment. While this submission has some merit, I do not consider it to be determinative, and I remain of the view that RN G did not make her expectations clear to RN O. Given Mrs B's condition at the time, I do not consider this to be acceptable.

252. RN G was required to collaborate with members of Mrs B's healthcare team to facilitate and coordinate her care.[49] It was particularly important for RN G to meet this standard when she was operating as Clinical Leader on 8 Month 2. I consider that RN G's communication with RN O, RN H, and EN J on the afternoon of 8 Month 2 did not meet this standard.

Clinical care and treatment

253. Following her assessment of Mrs B on the afternoon of 8 Month 2, RN G did not consider that admitting Mrs B to hospital was immediately necessary. As I have already set out, Ms Brady advised me that she would "not have hesitated" to send Mrs B to hospital that afternoon. Ms Brady found that RN G's failure to organise for Mrs

[49] Competency 4.1, Competencies for registered nurses; and Right 4(5) of the Code.

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B to be admitted to hospital following her assessment was a moderate departure from expected standards, and advised:

> "… What was she waiting for — she obviously thought [Mrs B] was quite unwell … and as there was an agency nurse not one of the regular staff on duty I would think it would have been appropriate to send [Mrs B] to the Public Hospital for further assessment."

254. I agree with that advice.

Summary

255. I consider that, on 8 Month 2 2011, RN G failed to organise for Mrs B to be admitted to hospital on the basis of her clinical assessment. RN G, as a manager, failed to ensure that Middlepark staff were complying with policies and procedures. This had a significant impact on the care Mrs B received. RN G therefore failed to provide services to Mrs B with reasonable care and skill, in breach of Right 4(1) of the Code.

256. I consider that RN G failed to appropriately communicate with other healthcare staff to coordinate Mrs B's care, and therefore breached Right 4(5) of the Code.

Opinion: Breach — RN H

257. RN H was the weekend RN at Middlepark. She worked from 7am until 4pm on Saturday and Sunday, and was on call from 5pm Friday until 7am Monday morning. She was the RN on call from 5pm on 8 Month 2 2011. In providing care as a registered nurse, RN H was required to comply with relevant professional standards.

Documentation

258. As a registered nurse, RN H was required to maintain clear, concise, timely, accurate, and current records.[50] I consider that RN H failed to meet this standard by failing to document the required follow-up actions after her diagnosis of a UTI on 3 Month 2 2011. RN H failed to note the need for a further urine specimen to be obtained in the EN/RN Communication Book, despite acknowledging that this was her usual practice. Although RN H appropriately organised a prescription for antibiotics after diagnosing Mrs B's UTI, I consider it more likely than not that she incorrectly recorded on Mrs B's medicines chart that the prescription was for a three-day course of antibiotics, when it was in fact for a six-day course. Because of RN H's error in this regard, Mrs B was not administered her full course of antibiotics.

Communication with other healthcare staff

259. RN H was required to communicate and collaborate with members of Mrs B's healthcare team in order to facilitate and coordinate her care.[51] I consider that RN H did not communicate effectively with other healthcare staff when she diagnosed Mrs

[50] Competency 2.3, Competencies for registered nurses.
[51] Competency 4.1, Competencies for registered nurses; and Right 4(5) of the Code.

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B's UTI on 3 Month 2 – in particular, there is no evidence that RN H asked other staff to obtain a clean urine sample at that time, which I consider to be unacceptable. In my view, it would also have been appropriate for RN H to have directly notified Dr L of Mrs B's condition at that time, to ensure that appropriate action was taken over the coming week. There is no evidence that this occurred.

260. I consider that it was inappropriate for RN H to accept that Mrs B was for palliative care based solely on her conversation with RN G on the afternoon of 8 Month 2. During that conversation, RN G had advised RN H that Mrs B had deteriorated and was for palliative care. I do not consider it adequate that RN H accepted this without further discussion or investigation. Up until that conversation, RN H had understood that Mrs B had a UTI that was being treated with antibiotics, but that she was otherwise stable. I would expect that, where a care plan has been changed in a significant way, as in this case, an RN would seek further information or explanation for such a change.

Clinical care and treatment

UTI

261. RN H diagnosed Mrs B's UTI on Sunday 3 Month 2 2011, and appropriately organised a prescription for antibiotics. However, RN H did not take appropriate steps at that time to ensure that a clean urine sample was obtained and sent for testing on the Monday morning. In my view, given Mrs B's symptoms and the results of the discarded dipstick test (which indicated a UTI), RN H should have ensured that further testing occurred as a matter of priority. As a result of the failure to obtain a further clean sample, Middlepark staff were unaware that Mrs B was resistant to the particular antibiotic she had been prescribed.

Assessment

262. When RN O contacted RN H on the evening of 8 Month 2, he advised RN H that Mrs B was "very unwell", and that her family wanted to send her to hospital. I agree with Ms Brady that, at this point, RN H should have either gone into work to assess Mrs B herself, or should have directed RN O to have Mrs B transferred to hospital immediately. Even if RN H's understanding that Mrs B was for palliative care had been correct, I would expect an on-call RN to take concerns about a resident's deteriorating condition more seriously than RN H appears to have done in this case.

263. In response to my provisional opinion RN H acknowledged that the care she provided that evening was inappropriate, and stated that:

> "Now when I look back at the events of that night I can see that I did so many wrongs. I failed [Mrs B], I failed her family…I don't know why I didn't question the fact that if [Mrs B] had indeed been made comfort cares why didn't she have stronger pain relief charted. And why her family wanted her admitted to hospital if they knew she was dying. I feel so upset to think that because of my poor judgement [Mrs B] and her family had to wait another four and a half hours before the ambulance took [Mrs B] to hospital."

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Summary

264. I consider that RN H failed to:

- organise for a clean urine sample to be obtained and tested;
- assess Mrs B on the evening of 8 Month 2; and
- organise for Mrs B to be admitted to hospital as soon as she was made aware that Mrs B was seriously unwell.

265. RN H therefore failed to provide services to Mrs B with reasonable care and skill, in breach of Right 4(1) of the Code.

266. I consider that RN H's failure to adequately document the need for Mrs B to have a repeat urine sample and the antibiotics prescribed breached professional standards. RN H therefore breached Right 4(2) of the Code.

267. I also consider that RN H's failure to communicate effectively with other healthcare staff to coordinate Mrs B's care was in breach of Right 4(5) of the Code.

Recommendations

268. I recommend that Oceania Care Company Limited undertake the following, within **three months** of the date of the final opinion:

- Provide evidence that its documentation system has been consolidated (in order to ensure improved communication amongst staff), and report to HDC on its implementation at Middlepark.
- Provide training to staff about current documentation policies, and the importance of having a comprehensive and up-to-date record of a resident's care and needs, and provide evidence of that training to HDC.
- Conduct an audit of patient records at Middlepark to assess compliance with documentation policies and professional standards, and report to HDC on the results of this audit.
- Use this report as a basis for staff training at Middlepark, focusing particularly on the breaches of the Code identified, and provide evidence of that training to HDC.

269. I note that, in response to my provisional opinion, Oceania provided a written apology for forwarding to Mrs B's family, apologising for its breaches of the Code.

270. I recommend that RN F apologise to Mrs B's family for her breaches of the Code. The apology is to be sent to HDC within one month of the date of the final opinion, for forwarding.

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271. I recommend that RN G apologise to Mrs B's family for her breaches of the Code. The apology is to be sent to HDC within one month of the date of the final opinion, for forwarding.

272. I note that, in response to my provisional opinion, RN H provided a written apology for forwarding to Mrs B's family, apologising for her breaches of the Code.

Follow-up actions

273.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited (trading as Middlepark Rest Home & Village), will be sent to the DHB, and the New Zealand Aged Care Association.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited (trading as Middlepark Rest Home & Village), will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RNs F, G and H.
- A copy of the final report with details identifying the parties removed, except the expert who advised on this case and Oceania Care Company Limited (trading as Middlepark Rest Home & Village), will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent nursing advice from Ms Glenda Brady

The following expert advice was received from Ms Glenda Brady on 29 December 2011, with additions made on 12 January 2012 and 2 March 2012 following requests from HDC for clarification of advice (those additions in bold).

"I (Glenda Brady) have been asked to provide an opinion to the Commissioner on —

Complaint: Middlepark Rest Home and Village

Reference 11/00528

I have read and agree to the Commissioner's Guidelines for Independent Advisors.

My Professional Qualifications are:

N.Z. Registered Psychopaedic Nurse — 1976

N.Z. Registered Psychiatric Nurse — 1980

N.Z. Registered Comprehensive Nurse — 1986

My Practising Certificate Number is: 54408

I have worked in Aged Care for approximately 16 years, the last two years as Clinical Manager at Oakdale Resthome in Cambridge, the previous 8 years as a senior Registered Nurse at Resthaven in Cambridge. I have been involved in all aspects of nursing in these facilities — including Registered Nurse on the roster, education and management roles.

Reference Materials: — Copies of:

— [Mrs A's] Complaint

— Oceania's group's response to the complaint dated 27/[…]/2011

— [Mrs B's] Clinical Records from Middlepark

— HDC's letter to Oceania Group dated 16/[…]/2011

— Email from Oceania Group on 2/[…]/2011

— Letter from Oceania Group dated 2/[…]/2011

— Email to Oceania Group on 8/[…]/2011

— Letter from [RN F] dated 19/[…]/2011

— Letter from Oceania Group dated 20/[…]/2011

— Email to Oceania Group on 21/[…]/2011

— Email from Oceania Group dated 22/[…]/2011

— HDC's letter to [EN J] dated 26/[…]/2011

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— Email from NZNO on 1/[…]1/2011

— [Dr L's] response to the complaint dated 9/[…]/2011

— [Mrs B's] clinical records from the hospital

— Registered Nurse Scope of practice and competencies obtained from www.nursingcouncil.org.nz

— Health & Disability Sector Standards

Advice Requested:

The purpose of this advice is to enable the Commissioner to determine whether, from the information available, there are concerns about the care provided by Middlepark Rest Home and Village which require formal investigation.

After reading through the many pages of information sent to me I don't believe there has been a lack of care to [Mrs B] — there is a Care Plan which has been regularly updated, food charts and fluid balance charts commenced when there have been concerns of food/fluid intake and weight loss.

There have been requests for Doctors' visits when there has been a change in health status and excellent documentation of care provided by the Caregivers — however I feel at times there has been a lack of documented response by the Registered Nurses in the Care Progress Notes when the Caregivers have documented a concern at times — for example (Reference Care Progress Notes Page 00213) 4/[Month 2]/11/ Incident/Accident form partially completed (Reference Page 00266) however nothing documented in the Progress Notes about the follow-up action, or the assessment by the Registered Nurse following the incident.

The Progress Notes are a record of care and I would not expect the Caregivers to be looking at the Incident/Accident Form for ongoing interventions and directives of care, even if this was verbally handed over at reports it should be documented.

Again on the 5/[Month 2]/11 (Reference Care Progress Notes Page 00213–00214) another fall — Incident Form (Reference page 00267) partially completed by the Caregivers, completed by the R/N however no documentation in the Progress Notes.

Again on 8/[Month 2]/11 (reference pages 00215–00216 Progress Notes) — documented concerns in the Caregiver's report in the Progress Notes however little response documented by the Registered Nurse in the Progress notes.

I consider this to be a mild departure from acceptable standards (**by the Registered Nurses on duty who were completing the Incident/Accident forms**) — all through [Mrs B's] stay at Middlepark Rest Home and Village there have been excellent records of care documented by the Caregivers, however there is a lack of regular documentation by the Registered Nurses and documentation is a record of care and part of the Scope of Practice of a Registered Nurse.

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However despite the care there has been a lack of communication between the staff especially during the period 3 [Month 2] 2011–9 [Month 2] 2011, firstly the Registered Nurses to the Enrolled Nurses and vice versa — antibiotics commenced (Reference page 00213) but the course not completed? **(Addit 2/[Month 1]/2012 — the medication Triprim has been signed for the 3 days yet on page 0004 [Mrs A's complaint to HDC] there is reference to the medication being returned to the Pharmacy. There is also reference to the medication on page 00020);** urine sample not collected for analysis by the laboratory to ensure correct antibiotic. (It is simple to obtain a clean sample by catheter when samples are being contaminated by faeces.) This is especially important to obtain for sensitivities to antibiotics — especially if the patient is not responding to current antibiotic treatment. [Mrs B's] deterioration in health status would have warranted this. (Urine samples can be very difficult to obtain at times from patients with continence problems or that are unwell.)

Handover sheets and communication books are not a record of care — all patient information, interventions, and changes in medication should be documented in the Progress Notes. Important information can be lost if not recorded and this is the case here — some staff not aware of an antibiotic being commenced, request for a urine sample not passed on, information not given to [Mrs B's] GP about the commencement of an antibiotic for suspected Urinary Tract Infection (UTI), blood tests not organised in a timely fashion.

I also believe that the Care giving staff are not consulting the On Call Registered Nurse in a timely fashion — a fall is a serious incident — in this case [Mrs B] had a history of falls so an assessment by a Registered Nurse should have been a priority — what if she had had a fracture and was moved by the staff before a complete assessment?

Again I consider this to be a mild departure from acceptable standards **(by the Registered Nurse on duty at that time)**. The caregivers have documented their assessment and ongoing cares.

However, despite all this there has been seriously inadequate communication to the family of [Mrs B] to advise them of her changes in health status and falls resulting in injury during this period —

(Falls (especially those resulting in injury), changes in health status of a resident and Doctor's visits (especially non routine visits) should be communicated to families as soon as practically possible.)

There appears to have been a number of Agency Staff working at Middlepark Rest Home and Village and from what I can understand there were some Hospital-level residents there following the earthquakes in Christchurch.

This I imagine would have been a difficult time for them and even more important that documentation and communication between staff and shifts be of paramount importance.

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I commend the Agency Registered Nurse [RN O] for notifying the family however I believe that the On Call Registered Nurse should have attended when he called as he did not know [Mrs B] very well or directed that [Mrs B] be transferred to the Public Hospital at that time.

This lack of communication with the family of [Mrs B] is a serious departure from acceptable standards **(the responsibility lies with The Registered Nurses on duty during this time and the On Call Registered Nurse when contacted)** — it is important to be communicating with families, keeping them up-to-date with changes in health status of their loved ones (which is inevitable in Aged Care), informing them of Incidents and Accidents — after all they have entrusted the care of their loved ones to us.

It is, I agree sometimes difficult to assess a patient who is elderly, however after reading the reports by the Caregivers and the Agency Registered Nurse I would not have hesitated to send [Mrs B] for assessment at the Public Hospital — even for peace of mind that I was doing all that is necessary for their wellbeing/ongoing care**. (I believe it would have been appropriate to have [Mrs B] assessed at the Public Hospital on the 8th of [Month 2] — low B/P, not eating and drinking well, not following commands (reference page 00216) [Mrs B] had been out with her family on the 2nd of [Month 2] (Reference page 00212) had subsequent falls and there was an obvious change in her cognition, mobility and general wellbeing.)**

With regards to the staff assuming that [Mrs B] was for Palliative Care — again a lack of communication — this should not be assumed — it should be a formal discussion with nursing staff, medical staff and family and interventions and ongoing cares documented.

Overall I believe that there has been a serious lack of communication — the report from the Facility Manager [RN G] (reference Pages 00020–00029) agrees with this and there has been several changes put in place to prevent a reoccurrence.

Standard of Care: Prior to the incidents (falls, urinary tract infection and general decline in health status) that led to the admission of [Mrs B] to the Public Hospital good communication between staff, Doctors and family had led to good care.

The standard of care deteriorated when this communication broke down — family not notified of change in health status, instructions from the Doctors not passed on or documented and staff not given clear instructions as to the care that was expected of them. I believe that during this period there was a moderate departure from acceptable standards.

Recommendations:

— That the facility looks at the handover process ensuring all that is verbalised is also written down.

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— That the Registered Nurse responds to the Caregivers written concerns in the Progress Notes both written in the notes as well as verbally.

— That the Handover Record … is only a prompt for a verbal report and that all relevant information is documented.

— That a diary be used for residents' appointments/ blood tests rather than a communication book.

— And most importantly that family are kept informed of any incidents/accidents or change in health status of their family members in a timely fashion.

Glenda Brady
29 December 2011"

The following advice was received from Ms Brady on 12 January 2012 (in response to further questions from HDC):

"Complaint: Middlepark Rest Home and Village
Reference 11/00528

…

It is difficult to name who is responsible without a roster to refer to and I find it difficult to read some of the signatures on the Care Progress Notes. I have also written that I do not believe there has been enough documentation by the Registered Nurses in follow-up to the reports of the Care Givers reports.

In answer to your questions:

1. The lack of communication between the nurses especially between 3 and 9 [Month 2] is a mild–moderate departure from acceptable standards.

   (It is difficult to determine that had a urine sample been obtained and [Mrs B] administered the correct antibiotic that she would have made a full recovery). However the series of not, and sometimes partial following of communication procedures/systems has resulted in [Mrs B] not receiving appropriate care in a timely fashion — For example — Doctors orders not carried out, urine and blood samples not obtained, plans of care not discussed and family not notified of health status changes and Accidents/Injuries.

2. The failure to obtain a clean urine sample by any method was a failure in communication once again, however as [Mrs B] was not improving after 3 days of the antibiotic — Trimethoprim and there were reports of strong smelling urine and discomfort I believe it would have been appropriate to get a clean sample for Laboratory testing. As the reports state that her urine was usually contaminated with faeces then a catheter sample would have been the most appropriate way to obtain this.

   The responsibility for this is with the Registered Nurse on duty.

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3. I do not believe that the pain management was appropriate for [Mrs B] during the period 3 to 9 [Month 2] 2011 — she was not eating or drinking well. She had nausea and vomiting and all her medications were oral (Reference page 00290–00291). [Mrs B] was also very sleepy and weak (Reference page 00216)

   There are reports of giving fluids by syringe (Reference page 00216) which can be quite dangerous and could lead to aspiration of fluids. Her pain was not well controlled.

4. I believe it would have been appropriate to have either contacted her GP — [Dr L] again or sent [Mrs B] to a public hospital on the 8th of [Month 2] — and this may well have been the instructions from her Doctor had she had the blood and urine tests that were documented in the Medical Notes (Reference page 00220) but were not communicated as per the Rest Home's systems of communication.

   Glenda Brady"

The following advice was received from Ms Brady on 26 February 2012 (after assessing further relevant information):

"COMMUNICATION: As I have commented earlier in my report that there has been a serious lack of communication with the family of [Mrs B], I also believe that this poor communication by the Rest home Staff also extends to their communication with the Doctor(s) who provided Medical Services to this resident:

— Had [Dr L] been informed of the fact that [Mrs B] was being treated for a UTI (Urinary Tract Infection) his treatment plan may well have been quite different.

— Had it been communicated to the Doctor that [Mrs B] was in obvious discomfort additional analgesia may have been charted on her Medication Chart. Perhaps not only orally but could also be given by subcutaneous or intramuscular injection if [Mrs B] was having difficulty taking oral medication.

(I see that she was on regular Codeine Phosphate 30mg tablets and Paracetamol Suspension 1gm/20mls of 250mg/5mls strength.)

Had the blood tests and a urine sample been obtained earlier again a different treatment plan may have resulted which may have prevented the outcome.

I continue to believe that this lack of adequate communication is a serious departure from acceptable standards.

LACK OF CARE: While I believe that prior to this series of communication failures that the care provided to [Mrs B] had been acceptable to the family,

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during the period of her latest illness and subsequent admission to the Public Hospital the inadequate communication has led to poor care and I change my decision to a Moderate Departure from acceptable standards. The responsibility lies with the Registered Nurses and the Facility Manager.

I believe it is important to take into consideration the difficult time it must have been in Christchurch following the earthquakes and the fact that the Rest Home had taken in Hospital-level patients which would have stretched the services provided.

Staff were obviously working longer hours and with a number of Agency Staff working at Middlepark Rest Home to ensure coverage on all shifts I can imagine these to be very trying times.

Glenda Brady"

The following advice was received from Ms Brady on 2 March 2012 (in response to requests for clarification from HDC):

"— Urine sample not obtained — Mild departure (it can be very difficult to obtain a clean, uncontaminated specimen from any resident that is not fully cooperative. However because of the obvious deterioration in [Mrs B's] health status as written in my report a clean specimen could have been obtained by using a catheter.

— Pain Management — Moderate Departure — [Mrs B] was not taking her oral medication well, and if she was on "Palliative Care" adequate pain relief should have been discussed with her Doctor, and family and appropriate medication charted. There are alternatives to oral medication.

— Referral to Public Hospital — Moderate Departure — [RN G] had seen [Mrs B] on the afternoon of the 8th of [Month 2], had taken her OB's and said to the agency R/N [RN O] that he may be looking at a hospital admission (Reference page 00023) What was she waiting for — she obviously thought [Mrs B] was quite unwell to make that statement and as there was an agency nurse not one of the regular staff on duty I would think it would have been appropriate to send [Mrs B] to the Public Hospital for further assessment.

— Attending Rest Home — Mild–Moderate Departure — [RN H] had been contacted by the Agency R/N [RN O] on duty on the afternoon shift with his concerns and then again by the staff on night duty. I believe it would have been prudent to visit after the second phone call to assess [Mrs B]. [The Agency R/N] states that '[Mrs B] was not in undue discomfort or he would have overridden [RN H's] decision and sent [Mrs B] to hospital regardless.' (reference Page 00024).

— Palliative Care — An adverse comment — not clarified by the staff."

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