Ms Savita Mistry

Registered Nurse, Ms E

Birkenhead Lodge Retirement Home

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC08672)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

This report considers the care provided to Mrs A while she was a resident at Birkenhead Lodge Retirement Home from 18 May 2006 until her admission to a public hospital on 29 April 2008. Towards the end of her stay at the Home, Mrs A's condition deteriorated, and she developed significant pressure sores.

Mrs A's daughter complained to the Health and Disability Commissioner (HDC) because, when her mother arrived at hospital, she was told by the staff that her mother was in very poor condition. The staff at the hospital also raised concerns about Mrs A's care, and the District Health Board subsequently investigated the care provided at the Home.

During the course of the HDC investigation, it was also found that clinical records were unreliable. Documents had been altered, added to, and/or dated as earlier than they had actually been completed, by some members of staff, allegedly at the instigation of the Manager and co-owner of the Home, Ms Savita Mistry. This has made it very difficult to ascertain exactly what care was provided to Mrs A. This report also comments on the appropriateness of financial charges for other services provided by the Home.

Complaint and investigation

On 28 May 2008 the Commissioner (HDC) received a complaint from Ms B about the services provided to her mother, Mrs A, by Birkenhead Lodge Retirement Home. The following issues were identified for investigation:

The appropriateness of the care provided to Mrs A by Birkenhead Lodge Retirement Home.

The appropriateness of the care provided to Mrs A by Ms Savita Mistry.

The appropriateness of the care provided to Mrs A by Registered Nurse Ms E.

The investigation was commenced on 3 June 2008, and was delegated to Deputy Commissioner Rae Lamb.[1]

[1] The investigation was extended on 25 June 2008 to include the care provided by Ms E.

Information was obtained from:

Ms B	Complainant/Mrs A's daughter
Mr C	Mrs A's son
Mr D	Mrs A's son
Ms Savita Mistry	Provider/Manager and registered nurse
Ms E	Provider/Registered nurse
Birkenhead Lodge Rest Home	Provider

Information was also obtained from general practitioner Dr G, podiatrist Ms I, a podiatrist team, a specialist wound care nurse, the District Health Board and the Ministry of Health.

Other parties:

Ms F	Registered nurse
Ms H	Caregiver

Information gathered during investigation

Background

On 18 May 2006, Mrs A (then aged 82) was admitted to Birkenhead Lodge Retirement Home (the Home) as she was unable to care for herself at home. In particular, her eyesight was very poor. It was arranged that, at an additional cost of $75 per week, she would have a larger room.

The Home is described as a 69-bed licensed retirement home, with no private hospital beds.[2] The Home is operated by a company, which holds certification for the facility. Ms Savita Mistry and her husband are shareholders and directors of the company.[3] Ms Mistry was also the manager of the Home.

At the time of Mrs A's admission, three registered nurses were employed: Ms Savita Mistry, Ms E and Ms F.[4] Ms E had worked at the Home since her arrival in New Zealand in 2004.

In her response to the provisional opinion, Ms E stated that "there were long periods when there was no [registered nurse] supervision on site for the caregivers". After

[2] As described in the Home's publication *Resident information book for rooms* (27 January 2003).

[3] References in this report to Birkenhead Lodge Retirement Home and the Home include the company.

[4] Ms F subsequently left and, at the time of Mrs A's admission to the public hospital, Ms Mistry and Ms E were the only permanent registered nurses. Ms E left the Home in July 2008.

3pm on weekdays and 1pm on weekends there was no registered nurse on site. Ms E added that, as she only worked 28 hours a week, she had "a very limited amount of time to care for each individual resident", and she was dependent on caregivers to report concerns.

Mrs A's care

On her arrival at the Home, Mrs A required some assistance with her daily care, mainly because of her poor vision. However, from mid-2007, she gradually became weaker and more dependent on staff. By September 2007, she was unable to stand unaided, and by March 2008 she was very frail, requiring full assistance with her care.

On 4 March 2008, Mrs A was reviewed by general practitioner Dr G on his regular Tuesday round at the Home, and afterwards he spoke to Mrs A's daughter, Ms B. Having discussed Mrs A's condition and whether it would be appropriate to refer her for further investigations, it was agreed that Dr G would refer Mrs A to a specialist geriatrician for review.

Mrs A's records include a wound treatment chart dated by Ms E on 27 March, describing "[right] lower leg small ulcer no ooze ? cellitis [sic]", and that Mrs A had been seen by ("S/B") a specialist wound care nurse who made occasional visits to the Home.[5] Ms E stated that the wound care nurse assessed Mrs A, and reported to her the wound care to be provided. In her interview with this Office, Ms E said that although she did not go with the wound care nurse, she was "sure" that the wound care nurse saw Mrs A. Subsequently, in her response to the provisional opinion, Ms E stated that the wound care nurse "may not have personally seen [Mrs A]".

The wound care nurse stated that she has no record of visiting the Home on or around 27 March, and has no recall or record of ever having reviewed Mrs A. Ms B also stated that it had never been mentioned to any family member that the wound care nurse had reviewed her mother.

On 28 March, it was noted in the progress notes that Mrs A had "redness from toes to knee". It was also recorded by Ms E on 31 March that Mrs A's "[right] lower leg continues to look inflamed", and the following day she was reviewed by Dr G, who prescribed antibiotics for cellulitis.

Dr G completed the geriatric referral on 28 March 2008. He explained that the reason for the delay in completing his referral was because he took the file back to his practice, and "inadvertently overlooked" the referral until 28 March. Dr G has subsequently apologised for having forgotten to make the referral in a more timely manner.[6]

[5] This is one of the documents Ms E subsequently stated was created at a later date.

[6] Dr G advised that he has reviewed his practice since this incident, and now takes the clinical notes and drug chart with him to his surgery, and to send the referral by facsimile.

On 18 April 2008, Mrs A was reviewed by a consultant geriatrician who concluded that "it would be advisable for [Mrs A] to be admitted electively … for further investigation".

On 29 April, Mrs A was admitted to the public hospital as planned. The transfer letter completed by the Home made no reference to any pressure sores, ulcers, or wound care.

Admission to the public hospital
On her arrival at the public hospital, Mrs A's condition was assessed. It was found that she had a pressure sore on her left heel that was black and necrotic, a pressure sore on her right heel, and two small pressure sores on her sacrum. She needed to be helped to eat and drink and required full assistance with all care. It was noted that both ears were blocked by wax.

Mrs A's condition improved while in hospital, and she was eventually transferred to a private hospital for continuing care. By the time of her transfer she was feeding herself.

Ms Mistry advised HDC that there was no record in the Home's documentation of a pressure sore on Mrs A's left heel, and that she was unaware of this sore.

Ms E's comments
Ms E accepted that she should have been aware of any resident who had a pressure sore, but she "never saw or knew about pressure sores on [Mrs A's] heels". However, Ms E submitted that she was aware of a sore on Mrs A's ankle, which she looked after. She also sought medical assistance when she thought cellulitis might be developing in the leg; antibiotics were subsequently prescribed. Ms E stated that, because of the hours she worked, Mrs A would have been wearing shoes at the times Ms E saw her, so she would not have seen the heels unless she specifically went to look at them.

Ms E also commented on the fact that on 1 April, Dr G did not note any pressure sore on Mrs A's heel, and nor did the consultant geriatrician when he assessed her on 18 April.

Ms B's comments
Ms B described her mother when she was admitted to the Home, and how she was when she left:

> "[S]he went in a well and fit woman suffering with blindness, slight dementia and very little bowel control. She was perky, great sense of humour and loved people. She left a shell of a person, cowering when people went near her and is only now speaking again."

Documentation

A significant issue in this case is the documentation that was provided by the Home after it and Ms Mistry had been notified of the complaint.

On 3 June 2008, Ms Mistry and the Home were asked to provide all relevant medical records for Mrs A, including care plans, progress notes, wound care and medication charts. Once these had been provided, it was noted that there was an inconsistency on a number of documents which suggested that the documents were not completed at the time they were signed and dated. In particular, when a blank Microsoft Word document was printed out from the Home's computer, a date was also printed out indicating the date on which the form was printed out. A number of documents provided by the Home had an automatic date printed on the document which was *later* than the date handwritten on the form. Most of these documents were signed by Ms E. (See **Appendix 1** for an example of one such document.)

In an interview, Ms E initially stated that the documents were completed contemporaneously. When the conflicting dates were put to her, she subsequently confirmed that a number of documents were not completed contemporaneously.[7] Ms E admitted that she had "pre-dated" a number of these documents. She also stated that Ms Mistry had "pre-dated" one document herself (an incident form, see below), and a caregiver, Ms H, had also been asked by Ms Mistry to complete a document. Ms E stated that, although a number of documents had been provided to HDC as contemporaneous documents (ie, written at the time of the events recorded), these documents were in fact completed by her in June 2008. Ms E stated:

> "In June 2008, HDC announced they were investigating Birkenhead Lodge and Savita Mistry's care of [Mrs A], and requested her records. I was approached by Savita's [husband], who said that Savita got in trouble last time with HDC[8] … and this time we'll get the documentation right. Savita also talked to me about the records. She persuaded me against my better judgement that we would tidy up some of the documentation so it was tidier and more thorough.
>
> …
>
> I have never been involved in anything like that before and now very much regret that I was persuaded to participate.
>
> Some of the documents I worked on during the week starting 16 June [2008]. I then went in on Saturday 21 June and Savita and I finalised the documents then.
>
> I wrote up some new documents. These were mostly reflections of what I knew of the care that had been provided to [Mrs A], but hadn't always been fully

[7] Ms E's lawyer stated that while Ms E was still employed at Birkenhead Lodge, she was under the control of her employer and at risk of being dismissed if she admitted to what had occurred.

[8] See Opinion 07HDC12520 (29 April 2008).

documented. Some of the documents were hard to read due to messy writing etc, so I rewrote them so they were more readable.

These are my recollections regarding particular documents which you have identified. They were all created on or within the few days before 21 June [2008]:

Wound treatment chart — The only wounds which I was aware of earlier this year were a small ulcer on [Mrs A's] right ankle (sometimes referred to as lower leg), which seemed to have arisen from her shoe rubbing, and a very small pressure sore on her sacrum. The ankle I checked myself and it improved within a few days. The caregivers told me that the sacrum sore had also cleared up. Therefore only the first few days of information in the chart are accurate.

Annual Resident's Health/Care Review — These were done regularly for residents, but I was unable to find one for [Mrs A], and wrote up this one from what I knew of [Mrs A's] care.

Problem Page — There was a problem page done by [Ms F], an RN who worked at Birkenhead previously. However, there weren't that many entries, so I went through [Mrs A's] progress notes and the doctor's notes and wrote up a revised problem page.

Weight Chart — The record of [Mrs A's] weight was spread over parts of several pages, I combined the results onto two pages, so they looked neater.

Activities Plan — As far as I recall [Mrs A] did have an activities plan, but it was not very readable, so I rewrote it.

Activities Plan Evaluation — There had been some monthly evaluations of the activities plan, but it was not up to date, so I rewrote it including my assessment of how [Mrs A's] activities had gone in more recent months.

Nursing Care Plan/s — ([another RN] who did some work at Birkenhead) had written up the first care plan for [Mrs A], but her writing was not very clear. I rewrote her plan (and added in more details of [Mrs A's] care that I was aware of). [Mrs A's] health deteriorated in about November, so I wrote another plan for the November onwards period. This was written on about 21 June 2008, reflecting the knowledge I had of [Mrs A's] care in late 2007 and early 2008.

Observation Chart — This was written up to mostly include observations from the doctor's notes, progress notes and blood pressure book.

Progress Page
I was also asked by Savita (along with a caregiver [Ms H]) to rewrite the last page of [Mrs A's] progress notes (starting 18.4.08). Savita was concerned that when [Mrs A] had been a bit poorly for a few days from 23 April, but had not been seen

> by a doctor. So the notes presented a more positive view of [Mrs A]. [Mrs A] did actually improve after that unwellness. At the time, taking into account [Mrs A's] fluctuating health status, on the days I saw her, I assessed that she did not need to see a doctor. If I felt that she had I would have called one.
>
> Savita also asked that I wrote in on that progress page more detail regarding events on 28 and 29 April (the caregiver had made short entries only). This information responded to the family's concerns."

The documents that Ms E advised were not contemporaneous were hand-delivered to HDC as attachments to a letter from the Home dated 23 June 2008, arriving on the same date. This was two days before Ms E was informed that she was personally under investigation by HDC.

In all, Ms E completed 19 documents in June 2008, dating them as having described earlier events. These documents included the nursing care plans (seven pages), annual resident's healthcare review (one page), observation charts (two pages), activities plan (three pages), weight charts (two pages), wound care plans (three pages), and the most recent progress notes (one page). Ms E also stated that the medication administration record (five pages) had been subsequently amended at Ms Mistry's instigation. Ms E advised that she was herself not involved in the amendment of the medication administration record, and she had not asked any other members of staff to do so. The medication administration record was signed by Ms H on nine occasions following Mrs A's admission to hospital on 29 April 2008.[9]

Ms Mistry has denied that she asked Ms E to alter documentation. She produced a statement from caregiver Ms H to state that Ms E was the person who asked her to retrospectively record progress notes. Ms H stated:

> "I was asked by [Ms E] to update my comments re [Mrs A's] Progress notes.
>
> I was given a blank copy [of the progress Notes] by [Ms E] and was asked to leave approximately nine blank lines then I transferred what I had previously written from the original notes."

Ms E stated:

> "I acknowledge that I asked [Ms H] about the form. However, she then asked me whether [Ms Mistry] wanted her to rewrite it, and I said yes."

The Home provided a copy of an incident form that was signed and dated 13 August 2006 by Ms Mistry, but which in fact had been completed at some time after 4 May 2008. The form referred to an incident when Mrs A fell and broke a window. This resulted in her sustaining cuts to her head and lower leg. When asked,

[9] 29 April, tea and bedtime; 30 April, teatime; 2, 3 and 4 May, breakfast and lunch.

Ms Mistry explained that the form had been recently written because the original form (which has not been provided to HDC) was "untidy and did not have much detail in it". She dated the form 13 August 2006 because this was the date of the incident.

Ms E stated that she was "frequently" told by Ms Mistry that the level of documentation was "less than that of a hospital", because the Home was a rest home, and not a hospital. Ms E stated that the Home was her first job as a nurse in New Zealand, and she "[relied] on Savita's experience".

In response to the provisional opinion, Ms Mistry submitted:

> "It is true that some documents (such as the incident form dated 13 August 2006) were completed at a later date, but there is no suggestion that they were not an honest recount of events. Such documents are not an attempt at falsification; rather at clarification."

Ms Mistry submitted that any conclusion that she was involved in the altering of documents by Ms E is unsupported by evidence and based on speculation. Ms Mistry also rejected suggestions that Mrs A's care was inadequate. She submitted that this was also speculative, given that the documentation was "not optimal".

In her response to the provisional opinion, Ms E submitted that her falsification of the documents was not a breach of Right 4 the Code, as this Right "only covers consumers having 'the right to have services provided'". Ms E's lawyer stated that Ms E's actions were not for her own benefit and she was put in a "most difficult position" by her employer.

Charges

The invoices for Mrs A's care were sent to Ms B, who paid them by cheque from her mother's account. It had been arranged between Ms B, Mrs A, and her bank, that Ms B could sign cheques on her behalf.

Room charges

As stated above, it was arranged for Mrs A to be in a larger room when she was admitted in May 2006. For this, Mrs A paid an additional charge of $75 per week. However, Mrs A was subsequently moved to a smaller room as it was nearer the nursing station. Ms Mistry confirmed that, while this move was not discussed with Ms B, it was mentioned on 15 January 2008 to "[Mrs A's] son who was visiting from [overseas]".

In her response to the provisional opinion, Ms Mistry stated that Mrs A was not moved to a smaller room while still being charged for a larger room. Ms Mistry stated:

> "She was given the smaller room free of charge after nursing staff assessed that she would be safer closer to the nursing station. [Mrs A's] belongings (including furniture) remained in the larger room."

Ms Mistry added:

> "[Ms B] was often overseas on business and not able to be contacted. Her other children do not reside in Auckland. Consequently, [Mrs A's] family were not always fully aware of their mother's status, and often had to be brought up to date when they visited the Home."

Ms B said that she was unaware that her mother was no longer in the larger room. Whenever she visited, her mother was in the main lounge. In addition, her two brothers, Mr D and Mr C, stated that neither of them was advised that their mother had been moved to a smaller room.

Ms E stated that Mrs A was moved to the smaller room around Christmas 2007, and after that date she never saw her again in her original, larger, room. Mrs A continued to be charged an extra $75.

Podiatry charges

Mrs A was charged for regular podiatry services, approximately every other month. According to the accounts, from 14 June 2006 until 19 March 2008 Mrs A was charged for 11 podiatry appointments, at a total cost of $600. The podiatry services were provided by podiatrist Ms I until September 2007, and by a podiatrist team from September 2007 onwards. Ms I and the two members of the podiatrist team stated separately that they recorded on index cards any care they provided to residents. These cards were retained at the Home, and Ms I added that the cards were kept in Ms Mistry's office.

The index card provided by the Home for Mrs A has three entries: 27 September and 29 November 2007, and 6 March 2008. The care described was that the toenails were cut and filed, and a small dressing was placed on her foot on 29 November 2007 (with no corresponding reference in the Home's notes). There are no entries by Ms I.

Ms I stated that she charged the Home $25 per resident; the podiatrist team stated that they charged $40 per resident. From 14 June 2006 to 18 April 2007, Mrs A was charged $50 on six occasions. From 13 June 2007 to 19 March 2008, Mrs A was charged $60 on five occasions.

Ms I stated that the nursing staff at the Home provided no assistance, and their sole responsibility was to bring residents for podiatry care and collect them afterwards.

Ms Mistry stated that charges were added "to cover the cost of administration, dressings, and nursing time assisting the podiatrist".

Cost of doctor's visit

Following Dr G's meeting with Ms B on 4 March 2008 after his regular weekly round, Mrs A was charged $60 for an "extra doctor's visit". Ms Mistry stated that Mrs A was charged because Ms B had "asked to see [Dr G]". Ms E explained that Ms B was

concerned about her mother's condition, so Ms E suggested she speak to the doctor, who was doing his round at the time.

Dr G stated that he did not charge for this visit as it was at the end of a regular weekly round.

Mrs A was also charged on 6 September 2006[10] and 20 February 2008[11] for extra doctors' visits ($60 on each occasion) and it is unclear whether these visits were in addition to regular visits by the doctor. The Home was specifically asked why these charges were applied, and on what date and by whom the service was provided. Mr Mistry replied in a letter dated 9 July 2008:

> "If a family member requests further visits that are not clinically indicated, the family must then pay for this."[12]

In her response to the provisional opinion, Ms B stated that she had never requested extra doctors' visits. The Home has provided no evidence that there were requests that resulted in the doctors' visits on 6 September 2006 and 20 February 2008.

In response to the provisional opinion, $480 and $180 was refunded to Mrs A to reflect, respectively, the excess podiatry and GP visit charges. Ms Mistry acknowledged that the Home's documentation did not show three doctors' visits as additional to routine visits. She submitted that the Home has since "changed recording practices to avoid any further confusion".

Job descriptions

Registered nurse (owner)
The job description of the Registered nurse (owner)[13] states the purpose of the position as:

> "To ensure safe delivery of professional nursing care, utilising the nursing process and to ensure the smooth operation in all aspects of holistic care and service.
>
> In essence, the nurse will provide expert advice on the planning and implementation of care plans, act as a resource person, and fulfil an educative role in working with the staff of the home."

The job description also sets out the responsibility to work with staff "to prepare a written comprehensive care plan for each resident", and to supervise the care of residents "who may need specialised nursing care, for example, … wound dressing".

[10] Mrs A was reviewed on 19 August by a doctor, described in the notes as "routine".

[11] Mrs A was seen by Dr G on 22 and 29 January 2008, and by another doctor on 1 February 2008. The doctors' visits appear to have been routine.

[12] Mr Mistry did not give any details of the services provided.

[13] The Home provided a copy of the job description, updated on 1 February 2008.

The job description includes the responsibility to "[train] staff to ensure that they adhere to care-plans", and to "[oversee] drug administration to ensure safe delivery of same".

Manager

The Manager job description[14] sets out the requirement of the manager to "plan and implement ongoing care direction" in accordance with the standards set out by the Ministry of Health (see **Appendix 2** for relevant standards). The job description also states that it is the manager's responsibility to ensure the completion of all nursing documentation, to monitor all accidents and incidents, and to ensure that accident forms are completed by staff and followed up.

Registered nurse

Key responsibilities in the Registered Nurse job description[15] are to "[work] with the manager and staff to prepare a written comprehensive care-plan for each resident", and the "maintenance of clinical records".

[14] Dated October 2000.

[15] Dated 13 March 2004.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 2

Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

…

RIGHT 4

Right to Services of an Appropriate Standard

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

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

Opinion: Breach — Savita Mistry

Ms Mistry was responsible for managing the Home as well as providing nursing services. As noted in a previous opinion,[16] she held major responsibility at the Home and seems to have wielded significant influence over the staff.

For the reasons set out below, I have found that Mrs A was provided with substandard care, and that Ms Mistry breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights.

Standard of care
It is difficult to be certain what care was provided to Mrs A. The only records provided contain documents subsequently created and/or altered. It is my view that this was an attempt to mislead this Office that a good standard of documentation had been recorded during Mrs A's time at the Home.

What is certain is that when Mrs A was admitted to North Shore Hospital on 29 April 2008, she was in a sorry state. Her condition had deteriorated until she was totally

[16] See 08HDC10236 (28 November 2008).

dependent on nursing staff, she could not eat or drink unaided, both ears were blocked with wax, and she had pressure sores on both heels and her sacrum. In the responses to the complaint, Ms Mistry and the Home did not comment on the pressure sores as, according to Ms Mistry, she was simply not aware of these. Ms E was also unaware of the sores, and submitted as mitigation that the sores were not noted by the consultant geriatrician when he assessed Mrs A on 18 April. However, the sores had developed by the time Mrs A was admitted to the public hospital 11 days later. In my view, good nursing care and communication between the staff would have resulted in the sores being noted and appropriately cared for earlier at the Home.

The most serious of the sores was on the left heel. It had developed to the point of becoming necrotic, without (it seems) the caregiver staff informing the registered nursing staff. Clearly, there was very limited supervision of the care provided by caregivers. (Ms E said there was no registered nurse on site after 3pm weekdays or 1pm during weekends to supervise the caregivers.) In this case, there was no regular or requested clinical assessment by a registered nurse of a highly dependent resident, whose condition was deteriorating.

The wound care charts supplied by Ms Mistry refer only to the cellulitis that developed in late March 2008 and, in any event, we have been informed by Ms E that she subsequently altered these charts. While I accept that Ms E did institute some treatment in relation to a sore on Mrs A's ankle, this care was largely undocumented, and the other pressure sores apparently went unnoticed and untreated.

Ms Mistry submitted that it was "speculative" to state that the standard of care was inadequate in the absence of documentation.

However, contemporaneous and accurate documentation is one of the cornerstones of good care. Without it, there is little evidence that timely and appropriate care has been delivered. There is also little information to guide caregivers and nurses, and to ensure the care is coordinated. In Mrs A's case, the documentation of care was of an extremely poor standard.

HDC found that documentation was inadequate in another case involving the care provided to a rest home resident who developed pressure sores.[17] The Commissioner was provided with the following advice from independent nursing expert Dr Stephen Neville:

> "Careful, meticulous and appropriate documentation that gives a factual account of a client's health and well-being is integral to professional nursing practice. All nursing documentation forms the cornerstone of the clinical decision-making process and the making of professional nursing judgments[18] … In addition,

[17] See http://www.hdc.org.nz/files/hdc/opinions/04hdc08400resthome.pdf (21 December 2005).

[18] Thompson, C. & Dowding, D. (eds) (2002), *Clinical decision-making and judgement in nursing*. Edinburgh: Churchill Livingstone.

> comprehensive documentation provides an audit trail of the clinical decision-making processes undertaken by nursing staff that have resulted in the provision of care."

Furthermore, in *Patient A v Nelson–Marlborough District Health Board*[19] Baragwanath J stated that it is through the medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). In my view, this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted.

Mrs A's condition on admission to the public hospital is a strong indication that she had been provided inadequate care, and the absence of reliable documentation supports this.

Ms Mistry's job description as registered nurse (owner) sets out her responsibilities to supervise the care of residents who require specialised care (particularly residents who require wound dressing), and to ensure the safe delivery of care.

In my view, the standard of care provided to Mrs A was inadequate and Ms Mistry was ultimately responsible in her role as manager, owner, and one of the registered nurses. She failed to meet her responsibilities to ensure appropriate care was provided.

Documentation
Instead of contemporaneous records of Mrs A's care, key documents have been provided that have been rewritten, altered, added to, or even created, many months after the care was given or events occurred. Documents have been dated as if written contemporaneously when they were not. Furthermore, while some documents are said to have been "tidied up" and rewritten, no originals have been provided. This undermines the credibility of the other documents provided and creates serious doubt about whether some records originally existed.

Certainly, the fact that the documentation needed to be constructed in an attempt to exhibit an adequate standard of documentation confirms that the documentation was substandard. Various professional standards[20] set out clear requirements for an accurate clinical record to be maintained. This has not occurred here.

Ms E has provided an account of having been approached by Ms Mistry's husband in order to alter documents, to ensure that his wife was not similarly criticised as she was

[19] *Patient A v Nelson–Marlborough District Health Board* (HC BLE CIV–2003–204–14, 15 March 2005).

[20] See **Appendix 2**.

following previous HDC investigations.[21] Ms E added that Ms Mistry was involved in the deception. Ms Mistry has denied she was behind these events, although she has confirmed that some documents were completed at a later date, including the incident report dated 13 August 2006.

I need to consider whether Ms E altered documents on her own initiative, or whether she did it at the bidding of Ms Mistry and her husband, for whom Ms E had worked since arriving in New Zealand.

To me, what is most relevant is that the altered documents were provided to HDC on 23 June 2008, yet Ms E was not notified that she was under investigation until two days later. The question to be asked is why Ms E would have altered documents prior to being personally under scrutiny? Ms Mistry is asking me to believe that, on her own and without any prompting, and for no possible personal benefit, Ms E decided to alter documents. These documents also covered care provided by other members of staff (eg, care plans), and it does not seem likely that Ms E would do this unless it had been at the behest of someone else.

While I acknowledge that caregiver Ms H provided a statement in which she says that Ms E asked her to make amendments to the progress notes, Ms E said this was at Ms Mistry's behest. Ms E's lawyer stated that Ms E's actions were not for her own benefit and she was put in a "most difficult position" by her employer. Again, it seems unlikely that Ms E would have done this on her own initiative at a time when she was not under investigation. I also note in passing that Ms H signed Mrs A's medication administration record on nine occasions indicating that Mrs A had received medication at the Home, when she was actually in hospital. This casts further doubt on the credibility of the documentation.

In further confirmation, Ms Mistry stated that she created a document retrospectively herself: the incident form purporting to be from 13 August 2006. Ms Mistry also stated that a new form was completed because the previous one was untidy and incomplete. She submitted that this was an attempt to clarify, not falsify documents. I find this reasoning is flawed. The earlier form has not been provided; Ms Mistry only provided this rationale when concerns about documentation were brought to her attention. She is asking me to believe that, on the basis of her memory, she chose to expand on the information contained in a form describing an event that occurred two years ago.

On balance, I find Ms E's account more credible. In my opinion, Ms Mistry asked Ms E to alter documents in an apparent attempt to mislead this Office. I am also satisfied that Ms Mistry wrote an incident form dated 13 August 2006 after 4 May 2008 in an attempt to mislead HDC.

[21] See 07HDC12520 (29 April 2008).

The Code of Conduct for registered nurses is very clear on this point: "attempting to defraud, dishonest dealings and/or falsifying records" is "behaviour which could be considered as a basis for a finding of professional conduct or imposing a penalty".

Appropriate documentation is essential for coordination between providers, and to ensure consistency and quality of care. Patient care and investigations should not be compromised by health providers seeking to avoid responsibility for their actions (or inactions) through misleading alterations to clinical records. This point is emphasised in Opinion 03HDC11066[22] and the Health Practitioners Disciplinary Tribunal's subsequent decision.[23] On appeal to the High Court, Courtney J stated:[24]

> "The word of a professional person must be reliable. Patients must be able to rely on their doctors. Those undertaking statutory functions for the protection of the community's interests such as the HDC must be able to rely on the information they are given."

As manager, Ms Mistry was responsible for ensuring that adequate documentation was completed and maintained. Quite clearly, in Mrs A's case, this did not happen. The most significant documents (care plans, medication administration records, wound care charts, etc) cannot be relied on as honest and accurate records of Mrs A's care.

Summary

In failing to ensure Mrs A was provided with services with reasonable care and skill in relation to wound care, as manager and registered nurse, Ms Mistry breached Right 4(1) of the Code. Ms Mistry also breached Right 4(2) of the Code by failing to ensure that appropriate documentation was completed, by altering a document herself, and by asking another member of staff (Ms E) to create and alter documents.

Her instruction to another to apparently falsify records is a particularly egregious act. As the owner and manager of the Home, Ms Mistry was in a position of power and influence over an employee. It appears she used this in an attempt to show herself and the Home in a better light. When the deception was discovered, she pointed the blame at others.

These are actions of the utmost seriousness, and deserve referral to the Director of Proceedings. In my view, it also warrants a referral of Ms Mistry to the Nursing Council of New Zealand to consider whether a competence review is necessary.

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[22] http://www.hdc.org.nz/files/hdc/opinions/03hdc11066gp.pdf (6 July 2005).

[23] *Re N* (Health Practitioners Disciplinary Tribunal, 58-Med05-15D, 31 August 2006).

[24] *Martin v Director of Proceedings* (High Court Auckland, 2 July 2008, Courtney J), paragraph 117.

Opinion: Breach — Ms E

Ms E admitted to having falsified documents, but only after the evidence was put to her at interview, after she had left employment at Birkenhead Lodge. Once discovered, she admitted her actions, and provided details of the documents she had altered or created. All of this she claimed (and I have accepted) she did at Mr and Ms Mistry's behest. Ms E stated that she is extremely regretful about her action, but nevertheless, as a registered nurse, she must bear the responsibility for it.

In her response to the provisional opinion, Ms E submitted that her falsification of the documents was not a breach of Right 4 of the Code, as this Right "only covers consumers having 'the right to have services provided'". 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."

Relevant to Ms E's amendment of records is the professional standard[25] that states that "attempting to defraud, dishonest dealings and/or falsifying records" is an example "of behaviour which could be considered as a basis for a finding of professional misconduct or imposing a penalty".

The Commissioner made comments in an earlier case,[26] where a midwife subsequently falsified clinical records, and in which it was concluded that she breached Right 4(2) of the Code:

> "In *Director of Proceedings v Martin*[27] the Health Practitioners Disciplinary Tribunal discussed the significance of amending or altering clinical records. At paragraph 156 the Tribunal stated: 'No health professional should mislead the Commissioner or any other person about their records.' The Tribunal considered that amending the clinical records and misleading the Commissioner about this was the most culpable misconduct in that case. While [the midwife's] actions are different from those of the defendant in *Martin* as she has admitted that she made retrospective amendments and alterations, I am concerned about her motivation for doing so. [The midwife] admitted to the inaccuracies and amendments only when they were specifically put to her. The alterations and additions to the notes give the impression that [the midwife] provided better care than she in fact did, which suggests that she was trying to mislead. Amending and adding to the clinical record is not consistent with professional standards, and [the midwife's] apparent attempt to provide a more satisfactory documentary account of her care has significantly undermined her credibility."

[25] Code of Conduct for Nurses (Nursing Council of New Zealand (NCNZ), March 2008).

[26] See http://www.hdc.org.nz/files/hdc/opinions/05hdc18619midwife.pdf (27 July 2007)

[27] Decision No 58/Med05/15D NZHPDT, 31 August 2006.

Ms E made retrospective amendments and alterations in a similar scenario to that of the midwife's in *Director of Proceedings v Martin*, above.

I am satisfied that a finding of a breach of the Code is warranted in relation to Ms E. As one of the registered nurses responsible for Mrs A's care, clearly Ms E did not adequately document the care she provided. Her failure to contemporaneously and accurately document the wound care in relation to Mrs A's ankle and suspected cellulitis is evidence of that. So is the subsequent need to construct appropriate documentation. Furthermore, in amending, altering and creating Mrs A's records, Ms E was not providing her with a service that complied with relevant standards.

I am satisfied that Ms E's behaviour is a very serious deviation from the standards expected of a registered nurse. Even though she has subsequently shown remorse, a finding that she breached Right 4(2) of the Code is appropriate, and a referral to the Director of Proceedings is also warranted given the seriousness of her actions.

Competence review
I am also concerned about the general nursing standards Ms E has exhibited. As a registered nurse she bore some responsibility for the substandard care provided to Mrs A, which included wound care and documentation of care planned and provided.

In her response to the provisional opinion, Ms E submitted that there has not been an assessment of the nursing care she actually provided, and that there is evidence that she provided "good nursing care" by her treatment of a "sore" on Mrs A's ankle which healed. Ms E accepts that she should have known about pressure sores on any resident, but submitted that Mrs A's heel wounds were not reported to her by the caregivers as she would expect. However, as previously noted, Mrs A's documentation was of an extremely poor standard, pressure sores went unnoticed, and documentation was so inadequate it needed to be retrospectively created or altered. While I am satisfied that Ms Mistry and the Home were ultimately responsible for the poor standards of care, as one of the registered nurses at the Home, Ms E cannot avoid all responsibility.

In my view, a referral of Ms E to the Nursing Council of New Zealand is appropriate, for the Council to consider whether a review of Ms E's competence is warranted.

Opinion: Breach — Birkenhead Lodge Retirement Home

Clinical care

Mrs A had a right to services provided with reasonable care and skill and in compliance with relevant standards during her time at the Home.

However, as described earlier, Mrs A was in a sorry condition when she was admitted to hospital on 29 April 2008. In particular, she had pressure sores that had been untreated, and her ears were blocked with wax. This is not the picture of a resident who had been adequately cared for by the staff of the Home.

Compounding this, the records are so unreliable that there is no real evidence that adequate care was provided. In simple terms, once under HDC scrutiny, it was necessary for the Home to construct documentation to give the appearance of a reasonable standard of records and care. Clearly, poor documentation was the norm at the Home, with all staff involved.

Standard 2.5 of the Health and Disability Sector Standards (Ministry of Health, NZS 8134: 2001) states:

> "[T]he 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/kiritaki."

Standard 5.2 states: "Consumer/kiritaki records are accurate, reliable, authorized and comply with current legislative and/or regulatory requirements."

In my view, Birkenhead Lodge Retirement Home and its staff did not provide Mrs A with appropriate and safe care in compliance with relevant standards, and therefore breached Right 4(2) of the Code, particularly in relation to documentation.

Charges

Right 2 of the Code states that a consumer has the right to be free from financial exploitation. In my opinion, if exploitation can be shown to have occurred, this is an indication that appropriate care has not been provided.

Mrs A was a vulnerable patient who was unable to advocate for herself. The invoices were trusted to be accurate and to reflect the care she was provided. For the reasons given below, in my view Mrs A was financially exploited by the Home as she was charged for services that were not provided, or excessively charged for services provided.

Podiatry

The podiatrists who provided services to residents of the Home documented their care on index cards kept at the Home (according to podiatrist Ms I, in Ms Mistry's office), and they charged either $25 or $40 per resident. Mrs A's card, with details of only three podiatry visits, was provided by the Home.

However, during her residence at the Home, Mrs A was charged for a total of 11 podiatry visits (for a total of $600), at either $50 or $60 each time. The Home stated that the "mark-up" of $20 or $25 was because of the extra work of the nursing staff, the dressings, and the administration costs. However, according to Ms I, the nursing

staff merely delivered and removed the resident, and the description by the podiatrist team of two visits to Mrs A did not involve dressings, and on the third occasion the dressing was so small it was not mentioned in the progress notes. As to charging an "administration fee", that is barely credible.

In any event, on the basis of the evidence provided, Mrs A was provided podiatry services on only three occasions, at what should have been a cost of $120. There is no evidence that the other eight visits charged for actually occurred.

Medical visit
Mrs A was charged $60 by the Home for an extra doctor's visit when her daughter spoke to GP Dr G at the end of his usual weekly ward round. Dr G advised that he did not charge for this visit. Again, on the basis of the evidence available, Mrs A was inappropriately charged, and was exploited financially.

It is also unclear why Mrs A was charged for extra doctors' visits on 6 September 2006 and 20 February 2008, as the visits as recorded in the clinical record appear to be routine. The Home was specifically asked why Mrs A was charged, and appeared to suggest that it was because Mrs A's family requested visits that were not "clinically indicated".[28] Ms B stated that she did not request any additional doctors' visits. Furthermore, the Home has acknowledged that its records do not show these as additional rather than routine visits.

Room
On her admission in May 2006, Mrs A was given a larger room, for which she was charged $75 extra each week. However, for purposes of "safety" (according to Ms Mistry), Mrs A was moved to a smaller room nearer the nurses station. Ms E estimated that this was around Christmas 2007, and added that from that date onwards she never saw Mrs A back in her old, larger, room.

According to Mrs A's family (Ms B and both her brothers) this move was never discussed with them, and the $75 per week additional charge continued. Ms Mistry stated that Mrs A's clothes and furniture were still in the larger room, and therefore it was appropriate to continue to charge for it. While I accept that there may have been a good clinical reason to move Mrs A nearer to nursing staff for observation purposes, she no longer enjoyed the facilities of the larger room. To continue to charge her for this purely because some of her belongings were in it, and without talking to her family about it, was inappropriate and financially exploitative.

Ms Mistry submitted in her response to the provisional opinion that as Mrs A's belongings remained in her room, the smaller room was therefore additional and provided "free of charge". Ms Mistry said that Ms B was "often overseas on business and not able to be contacted". These are not adequate reasons to continue to charge

[28] Letter from Mr Mistry dated 9 July 2008.

Mrs A for a larger room, or for failing to discuss the matter with Ms B, who needed to know what was being paid for and why, and given a choice as to whether to continue paying for a larger room.

Summary
The Home's refund of $660 is appropriate ($480 for podiatry charges and $180 for GP charges). Nevertheless it does not change my view that the Home financially exploited Mrs A, as the Home has provided no credible reason for the excess costs assigned in relation to her podiatry care, the visit by Dr G on 4 March 2008, and the charge for approximately four months for a room she did not stay in. Accordingly, Birkenhead Lodge Retirement Home breached Right 2 of the Code. I will bring this to the attention of the DHB, and recommend a financial audit.

Other comment — Dr G

General practitioner Dr G reviewed Mrs A on 4 March 2008, and decided to refer her to a geriatrician for a specialist review. However, he did not complete this referral until over three weeks later, on 28 March 2008. While I accept that Dr G has since apologised for his lapse and reviewed and changed his practice, I have taken the opportunity to remind him of a need to take more care in the organisation of his practice.

Naming of Ms Savita Mistry

In an opinion released earlier this year, HDC found that Ms Mistry breached Right 4(1) of the Code for providing substandard care to a resident, and by failing to ensure completion of documentation to an appropriate standard.[29]

In another opinion released on 28 November 2008, Ms Mistry failed to document a resident's care to an acceptable standard, and failed to provide her with care of a reasonable standard and in accordance with professional standards. Accordingly, Ms Mistry breached Rights 4(1) and 4(2) of the Code.[30]

In light of my findings in this current case involving the care provided to Mrs A, I consider that the public interest warrants naming Ms Mistry in this report. She has been found in breach of the Code in relation to three separate episodes of care within

[29] See Opinion 07HDC12520 (29 April 2008).

[30] See Opinion 08HDC10236 (28 November 2008).

the past five years and each breach involved at least a moderate departure from appropriate standards.

Follow-up actions

- Ms Savita Mistry, Ms E, and Birkenhead Lodge Retirement Home will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Nursing Council of New Zealand, recommending that Ms Mistry and Ms E undergo a review of their competence to practise as registered nurses.

- A copy of this report will be sent to the Ministry of Health and the DHB, recommending that a financial audit of Birkenhead Lodge Retirement Home is performed.

- On completion of the Director of Proceedings' process, a copy of this report, with details identifying the parties removed except the name of Ms Mistry and Birkenhead Lodge Retirement Home, will be sent to Healthcare Providers New Zealand, the Association of Residential Care Homes, the New Zealand Nurses Organisation and the Quality Improvement Committee, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings laid a charge against the nurse before the Health Practitioners Disciplinary Tribunal. The nurse entered a guilty plea and the matter proceeded by way of agreed summary of facts. The Tribunal upheld the charge and went on to impose the following penalty: a fine of $1500, censure, and an award of 25 percent of the Director's and the Tribunal's costs. Conditions were imposed on her practise in the form of training on professional ethics. The nurse filed an appeal in the High Court challenging the Tribunal's decision to decline permanent suppression of her name. The appeal is pending.

The Director brought a charge before the Health Practitioners Disciplinary Tribunal alleging professional misconduct by Ms Savita Mistry. The charge comprised a

Names have been removed (except Birkenhead Lodge Retirement Home, Ms Savita Mistry) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

number of allegations arising out of care provided to three separate rest home residents over a period of two years.

There were multiple problems relating to the care of residents (including inadequate care by Ms Mistry herself), as well as management issues and a failure to maintain adequate documentation. Ms Mistry also misled the Health and Disability Commissioner by forwarding to him an incident form she had re-written.

The Tribunal upheld the charge in a decision dated 10 December 2009 and imposed the following conditions:

- Supervision for 12 months;
- Not to practice in sole charge or in a supervisory role for three years.

The Tribunal also recommended a competence review before any annual practising certificate re-issues. Ms Mistry was censured, fined $7,500 and ordered to pay costs to HDC and the Tribunal totalling $18,500.

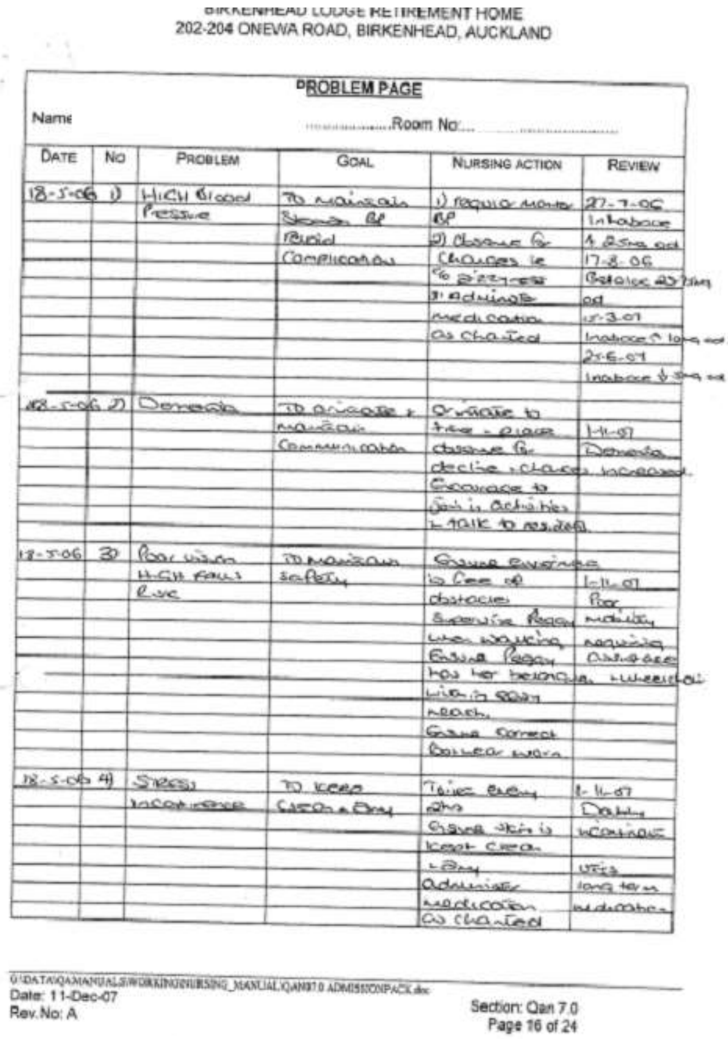
The Health Practitioners Disciplinary Tribunal's decision is available at: http://www.hpdt.org.nz/portals/0/nur09123ddecanon.pdf

Claims against Birkenhead Lodge in the Human Rights Review Tribunal are pending.

Appendix 1

Example of altered document

Below is a document written in June 2008, but initially claimed by Ms E to have been written on dates between 18 May 2006 and 1 November 2007. The footer of the document has the date of 11 December 2007, which means that the blank document on which Ms E wrote was not printed out until on or after that date. Consequently, Ms E could not have written this document on the dates on which she originally claimed.


BIRKENHEAD LODGE RETIREMENT HOME
202-204 ONEWA ROAD, BIRKENHEAD, AUCKLAND

PROBLEM PAGE

Name ....Room No:...........................

DATE	NO	PROBLEM	GOAL	NURSING ACTION	REVIEW
18-5-06	1)	High Blood Pressure	To maintain stable BP Avoid complication	1) regular monitor BP 2) Observe for changes ie dizziness 3) administer medication as charted	27-7-06 Increase [illegible] 17-8-06 [illegible] 15-3-07 Increase [illegible] 25-6-07 Increase [illegible]
18-5-06	2)	Dementia	To orientate & maintain communication	Orientate to time, place. Observe for decline, changes. Encourage to join in activities & talk to residents.	1-11-07 Dementia increased.
18-5-06	3)	Poor vision High falls risk	To maintain safety	Ensure environment is free of obstacles. Supervise Peggy when walking. Ensure Peggy has her belongings within easy reach. Ensure correct footwear worn.	1-11-07 Poor mobility requiring assistance, wheelchair.
18-5-06	4)	Stress incontinence	To keep clean & dry	Toilet every 2hrs. Ensure skin is kept clean & dry. Administer medication as charted	1-11-07 Daily incontinent. UTIs long term medication.

G:\DATA\QAMANUALS\WORKING\NURSING_MANUAL\QAN07.0 ADMISSIONPACK.doc
Date: 11-Dec-07
Rev.No: A

Section: Qan 7.0
Page 16 of 24

Names have been removed (except Birkenhead Lodge Retirement Home, Ms Savita Mistry) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 2

Other relevant standards

Code of Conduct for Nurses (Nursing Council of New Zealand [NCNZ], March 2008)

"Some examples of behaviour which could be considered as a basis for a finding of professional misconduct or imposing a penalty are listed below:

…

attempting to defraud, dishonest dealings and/or falsifying records."

Safe Management of Medicines: A Guide for Managers of Old People's Homes and Residential Care Facilities (Ministry of Health, September 1997).

"…

Every manager of a residential care facility must take all reasonable steps to ensure that at all times the storage, administration and disposal of medicines are strictly controlled and that safety, efficacy and accuracy are maintained with respect to 'the right dose being administered to the right person in the right form at the right time'; as prescribed by the medical practitioner.

…

Administration procedure

…

6. Record on the Medication Administration Record sheet that the medicine has been administered and taken, by signing in the space provided. The sheet should also allow the recording of withheld doses, refused doses or extra doses given in the event of wastage.

…"

Competencies for the registered nurse scope of practice (NCNZ December 2007)

"Competency 1.3 Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by nurse assistants, enrolled nurses and others.

…

Competency 2.1 Provides planned nursing care to achieve identified outcomes.

…

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

New Zealand Health and Disability Sector Standards (NZS 8134: 2001), Ministry of Health.

"…

Standard 2.5: 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/kiritaki.

…

Standard 5.2: Consumer/kiritaki records are accurate, reliable, authorised and comply with current legislative and/or regulatory requirements.

Standard 5.3: Consumers/kiritaki receives medicines in a safe and timely manner that comply with current legislative and regulatory requirements.

…"