A Rest Home

Nurse Manager, Ms D

A Report by the

Deputy Health and Disability Commissioner

Case 08HDC20820

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive Summary

Background

1. Mrs A was admitted to a rest home[1] after suffering a stroke in June 2006 at age 78. She was a resident from 4 July 2006 until February 2009.

The Rest Home

2. The rest home is a large facility, with a range of accommodation options including self-contained villas, apartments, serviced apartments and rest-home beds, including hospital-level care beds.

3. The rest home is part of a group of retirement complexes that are situated throughout New Zealand. The rest home uses policies and processes that are generic to the group.

4. During Mrs A's time at the rest home, three medication errors occurred. Two involved mistaken identity. The third involved Mrs A not being supervised whilst taking her medication, and her medication being found loose in her room.

5. Mrs A had dementia and was known to wander. She was found outside the rest home complex on a number of occasions. She also had a number of falls.

6. Ms D has been Nurse Manager at the rest home since October 2008. As such, she has responsibility for motivating and organising a team of staff who are responsible for the delivery of health-based services throughout the facility to support the customers to live a safe, satisfying and dignified life within the rest home. One of the key performance indicators for the position was "openness", which required her to have excellent communication with the residents and their families, and to ensure health care is provided in an open manner with the full understanding of the customer and his or her family if required (having due consideration to privacy issues).

Decision summary

7. The three medication errors were caused by individual error. The rest home had adequate policies, procedures and training in place to help prevent such errors, and the care provided to Mrs A generally was of an appropriate standard.

8. Although there was no breach of the Code of Health and Disability Services Consumers' Rights (the Code), this case was a reminder of the importance of personal relationships.

9. There was room for improvement in the communication between Ms D and the family in relation to both the second medication error and concerns about whether the rest home continued to be a safe and appropriate home for Mrs A.

10. The Deputy Health and Disability Commissioner asked the rest home to report to HDC on how it accommodates the needs of clients with dementia who like to walk.

[1] Throughout this report, both the facility and the owner of the facility will be referred to as "the rest home".

Complaint and investigation

11. This report is the opinion of Tania Thomas, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

12. On 17 December 2008, the Health and Disability Commissioner (HDC) received a complaint from Ms B and Ms C about the services provided to their mother by the rest home. An investigation was commenced on 3 April 2009, and the following issues were identified for investigation:

- *Whether the rest home provided health care of an appropriate standard to Mrs A from November 2007 to February 2009.*
- *Whether Nurse Manager Ms D provided health care of an appropriate standard to Mrs A from 13 October 2008 to February 2009.*

13. The parties involved were:

Mrs A	Consumer
Ms B	Complainant/Mrs A's daughter
Ms C	Complainant/Mrs A's daughter
A rest home	Provider
Ms D	Provider/Nurse Manager
Ms E	Registered nurse
Ms F	Registered nurse

Also mentioned in this report:

Ms G	Facility Manager
Ms H	Clinical Services Manager
Ms I	Nurse Manager
Dr J	GP
Mr K	Area Manager

14. Information was reviewed from:

Mrs A's daughters
The rest home owner
Ministry of Health
Ms D, Nurse Manager
Ms G, Facility Manager
Ms H, Clinical Services Manager
Ms I, Nurse Manager

15. Independent expert advice was obtained from registered nurse (RN) Wendy Rowe (see **Appendix A**).

Information gathered during investigation

Mrs A

16. Mrs A was admitted to a public hospital on 16 June 2006 after suffering an intracranial haemorrhage, resulting in right hemianopia[2] and right visual-spatial neglect. She was assessed as requiring hospital-level care and, on 4 July, Mrs A was discharged from the hospital's rehabilitation service to the rest home. Mrs A was not placed in the hospital wing of the rest home initially because of lack of space.

17. Although Mrs A had some dementia, she is reported by her family as having maintained an excellent sense of humour. Despite suffering from confusion at times, she enjoyed conversation and activities. For example, the general practitioner who saw her in November 2007 referred to her in a letter as alert, chatty and humorous.

18. Mrs A was well supported by her family. In particular, two of her daughters, Ms B and Ms C, were regular visitors, and took a keen interest in her well-being.

Nurse Manager Ms D

19. Ms D graduated as a registered nurse in 2006, and had been involved in the care of the elderly since 2001, as a senior caregiver. Following registration, she was employed as Nurse Manager of another rest home within the same group, and transferred to this rest home in October 2008. She remains in the position of Nurse Manager. Documentation shows that Ms D was fully orientated to the role of nurse manager, including the medication management policy.

20. The position description for Nurse Manager states:

> "The Nurse Manager is responsible for motivating and organising a team of staff who are responsible for the delivery of health based services throughout the [rest home] to support the customers to live a safe, satisfying and dignified life within the [rest home]"

21. Under the heading "Key Performance Areas", the position description includes the following indicators for the heading "Openness":

> "Has established excellent communication with customers and families.
>
> Health care is provided in an open manner with the full understanding of the customer and their family if required (having due consideration to privacy issues)."

Mrs A's admission to the rest home, July 2006

22. On assessment of Mrs A at the time of admission, the rest home's GP noted a history of left occipital lobe haemorrhage resulting in right hemianopia and right visual-spatial neglect, Alzheimer's disease, a drug reaction to the Alzheimer's medication Aricept, osteoarthritis, migraine, and a history of (surgically treated) bowel cancer and shingles. The GP noted that Mrs A was "[a]lert, friendly ... [and] comfortable",

[2] Loss of half the field of vision.

although she was not well orientated to date and time and had moderately oedematous[3] ankles.

Overview of care

July 2006–November 2007

23. The care and support plan completed at the time of admission states that Mrs A was "fully mobile but is a wanderer and leaves the building on occasion". A plan was developed to ensure that Mrs A was monitored at all times and to distract her if she was confused. Under "falls management" it is noted that Mrs A required a walking frame at all times.

24. Mrs A's daughters explained that they were pleased that their mother remained mobile, and were prepared to accept a level of risk attached to her being able to walk about the premises. It is not clear from the documentation whether the rest home discussed the relative benefits and risks of Mrs A walking unaccompanied outside the rest home.

25. On 20 July 2006, the GP was called to assess Mrs A following a fall. Although Mrs A had suffered facial and leg abrasions and bruising, she was not seriously injured.

26. Mrs A was reviewed again by the GP on 7 September 2006, regarding an "anxiety attack", and by another GP on 16 November and 1 February 2007. Mrs A was generally well on each occasion, apart from a possible concern about urinary retention at the last appointment.

27. From time to time during Mrs A's residence at the rest home, wandering was raised as a concern by the staff or the family. On 9 December, a "long term behaviour management plan" was developed in an attempt to try to keep Mrs A safe. The plan was to continue to monitor her as much as possible, distract her with activities, and reinforce that it was not acceptable for her to wander. This plan was reviewed approximately weekly until 21 March 2007, then monthly until January 2008. No changes were made during this time.

28. While Mrs A continued to walk unaccompanied outside the building, no further falls were recorded until June 2007.

29. On 24 June 2007, Mrs A was found by care staff after a serious fall. She suffered a deep laceration to her left cheek and suspected head injury. An ambulance was called to transport Mrs A to the public hospital, where she was treated in the emergency department and discharged the same day. Mrs A reported a minor fall to caregivers on 2 September, and on 10 November her son witnessed a fall in her room. Mrs A was in significant pain after the 10 November fall, and an X-ray taken 14 November revealed fractured ribs and an older thoracic vertebrae injury.

30. On 7 November 2007, a new GP, Dr J, reviewed Mrs A because of her increased episodes of wandering. Dr J decided to refer Mrs A to a psychogeriatrician at the

[3] Swollen owing to fluid collection.

public hospital. His role is to review any concerns, and advise on how to deal with any issues (such as wandering), and to assess whether the current level of placement is still appropriate.

31. On 29 November 2007, Mrs A was given the wrong medication. This error is set out in detail from paragraph 49.

December 2007–May 2008

32. On 20 December 2007, the psychogeriatrician saw Mrs A with Ms B at the rest home. In his report, he noted that she "carries off her current placement well but staff has been concerned by a number of episodes where she has wandered out of the building". He also records that Ms B had told him that these episodes had occurred on Sunday afternoon when staff numbers were at their lowest and when Mrs A was confused about why she was in care. He suggested a reduction in medication, and a move to the hospital section. He stated that "if problems continue or the family find the risks are indeed intolerable, it will be necessary to transfer to a higher level of care".

33. Mrs A saw a social worker from the public hospital on 4 February 2008. Her medication was reviewed. She was noted to be disorientated to time and place, but was not disturbed by this. The medication change appeared to have caused no problems, and Mrs A was noted to be wandering less frequently. She was discharged from the service.

34. On 17 March 2008, the family met with the nurse manager, Ms I, to discuss Mrs A's continued wandering. During the meeting it was decided that it would be best if Mrs A was moved to the hospital wing where there would be more staff available to monitor her.

35. On 13 April, Mrs A was discovered by her daughter, Ms B, to be disorientated and confused. She did not recognise her daughter, could not mobilise well, and complained of a right-sided headache. Mrs A's daughter took her to the public hospital, where she was diagnosed with delirium due to urinary tract infection, and admitted for antibiotic administration. Mrs A was discharged back to the rest home on 15 April.

36. In a letter dated 15 April 2008, Mrs A's family made a written complaint directly to the rest home about the standard of nursing care. The letter raised a number of issues, primarily the failure of the registered nurse on duty on 13 April to seek urgent treatment for Mrs A. The letter also recorded the family's concerns about previous incidents, including the medication error in November 2007, the rest home response to falls, and communication with family members.

37. On 2 May 2008, rest home Manager Ms G and Ms I met with Mrs A's daughters to discuss concerns raised by the family in their letter of 15 April. As an outcome of the meeting, Ms G developed the following action plan:

- take a daily urine sample from Mrs A for the next six weeks, and record test results;
- ensure that Mrs A's legs are moisturised, and support stockings put on daily;

- notify Mrs A's daughters prior to their mother's three-monthly GP review, and ensure that one of the daughters is contacted directly if the family are to be notified of any incident;
- ensure that Mrs A is assessed by the GP one week before the completion of her current antibiotic regime;
- ensure that Mrs A is provided with appropriate pain relief;
- meet monthly with Mrs A's daughters to discuss her care, and any issues that may arise.

38. The rest home also advised the family of the actions it had taken in relation to the registered nurse who was on duty on 13 April, when Mrs A was found by her daughter disoriented and confused, complaining of a right-sided headache.

August 2008

39. On 19 August, Mrs A was found unresponsive in her room by care staff. A right facial droop was noted by her daughter, who accompanied her to the public hospital. Mrs A improved over time, and was diagnosed with a likely cerebrovascular accident (stroke) with possible seizure. She was discharged back to the rest home on 20 August 2008.

October–December 2008

40. On 13 October 2008, Ms D took over the position of nurse manager. The rest home told HDC that Ms D had identified that:

> "due to wandering [Mrs A] needed to be reassessed for her suitability as a hospital level resident, with a view to [Mrs A] potentially being assessed as requiring dementia level care".

41. The rest home also advised that Ms D directed staff to complete an incident form whenever Mrs A was found wandering, and to notify her family each time it occurred. During the period 13 October to 31 October, staff completed two incident forms relating to Mrs A's wandering.

42. On 31 October 2008, Ms D met with Mrs A's family to discuss her wandering and develop an action plan to reduce incidents in future. Following the discussion, a number of interventions were agreed upon to alert staff to Mrs A's wandering and to prevent her wandering in the first place. An action plan dated 4 November 2008 records the objective as "to try to reduce the incidence of wandering in [the] afternoon". The actions to be taken included taking Mrs A to the lounge to watch television, sitting her next to another resident, providing an extra cup of tea at about 4pm, and using a sensor mat next to Mrs A's bed to notify staff if she left her room.

43. Mrs A's daughters told HDC that the interventions put in place were at their suggestion. They do not remember whether Ms D discussed with them the direction that staff were to phone them every time Mrs A wandered. Ms G told HDC that "[a]s part of the plan it was agreed that the rest home would contact the family every time [Mrs A] wandered". The family told HDC that they did not consider that they needed to be contacted on each occasion, including for example on 12 January, when Mrs A

avoided the sensor mat and left her room during the night. On that occasion, she did not leave the building, but is noted to have wandered near the nurse's station at 2am.

44. The success of the interventions was reviewed on 10 December, 23 December, and 5 January 2009.

45. In November, Mrs A was noted to have wandered on two occasions.[4] In December, incident reports record that Mrs A was found wandering on eight occasions.[5] On each occasion, either Ms B or Ms C was telephoned by staff from the rest home. This included one incident on 16 December, when Mrs A was noted to have wandered outside in the rain at 2pm. This was on the same day that Mrs A was administered morphine in error.[6]

Further request for reassessment

46. On 3 December 2008, Dr J wrote a note to an organisation responsible for assessing needs of older people. He asked for an assessment of the appropriate level of care for Mrs A "as requested by Nurse Manager".

47. On 10 December, Dr J saw Mrs A with her daughters, as part of the standard three-monthly review. He noted that Mrs A was wandering in the afternoons. He noted in the clinical record to "refer to psychogeriatrician for review re wandering. I think she is OK here but referred to Psych Ger at request of Nurse Manager."

48. On 12 December, Dr J wrote to the public hospital to request a psychogeriatrician assessment for Mrs A, stating that the nurse manager was "concerned [regarding] risks from wandering and requests consideration of ?dementia unit". He requested assessment and "offer opinion re safety".

Medication errors

Introduction

49. While Mrs A was resident at the rest home three medication errors occurred. Two of these errors were made by agency nurses, and involved giving Mrs A medication that was meant for another resident. The third error was made by a nurse employed by the rest home who did not ensure that Mrs A had swallowed her medication.

Medication policy

50. The rest home's Medication Policy Guidelines — Administration of Medication requires that a registered nurse (or an enrolled nurse or senior caregiver assessed as competent by the Manager) administers medications. The nurse must "positively identify" the resident. The medication is then checked against the medication chart. After the medication has been given it is recorded on the medication chart. The nurse must also "[e]nsure oral medication is swallowed".

51. In the case of controlled drugs, including morphine and pethidine, "[t]wo registered nurses must check the dispensing and administering of the controlled drug …" When

[4] 18 and 22 November.
[5] 1 December at 4.30pm and 6pm, 4, 7, 8, 9, 16 and 25 December 2008.
[6] See paragraph 49 following.

there is only one registered nurse on duty; a senior caregiver should be used as a witness.

52. Medication charts are stored in a folder in the drug room. At the bottom of each medication chart is a box for "Cautionary & Advisory Instructions".

53. In the case of an error, the *Medication Policy Guidelines — Errors, Incidents and Adverse Reactions* requires that all incidents must be reported on an Accident, Incident & Hazard form. Adverse reactions and suspected adverse reactions to medications are to be reported to the medical officer. Family are to be notified of any administration errors.

54. The Clinical Services Manager, Ms H, is responsible for ensuring all clinical policies and procedures, including the medication management policy, are current and in line with best practice and legislative requirements.

Identification of the correct resident

55. The rest home advises that, to assist nurses to identify the correct resident to administer medication to, the fundamental RN check would have been to match progress notes, medication charts and room number. To assist with this, the rest home says:

- All residents' rooms were clearly numbered at all times;
- Residents' room numbers were "clearly indicated on the resident's progress notes"; and
- Mrs A's medication chart had "'ALERT' SAME NAME RESIDENT (CHRISTIAN)" handwritten at the top.

56. The rest home told HDC that the alert was written on Mrs A's chart before the first error. The medication chart provided was apparently superseded by another chart in 2008, but this chart was not able to be located by the rest home. The medication chart for the resident whose medication was later given to Mrs A did not have an alert on it at any time.

57. The rest home further advised that nurses could check the resident's clothing, to confirm his or her identity.

58. The Care Progress notes have a sticker attached to every second page, with Mrs A's name and details, including her room number — "66". However, in March 2008, Mrs A moved from room 66 to room 33. From that date, the room number "33" is handwritten on some pages, but the sticker was not updated with the correct room number.

Agency nurses

59. As part of its contract with the agency providing temporary nursing staff, the rest home must provide agency staff with orientation to its standards, policies, procedures and guidelines. The rest home advised HDC that the agency nurses involved in the

following incidents did undergo orientation prior to commencing work at the rest home. The agency nurses also completed a drug competency test. This includes knowledge of the requirement that the right drug is administered to the right person.

60. Agency nurses, like any registered nurse, have a professional responsibility to maintain their competence and demonstrate a safety to practise. Every registered nurse must comply with the competencies set out by the Nursing Council of New Zealand. In accordance with competency 1.1, registered nurses are expected to practise responsibly and in accordance with relevant policies.[7] The acceptance of responsibility for actions within the scope of practice is a key indicator of meeting this competency.

61. Competency 2.1 states that registered nurses must provide "planned nursing care to achieve identified outcomes".[8] An indicator of this competency is that medications are administered in compliance with the law, relevant policies and guidelines and according to prescriptions.

Medication error — 29 November 2007

62. On 29 November 2007, Mrs A was administered the antidepressant amitriptyline (10mgs), the sleeping pill temazepam (10mgs), and paracetamol (1mg) in error. The medications were prescribed for another resident with the same first name. In this case, the registered nurse administering medications confused Mrs A with another resident. The registered nurse, Ms E, was an agency nurse.

63. In an account to rest home management, Ms E explained that she did not realise that there were two patients with the same first name. She became confused because there were no room numbers on any of the rooms,[9] and when she spoke to one of the caregivers about the other resident it was her understanding that she was pointed towards her room. However, this turned out to be Mrs A's room.

64. Immediately after realising her mistake, Ms E reported the error to the on-call doctor and the on-call registered nurse, in accordance with the rest home's *Medication Policy Guidelines — Errors, Incidents and Adverse Reactions.* Ms E followed the doctor's instructions to observe Mrs A regularly, and immediately completed an incident form.

65. Mrs A's family was notified, and the rest home, Ms E, and the nursing agency apologised for the error. The manager of the rest home, Ms G, told the family that the registered nurse's behaviour was "inexcusable" and "her employment at [the rest home] ceased".[10] Mrs A's daughters say that the letters of apology from the nurse and the agency were not provided to the family until a meeting in May 2008.

66. The rest home told HDC that following the incident, a red label with the words "duplicate name" was added to Mrs A's file, in order to alert staff that there was

[7] Nursing Council of New Zealand, *Competencies for registered nurses* (Wellington, December 2007).
[8] Nursing Council of New Zealand, *Competencies for registered nurses* (Wellington, December 2007).
[9] As noted above, the rest home advised that there were door numbers on all rooms at the time.
[10] The agency director (who has since resigned) wrote a letter to [the rest home] dated 6 December 2007, in which he stated that in relation to Ms E, he did not feel he could "continue to offer her work in [his] company".

another resident with the same first name. Mrs A's family was advised of the actions taken.

Medication error — 16 December 2008

67. On 16 December 2008, agency nurse Ms F gave Mrs A 20mg of M-Eslon (morphine) in error. As with the previous medication error, the medication was intended to be administered to the other resident. The Medication Policy Guidelines — Administration of Medication requires the nurse to be accompanied by another nurse or senior caregiver when administering a controlled drug. Ms F said she was the only registered nurse on duty at the time. It is unclear whether she was accompanied by a senior caregiver at the time she administered the morphine to Mrs A.

68. In a written explanation of the incident, Ms F (who was working for the agency Nurse Plus) advised that the facility was short-staffed and, as a result, the caregivers were assigned additional patients. She explained that during the medication round she was interrupted with various requests from the caregivers. After she attended to these issues she picked up the wrong medication chart, mistaking the other resident's medication chart for that of Mrs A. As a result, she administered the other resident's medications to Mrs A.

69. The registered nurse immediately notified Nurse Manager Ms D, telephoned Dr J for advice, and notified Mrs A's family. She also completed an Incident/Accident Form.

70. The clinical record notes that Mrs A was sighted by Ms F at 10.30am, 12.30pm and 2pm, and overnight. She was reviewed by Dr J the following day. Ms D spoke to the family at 3.30pm. According to a separate Incident/Accident form (IAH form) completed in relation to Mrs A wandering at 2pm, the family questioned whether the wandering was due to the medication error. Ms D told HDC that she documented the call in the IAH form.

71. The IAH form records: "Spoke to family regarding wandering. Family questioned whether due to medication error. I suggested would make her sleepy and that she had been continuing to wander anyway despite us following [the] action plan. Informed that Dr would check tomorrow. All procedures followed. Family requested protocols and procedures and explanation of how error occurred."

72. The medical notes for 16 December include a note signed by Ms F that she had contacted the family, and a note signed by Ms D stating "Family rang regarding [Mrs A] wandering".

73. The rest home advised that the incident was discussed with the agency nurse concerned. An investigation into the incident concluded that the nurse "followed [rest home] policies and procedures".

74. On 12 January 2009, Ms G passed on a letter dated 3 January from Ms D to Ms C. This letter stated:

> "Whilst I noted your comments regarding questioning whether her wandering in the afternoon was due to confusion from the medication, her pattern of

> wandering has increased on other days too despite the implementation of the action plan as agreed."

75. Further, Ms D explained that the mistake was made as a result of "human error", the registered nurse having made "a genuine mistake in [relation to] which [resident] she thought she was administering the medication to".

76. Ms D advised Ms C that:

> "[a]s a consequence of this there has been a discussion regarding how we can increase the chance of this mistake being avoided and have implemented larger sheets with larger photographs of residents and a warning if there are two residents with the same first names".

77. Following this incident, the rest home states that it took a number of steps to prevent recurrence, including:

- ensuring that all registered nurses, including agency nurses, have completed drug competency tests, relating to drug administration and documentation;
- ensuring that care staff have completed in-service education (facilitated by Radius Pharmacy) regarding medication administration;
- all drug chart covers include a colour photograph of each resident, the resident's room number, and a warning sticker if two residents share the same name;
- a laminated sign has been affixed to the drug trolley, reminding other staff PLEASE DO NOT INTERRUPT THE REGISTERED NURSE DURING MEDICATION ROUND UNLESS A RESIDENT IS IN NEED OF ASSISTANCE — SEE NURSE MANAGER IF APPROPRIATE;
- the recruitment of additional permanent staff to fill vacant positions previously filled by agency staff. The rest home is now fully staffed;
- introducing a robotic system of medication administration.[11]

Loose medications found — 8 January 2009

78. On 8 January 2009, one of Mrs A's daughters found her mother's medications loose in her room as a result of the nurse administering the medication not having ensured that the medication was actually taken.

79. The Medication Policy Guidelines — Administration of Medication requires the nurse to ensure that the medication has been swallowed.

80. Following review of this incident, the registered nurse who administered Mrs A her medications on this occasion explained that she made an error of judgement that Mrs A was capable of taking her medications unattended. In a letter to Ms C, Ms G, rest home manager, explained how the error was made, and said that she had discussed with all registered nurses the need to supervise Mrs A when administering her medication.

[11] Medications are pre-packaged and the medication charts are computer generated for each patient.

Complaint

81. On 11 January 2009, Ms C made a complaint directly to the rest home, in which she raised her concerns in relation to the recent medication errors. Referring to the medication error on 16 December 2008, Ms C noted that she had earlier asked for details of the processes and protocols that would be initiated to ensure such an error would not occur again. She also stated:

> "To date I have not received a letter from [Ms D]. Can you please arrange for this letter to be sent as soon as possible? As you will be aware this is the second serious medication error concerning [Mrs A], both involving agency nurses. [Mrs A's] family is very uneasy that failings regarding the safe provision of medications have not been rectified."

82. Ms C also raised a number of additional concerns, including finding Mrs A not wearing her hip protectors, advising that the caregivers were unable to fit the protectors correctly when asked, and finding Mrs A not wearing her glasses when they were sitting on her dressing table.

83. In response to this complaint, the rest home made the following changes:

- a notice was placed in Mrs A's room reminding staff that she must wear her hip protectors. New staff were shown how to correctly fit these protectors, and her long-term care plan was updated to include this requirement;
- caregivers were reminded that Mrs A wears glasses;
- basic standards of care were discussed during an in-service seminar on elderly abuse;
- the registered nurse who did not witness Mrs A swallowing her medications was reminded of the need to do this.

84. In her response to HDC, Ms D apologised if she gave the impression that she was not concerned about the medication error in December 2008. She advised that "[t]he care of [Mrs A] is and was paramount and my focus at the time was minimising the risk to her rather than focusing on the error". As noted above, on 12 January Ms G provided the family with a copy of Ms D's letter dated 3 January.

Additional quality improvements carried out by the rest home

85. the rest home has provided staff with the following in-service training:

- long-term care plan development
- initial care and support plan writing
- short-term acute care plan management
- admission procedures
- long-term care plans and communication with family
- standards of practice, including nurses' Code of Conduct
- medication administration.

86. In addition, the rest home advised that all registered nurses (including agency nurses) have completed drug competency tests, 24 staff members are completing the National

Certificate in "Support of the Older Person", and two caregivers and one registered nurse are undertaking a palliative care course.

87. Ms H, who is responsible for the investigation of adverse incidents and implementation any necessary changes, advised that the medication management policy was reviewed in May 2009. Ms H has developed a generic training audit tool to ensure that staff comply with the relevant standards, including the medication management policy. In addition, a medicine management tool is now available on-line to ensure that each facility complies with the relevant standards.

Ministry of Health audit

88. On 19 November 2008, HealthCERT conducted an unannounced inspection of the rest home, after receiving complaints about the care provided to residents.

89. The audit found a number of service areas where corrective action was required to comply with Health and Disability Sector Standards. An implementation plan was required to be submitted to the Director-General of Health within one month of the inspection report being received by the rest home.

90. Areas that required action included: removing means of taking short-cuts that could endanger resident safety; reviewing policies and procedures and incident reporting, particularly to ensure adequate detail to identify residents at risk of relapsing after illness; documenting unplanned hospital admissions on incident forms; ensuring complaints are managed as per the rest home policy; ensuring that families are engaged in decision-making, and communication with them is documented; ensuring regular review of resident progress notes and indicators of well-being (for example, weight) and implementation of short-term care plans where necessary; ensuring frequent assessment, monitoring and observation of unwell residents; and ensuring that the storage and administration of medicines complies with legislation, regulations and guidelines.

91. In February 2009, the rest home submitted an implementation plan to address the shortcomings identified by the HealthCERT audit. On 10 April 2009, the Ministry of Health advised that the rest home had attained many of the Health and Disability Sector Standards, and it would continue to liaise with the rest home Area Manager until all sector standards were met.

92. In June 2009, the rest home submitted a progress report to HealthCERT which has been accepted with no request for any additional changes.

Mrs A

93. On 29 January 2009, Mrs A was reassessed by the social worker from the public hospital. The assessment indicates that, on the basis of the Incident and Accident forms, the incidents of wandering had become more pronounced. The letter notes that the family had chosen another rest home, and a bed was being held for Mrs A in a secure dementia wing.

94. Mrs A's daughters told HDC that they had decided to move Mrs A before the assessment took place, because of their concerns about the rest home. They explained

that although they wanted Mrs A to remain in hospital level care as long as possible because despite her dementia she was still cognitively able, they were concerned that she not be subjected to more moves than essential. Mrs A was transferred to another rest home facility on 5 February 2009.

Response to my provisional opinion

Ms D

95. Where appropriate, Ms D's comments in response to my provisional opinion have been incorporated into the "information gathered" section of this report. In addition, Ms D responded as follows:

Communication with the family about wandering

96. In relation to contacting the family on each occasion Mrs A wandered, Ms D explained there were three reasons why the contact with the family was important:

- First, that it was a requirement by the rest home that family members were contacted, as noted in the IAH form;
- Second, Ms D says that it was agreed at the meeting on 31 October 2008 that the family would be contacted each time she wandered, and Ms D provided a letter from Ms G saying that she attended the meeting and stating that as part of the plan it was agreed that the rest home would contact the family every time Mrs A wandered; and
- Third, Ms D noted that on 15 April 2008, the family had complained that the rest home had failed to adequately inform family contacts after Mrs A was found wandering outside the village in March 2008. On that occasion, a message had been left on an answerphone, and the family complained that other family contacts were at home and available.

97. Ms D stated that the reason for contacting the family after she was found wandering at 2am was not because it was a safety issue, but because "the disguising of the sensor mat was no longer working".

98. Ms D further notes that although the family were prepared to accept a level of risk attached to Mrs A wandering, her clear understanding, which she had discussed with auditors from HealthCERT, was that "we cannot abdicate the responsibility of safety to family members". She provided a photograph of the train tracks close to the gate of the rest home, and stated that "[t]here was a real safety issue for [Mrs A] considering that we are so near the railway lines … without any barriers and several times she was outside the gates".

Response to the medication error

99. Ms D explained that she believed that the registered nurse who made the error should "be allowed to follow through and approach the family with an apology and what steps she had made to minimise the side effects".

100. Ms D stated that she does not agree that the focus of her discussion with the family later in the day was on the issue of wandering. She says that it was only a part of the discussion "as the other part was a request from [Ms C] to have an update on what steps were put in place to reduce wandering and minimise risk, what our policies and procedures [were] and what disciplinary [action] we were to take against the RN".

101. Ms D stated that she believed staff were vigilant, and noted that Mrs A was observed "only a few moments before she wandered. It is impossible for any facility to monitor someone constantly." Ms D referred to the expert advice, saying that "incidents were followed up by management appropriately, and in relation to the medication errors, on each occasion the incidents were taken seriously and the family were involved in the investigations and the outcomes".

102. Ms D provided additional information about the steps she has taken to encourage an open style of management with staff, residents and family members. She advised that she has introduced several new initiatives including:

- Contacting family to ask if they have any concerns or questions;
- A communication book in each resident's room for information sharing between the family, the key worker and caregivers;
- Letters sent to the family to update them about their key worker and primary caregiver;
- "Meet and Greet" social occasions; and
- Meetings with families about new ideas.

103. Ms D stated:

> "My door is always open and I often have residents/families/staff just 'popping in' at which I always turn away from my computer, put down my pen and give my full attention to them as part of the openness.
>
> …

> I acknowledge that I walked into a very difficult situation. It is a very emotional period when family members have to contemplate moving their loved ones as this causes disruption in their lives and I have great empathy with the families and residents involved. My communication with [Mrs A's] family was always professional, open and empathetic regarding this but I could not abdicate my responsibility to both [Mrs A] and our other residents at [the rest home]."

Opinion

No breach but adverse comment — the rest home and Ms D

104. *Overview*
In the course of this investigation, I have been reminded that, while good policies and procedures are a necessary part of a quality health service, it is the personal relationships between individuals that make the difference. Sound policies and procedures do not necessarily amount to good care. Although Ms D was the Nurse Manager at the time when I consider communication could have been better with the family, I acknowledge that she arrived at a time when the rest home was clearly having some difficulties, as evidenced by the HealthCERT audit in November 2008.

105. In this case, the clinical advice from Ms Rowe concludes that the care provided to Mrs A was appropriate.

106. I consider that although the care may have been reasonable, it was far from reaching the level of care that families want when they entrust the care of their family member to a rest home. On that basis, I have decided that although there has been no breach of the Code, there are lessons to be learnt from this complaint.

Medication errors

107. On three occasions, medication errors were made by individual nurses. In all the circumstances, and taking Ms D's response to my provisional opinion into account, I agree that after the second medication error, correct procedures were followed by Ms D and the nurse involved. The nurse contacted the family and the GP and completed the appropriate paperwork. I accept that Ms D took steps to prevent the same error occurring again in a timely and appropriately documented manner. On that basis, I consider there was no breach of the Code in this case.

108. However, where there was room for improvement was in the communication between Ms D and the family after the medication error. In particular, I consider that the conversation between Ms D and Ms C on 16 December 2008 was unhelpful, and Ms D should reflect on the way she approached that discussion.

109. In contrast to the first medication error, the family were not satisfied with Ms D's response to the medication error in December 2008. From their point of view, this was the second time Mrs A had been given a different person's medication. This time, it was morphine — a controlled drug. Despite being observed by staff on the advice of

the GP, Mrs A was not seen leaving the building. Ms C spoke to Ms D in the afternoon. This is what Ms D recorded about that phone call:

> "Spoke to family regarding wandering. Family questioned whether due to medication error. I suggested would make her sleepy and that she had been continuing to wander anyway despite us following action plan. Informed that Dr would check tomorrow and all procedures followed. Family requested protocols and procedures and explanation of how error occurred."

110. While I acknowledge that Ms D has said that the conversation was only partly about the wandering, after reading Ms D's notes of the conversation on the IAH form, it is apparent to me that the primary focus of the discussion from Ms D's point of view was the fact that Mrs A had wandered. To be blunt, that is what the form says: "spoke to the family regarding wandering". This is also what is recorded in the medical notes, and it is consistent with the agreement apparently reached with the family that they would be contacted each time Mrs A wandered. It appears from the records that Ms C asked about the wandering in the context of the medication error, and Ms D responded by referring to the action plan not working.

111. On this occasion, I do not consider that the way the phone call was managed was helpful. There had been a serious medication error, and in my opinion Ms D should have responded better to the family's concerns about the matter. The family was clearly concerned about the medication error, not the wandering. This was not the time to discuss the action plan. In my opinion, it would have been more helpful for Ms D to have concentrated on apologising for the medication error. I draw the rest home and Ms D's attention to HDC's Guidance on Open Disclosure 2009, attached as Appendix B. In particular, a disclosure should include acknowledgement of the incident, an explanation of what happened, how it happened, why it happened, what actions have been taken to prevent it happening again (if appropriate), and a sincere apology.

Communication with the family

112. Mrs A's daughters were frequent visitors at the rest home. It is clear that they took a close interest in their mother's welfare, and were proactive in their attitude to issues that arose from time to time.

113. It seems that they did not share the level of concern held by Ms D about their mother's wandering. In response to my provisional opinion, Ms D pointed out that, as nurse manager, she had a responsibility to ensure Mrs A's safety, and to refer her for further assessment if she had concerns. It is appropriate that she made referrals for reassessment in December 2008. Ms D also stated that she could not abdicate responsibility for safety to a family member. I agree.

114. It is also appropriate that the nurse manager arrange for the family to be notified of incidents and accidents. In response to my provisional opinion, Ms D said that the family were contacted for three reasons. First, it was a rest home requirement. Second, it was agreed at the meeting in October 2008 that the family would be contacted each time Mrs A wandered. Third, Ms D said the family had complained when they were

not contacted in March 2008 when Mrs A had been found wandering outside the village.

115. I remain of the view that the overarching reason for contacting the family every time she wandered was to prove to the family that Mrs A's wandering was not able to be managed, and she needed to move to a more secure residence.

116. While I accept that Ms D can point to other reasons why the family would be contacted about Mrs A's wandering, I note Ms D's further comment — that she "walked into a very difficult situation. It is a very emotional period when family members have to contemplate moving their loved ones."

117. It is not ideal when the rest home and the family do not agree on the point at which the rest home is no longer able to cater for the resident's needs. In this case, it seems there was a difference in views about whether the point had been reached where Mrs A could no longer safely remain at the rest home. In her response to my provisional opinion, Ms D set out her concerns about Mrs A's safety, in particular because of the proximity of the railway lines. However, I note the GP's comment on 10 December 2008 when he recorded in the clinical record a referral to a psychogeriatrician for review in relation to her wandering: "I think she is OK here but referred to Psych Ger at request of Nurse Manager." I also note that Mrs A's tendency to wander had been recorded and steps taken to manage this since she was admitted to the rest home in 2006. However, she had not been assessed as requiring secure care.

118. I note that the HealthCERT audit in 2008 found there were shortcomings in relation to the rest home ensuring that families are engaged in decision-making. The decision to move a family member into secure care is important and can be difficult. In this case, Ms D took the appropriate step of requesting an assessment by the psychogeriatrician when she was concerned about Mrs A's wandering. However, I remain of the view that the phone calls to the family on each occasion Mrs A wandered did not lead to increased engagement by the family in this decision-making process. I note the improvements Ms D says she has instigated, such as telephoning families to discuss issues or concerns, and the addition of a communication book to share information between the family and staff. I am pleased that Ms D has made changes to the way the rest home communicates with families.

119. As stated at the beginning of this opinion, in a quality health service, personal relationships between individuals make the difference. I am sure that Ms D will have reflected on the way that she communicated with the family.

Care of residents who like to walk

I am also concerned that no thought appeared to have been given to providing Mrs A with opportunities to walk safely, other than to confine her to the building. It is not uncommon for people with moderate dementia to want to walk. However, they may also benefit from the opportunities for social interaction provided in the rest home and hospital level care setting. I would like the rest home to consider how it currently provides for people who have been assessed with a level of dementia appropriate for

rest home or hospital level care, but who like to walk, and what improvements they could make.[12]

General care

120. I acknowledge the family's concerns that the general care provided to Mrs A began to deteriorate towards the end of her stay at the rest home. However, as noted by Ms Rowe, there was regular documentation in relation to attempts to address these issues, including transferring her to the hospital wing and review by both the GP and a psychogeriatrician. There is also regular documentation in relation to Mrs A's hip protectors. I note Ms Rowe's opinion that "[t]here is no indication in the documentation that the level of care provided … was inadequate". In addition, Mrs A presented increasingly challenging behaviour, which was identified, and appropriate reassessment occurred.

Conclusion

121. Mrs A relied on those caring for her at the rest home to look after her. She was not able to advocate for herself, and was fortunate that members of her family were able and willing to involve themselves to the extent they could. However, on a day-to-day basis, Mrs A and her family depended on rest home employees to provide care. Although the rest home had appropriate policies and procedures to support good practice by employees, these did not prevent three medication errors.

122. I have carefully considered whether these errors were the result of a culture of non-compliance. In this case I am unable to reach such a conclusion. However, although I have not found either the rest home or Ms D in breach of the Code, from the perspective of this consumer's family, the care did not meet their expectations, and there are lessons to be learnt from their experience.

Other comment

Agency nurses

123. Registered nurses are expected to practise with responsibility and in accordance with relevant policies (Nursing Council of New Zealand Competency 1.1).[13] The acceptance of responsibility for actions within their scope of practice is a key indicator of meeting this competency.

124. Competency 2.1 states that registered nurses must provide "planned nursing care to achieve identified outcomes".[14] An indicator of this competency is that medications are administered in compliance with the law, relevant policies and guidelines, and according to prescriptions.

[12] For example, by providing adequate fencing or appropriate opportunities for the resident to walk under supervision.
[13] Nursing Council of New Zealand *Competencies for registered nurses* (Wellington, December 2007).
[14] Nursing Council of New Zealand *Competencies for registered nurses* (Wellington, December 2007).

125. Both Ms E and Ms F underwent orientation to the rest home's policies and procedures, including the medication administration policy, when they started at the rest home. However, neither of them took adequate steps to "positively identify" Mrs A before giving medications to her. Simply checking a patient's first name is not sufficient, particularly in circumstances where the nurse is unfamiliar with the patient. In addition, Ms F was not accompanied by another registered nurse when administering morphine, a controlled drug, as directed by the rest home's policies.

126. It was also the nurses' responsibility to adequately check they were administering the right medication to the right resident. In not doing so they failed to provide Mrs A with services with reasonable care and skill.

127. In this case, both Ms E and Ms F took immediate action in reporting the error and took corrective action in accordance with policy. However, I plan to send a copy of this report to both nurses and the Nursing Council of New Zealand, highlighting the errors made.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand.
- The rest home is to report to HDC on what strategies the rest home has in place to ensure that their clients with dementia who like to walk are able to do so safely.
- A follow-up visit from HDC will be made to the rest home to ensure all steps stated as having been taken to prevent recurrence are in operation.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to HealthCERT, and it will be advised of the rest home and the rest home's names.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert nursing advice from Wendy Rowe[15]

I have been asked to provide an opinion to the Commissioner on case number 08/20820. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I am a registered nurse with 24 years of nursing experience. I spent the first 15 years of my career working in a hospital in a variety of settings, mainly medical and rehabilitation, then worked for seven years in the private sector primarily in the aged care areas. My last job was as a senior Academic staff member at a polytechnic. I now work full time as a Clinical Nurse Manager of a convalescent care facility that is owned by a DHB, which includes hospital level care, slow stream rehabilitation, palliative care and GP admissions. I have a Bachelor of Nursing, a Master of Arts and a Certificate in Adult Teaching and Education, and I am currently completing a postgraduate certificate in Adult and older Adult at Massey University.

Purpose

To provide independent expert advice about whether the rest home, … Nurse Manager [Ms D] provided an appropriate standard of care to [Mrs A].

[The summary of the complaint and list of documents sent to Ms Rowe has been removed to avoid repetition.]

Expert Advice Required

1) The appropriateness of health care provided to [Mrs A] by [the rest home], from November 2007 to February 2009.

• There is evidence of adequate policies and procedures during this timeframe to guide staff in delivery. Incidents were followed up by management appropriately [as noted in [Ms D's] response to HDC complaint]. Client progress notes indicate care delivery at an acceptable level provided by staff during this time.

• Medication policy guidelines clearly outline procedures that include such things as security, charts, prescribing, supply of medicines and administration. Within these guidelines there is a section for controlled drugs. With the event of all three medication errors the correct processes were implemented and changes occurred to minimize the risk of the same error occurring again. On each occasion the incidents were taken seriously and the family were involved in the investigations and the outcomes.

• Progress care notes during the period indicate personal cares completed on a daily basis. There are many entries pertaining to falls, incontinence, wandering and confusion. Relative contacts are well documented.

2) The appropriateness of health care provided to [Mrs A] … from November 2007 to 13 October 2008.

• There is evidence of a complaint (April 2008) by [Mrs A's] family about the care received in April 2008. The RN in question subsequently resigned (March 2008). [Mrs A] was re-admitted to hospital following a UTI. Other concerns were pertaining

[15] Parts of this advice have been removed where the advice refers to a provider who is not the subject of this report, to protect that person's privacy. Where deletions have been made, this is indicated by "…".

to a fall, pain and medication error were noted in this complaint. These concerns were appropriately dealt with at the time by the management team. During March 2008 [Mrs A] was moved from the rest home to the hospital wing as a result of an assessment by the Nurse Manager.

• During May 2008 a family meeting was held and issues were discussed and documented in a letter to [Ms C]. A monthly meeting was arranged with the family [referred to in letter dated 2 May 2008] to ensure any issues were addressed.

• There is evidence that assessments were completed and a plan of care initiated. There is a lack of evaluation of the short term or long term care documented [refer to the care plan].

• There is no indication in the documentation that the level of care provided during this period of time was inadequate. Progress notes indicate that …staff provided a level of care appropriate during this period of time.

• There are indications that agency nursing staff were being used during this time and that some documentation may not be familiar to them, however there is no evidence of a lack of care on the nursing agency staff behalf.

3) The appropriateness of health care provided to [Mrs A] by Nurse Manager [Ms D] from 13 October 2008 to February 2009.

• Area Manager, [Mr K] [in his letter dated 27 April 2009] indicates that [Ms D] identified [Mrs A] required re-assessment for hospital level or dementia level care. Incident forms were completed whenever she wandered and the family were notified each time this occurred. A family meeting outlined the use of a sensor mat, extra conversations and cups of tea in the lounge were suggested as possible solutions for the wandering at this time.

• There is evidence that [Ms D] appropriately followed up on the second medication error [[Ms D's] response to complaint].

• Incident forms were completed and followed up appropriately during this time [refer to care plan].

• Progress notes indicate that [Ms D's] staff provided an appropriate level of care during this period of time. Sequencing of care progress notes is sometimes difficult to follow as it is not always in chronological order. All staff need to write in the same place [refer to continuation notes on 25 August 2008].

4) Did the rest home have appropriate policies and procedures in place for the administration and storage of medications? If not, please state what additional policies and procedures are necessary.

• The medication policy guidelines state [under controlled drugs] "witness dispensing and administering." It is not clear in evidence if the registered nurse checked the narcotic medication with another staff member and then dispensed individually or not. If the RNs had taken the second person to the patient then it may have been obvious that the medication was being given to the wrong person.

• [Administration of medication policy] indicates that the RN will "positively identify" the resident before any medication can be given to that person. Although this is best practice the RN at the time indicated she was distracted.

• The guidelines indicate that medications are stored in a secure condition. There is no indication that the medications were not stored appropriately.

5) Did the rest home have appropriate staff training and competence assessment for the administration and storage of medications? If not, please state what further training and assessment is necessary.

• There is evidence of a drug competency test [template provided by the rest home] which is comprehensive. There is no evidence however of who had completed this test.

• The medicine policy includes flow charts showing the staff how to administer medications. This flow chart includes such things as "check photo" and ensure "medication is swallowed". Also [on mediation policy flow chart, reviewed in January 2008] there are instructions on how to manage a medication incident. The flow chart indicates the steps to take following an incident occurring. These are all standard procedures.

6) Did the rest home …respond appropriately to the first medication error involving [Mrs A], on 29 November 2007? If not, what further response was necessary?

[Mr K], Area Manager [in his letter dated 27 April 2009] indicates that the response from the staff following the medication error on November 2007 was effective and in accordance with [rest home] procedures. Apologies were made and the RN involved in this incident resigned.

7) Did the rest home and Nurse Manager [Ms D] respond appropriately to the second medication error involving [Mrs A], on 16 December 2008? If not, what further response was necessary?

• [Ms D] indicates [in her response to the complaint] she was informed by the agency RN that she had made a medication error. All appropriate steps were taken by the RN as per the policy and an incident form was completed [dated 16 December 2008]. On the same day the Nurse Manager spoke to [Ms C] the patient's daughter about the incident. [Mrs A] was monitored that day and seen by the GP the following day [refer to continuation notes]. Further procedures were instigated as a result of this error by the Nurse Manager [Ms D] to avoid a repeat happening.

• RN [Ms F's] written evidence indicates that the facility was short staff [dated 16 December 2008] and does not say in her evidence [anyone] checked the medication with her. On discovering the error the RN took all the steps to ensure that the patient was monitored appropriately and the document completed. RN [Ms F] does not indicate in the care progress notes which medication was given by mistake. Evidence of close monitoring by the staff followed this incident [refer to continuation notes].

• This incident led to [the rest home] introducing a Robotic system of medication administration. All of the RNs then completed drug competency tests and in service education (no evidence of this given). Photos were placed on all drug charts to

identify individuals as well as room numbers added. A notice on the medication trolley indicated not to interrupt the RN during medication rounds.

• [The rest home] now have their own staff and most RN shifts are covered internally. [Mr K], Area Manager indicates that since these steps have been taken there have been no more medication errors.

8) Did the rest home and Nurse Manager [Ms D] respond appropriately to the third medication error involving [Mrs A], on 8 January 2009? If not, what further response was necessary?

• Medication policy guidelines states "ensure all medication is swallowed. It must not be left for the resident to take later." Obviously this did not happen on this occasion.

• An incident form was completed following this medication error [dated 8 January 2009] re medication found by daughter and was followed up by both an audit of the medication management at the time [dated 22 November 2009] and the Manager [letter dated 23 January 2009].

• Letter to [Ms C] on 23 January 2009 discusses a number of issues including medication error and the actions taken by the Manager [dated 23 January 2009].

9) Were appropriate steps taken by the rest home and the nurse managers to ensure that [Mrs A] was dressed appropriately (with hip protectors and glasses)? If not, what further steps should have been taken?

• Evidence in entries in the care progress notes that the hip protectors were being worn along with pressure stockings [entries between 22 June and 10 July 2008].

• Care progress notes indicate [Mrs A] was able to remove both her incontinence pads and her hip protectors on her own. Sometimes the staff had trouble finding them [22 October 2008].

• No indication that the staff did not dress her appropriately in the documentation provided. Many entries pertaining to being washed and dressed, incontinence issues are discussed and products worn are identified.

10) Were appropriate steps taken by the rest home and the nurse managers to follow agreed interventions to stop [Mrs A] wandering? If not, what further steps should have been taken?

• Following a family meeting to discuss issues and concerns [referred to in the rest home response dated 27 April 2009] all episodes of wandering were documented and an incident form completed. This included a family member being contacted each time.

• A sensor mat was also used to alert staff to wandering and this was discussed with the family at the meeting.

• There are ongoing entries in the care progress notes of continued wandering activities between 2007–2009. On 17/03/08 there is an entry from the Nurse Manager planning a move [Mrs A] to the hospital wing due to the wandering behaviours [17 March 2008].

Overall comments

• There were a number of improvements made by staff towards care of [Mrs A] following complaints and family meetings.

• Drug competency tests were completed in January 2009 for all nurses, plus agency staff used to ensure all staff are educated re medication management.

• Issue of use of agency staff over this period of time have been managed with employment of more permanent staff.

• In November 2008 HealthCERT completed issues based investigation audit and the report indicates areas for improvement and a review of the care plans and incomplete progress notes. These two areas require some additional improvements as stated in the report.

• The Area Manager, [Mr K], indicates a series of in service education sessions have taken place to improve the staff understanding of medication management and a variety of other topics. Staff have also been able to attend education sessions externally to the organisation.

I believe that the rest home, … or [Ms D] did provide an appropriate standard of care for [Mrs A]. There are some areas that the facility could improve on as stated in this report. I believe these are of a minor nature as steps have already been taken to improve aspects of the care delivery. There is evidence of ongoing communication between the [Mrs A's] family and the staff at the rest home on a regular basis to ensure her individual needs were being met on a daily basis.

Thank you

Wendy Rowe (MA, BN, RN, CATE),

Appendix B — Guidance on Open Disclosure Policies

HDC wishes to promote a clear and consistent approach by DHBs to open disclosure. It is what consumers want and are entitled to. Right 6 of the Code of Health and Disability Services Consumers' Rights gives all consumers the right to be fully informed (i.e., to receive the information that a reasonable consumer in his or her situation would expect to receive). Consumers have a right to know what has happened to them.

Internationally, there is a move towards the development of national standards and hospital policies to promote open disclosure. DHBs have a legal duty to take steps to ensure that open disclosure is practised by staff and supported by management. Part of HDC's Strategic Plan 2006–2010 includes the target that all DHBs will have open disclosure policies in place by 2010.

Set out below are guiding points that DHBs should include when developing such policies:

WHAT SHOULD OPEN DISCLOSURE INCLUDE?

• A consumer should be informed about any adverse event, i.e., when the consumer has suffered any unintended harm while receiving health care.[16]

• An error that affected the consumer's care but does not appear to have caused harm may also need to be disclosed to the consumer. Notification of an error may be relevant to future care decisions — whether or not to go ahead with the same procedure on another occasion. The effects of an error may not be immediately apparent.

• A disclosure should include acknowledgement of the incident, an explanation of what happened, how it happened, why it happened and, where appropriate, what actions have been taken to prevent it happening again. (In some situations specific actions will need to be taken straight away, whereas in other situations where the explanation is still unfolding, the actions that need to be taken may take longer to identify.)

• A disclosure should include a sincere apology. This is the provider's opportunity to say, "We are sorry this happened to you." It is not about allocating blame for the event's occurrence, but acknowledging the seriousness of an adverse event and the distress that it causes. Apologies can bring considerable comfort to the consumer and have the potential to assist with healing and resolution.[17] In some situations, an apology may be critical to the consumer's decision about whether to lay a formal complaint and pursue the matter further.

• The consumer should be given contact details and information about the local health and disability consumer advocate as well as options for making a complaint.

[16] Massachusetts Coalition for the Prevention of Medical Errors, *When things go wrong: responding to adverse events* (2006) 4.

[17] See D Frenkel and C Leibman, "Words that heal" (2004) 140 *Annals of Internal Medicine* 482; J Robbennolt, "Apologies and legal settlement: an empirical examination" [2003] *Michigan Law Review* 102.

WHY IS OPEN DISCLOSURE IMPORTANT?

• Because ethically and legally it is the right thing to do.[18]

• There are a number of rights under the Code of Health and Disability Services Consumers' Rights (the Code) that are relevant to open disclosure (see below).

• Open disclosure:

- affirms Consumers' rights;
- fosters open and honest professional relationships; and
- enables systems to change to improve service quality and consumer safety.

• Because the physical harm from an adverse event is often compounded by an emotional or psychological harm when consumers discover that relevant information has been withheld from them.[19]

• Consumers want to know when things go wrong and why, and DHBs have a legal duty to promote the disclosure of such information in accordance with their organisational duty of care.

• Consumers want to know what the consequences could be for them and their ongoing care. It is important to discuss how the event could change anticipated care and any effects the consumer may experience as a result.

• Consumers are also interested in any action taken as a result of the error or adverse event. Many are concerned that the same thing does not happen to anyone else, that changes are made to the healthcare system, and that staff learn from the experience.[20]

• It also helps ensure consumers are advised that they may be entitled to compensation under ACC, so appropriate forms can be completed in a timely manner.

WHO SHOULD BE INVOLVED IN THE DISCLOSURE?

• The health professional with overall responsibility for the consumer's care should usually disclose the incident.

• Research suggests that consumers prefer to hear from a practitioner whom they have already seen, and with whom they have built a rapport. Where this is not the health professional with overall responsibility, both practitioners should be in attendance.[21]

• Research suggests that disclosures by hospital administrative staff or management alone are not well received, although in some cases, particularly where significant harm has resulted, it may be appropriate for senior management to attend with clinicians.

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[18] See R Lamb, "Open disclosure: the only approach to medical error" (2004) 14 *Quality and Safety in Health Care* 3.

[19] See C Vincent and A Coulter, "Patient safety: what about the patient?" (2002) *Quality and Safety in Healthcare* 11(1): 76–80.

[20] M Bismark, E Dauer, R Paterson and D Studdert, "Accountability sought by patients following adverse events from medical care: the New Zealand experience" (2006) 175 *CMAJ* 889; M Bismark and R Paterson, "'Doing the right thing' after an adverse event" (2005) 1219 *NZMJ* 55; A Witman, D Park and S Hardin, "How do patients want physicians to handle mistakes? A survey of internal medicine patients in an academic setting" (1996) 156 *Archives of Internal Medicine* 2565; M Higorai, T Wong, G Vafidis, "Patients' and doctors' attitudes to amount of information given after unintended injury during treatment: cross-sectional, questionnaire survey" (1994) 318 *BMJ* 640.

[21] *Disclosure of harm 'Good Medical Practice'*, New Zealand Medical Council, December 2004 (available at www.mcnz.org.nz).

WHEN/WHERE SHOULD THE DISCLOSURE TAKE PLACE?

• Disclosure should be made in a timely manner, usually within 24 hours of the event occurring, or of the harm or error being recognised.

• Although disclosure to the consumer concerned should not occur until he or she is medically stable enough to absorb the information and is in an appropriate setting, there is likely to be a suitable person (i.e., someone who is interested in the welfare of the consumer and is available) who should be informed. This may include an enduring power of attorney or legal guardian.

• In the immediate aftermath of an adverse event, providers may be searching for answers too. In these circumstances it is appropriate to acknowledge the limits of what is known, and to make a commitment to sharing further information as it becomes available.[22]

• It is important to emphasise that open disclosure is not a single conversation, but a process of ongoing communication. Communication should continue until the consumer has all the information and support needed.

• If the incident occurred in a team environment, it may be beneficial for the team to meet prior to the disclosure taking place. The Medical Council of New Zealand's guidelines for doctors suggest that the team meet to discuss:[23]

- what happened
- how it happened
- the consequences for the consumer, including continuity of care
- what will be done to avoid similar occurrences in the future
- who should be present when the harm is disclosed to the consumer.

• It might not be possible, however, for the team to discuss the incident and any harm before a discussion with the consumer takes place. An opportunity for the team to debrief should not unreasonably delay the consumer's (or his or her representative's) receipt of information.

• It may be appropriate for an early initial disclosure to occur, followed by a more detailed discussion with the consumer once the team has had an opportunity to meet.

HOW SHOULD OPEN DISCLOSURE TAKE PLACE?

• Disclosures should generally be made to the individual consumer and any family/whanau/key support people the consumer wishes to have present.

• In some situations where the consumer has died or been significantly compromised, disclosure will need to be made to a third party.

• In circumstances where discussion with the consumer is not possible or appropriate, his or her next of kin, designated contact person, or representative should be informed.

• Consideration must be given to the consumer's cultural and ethnic identity and first language, and the support needed.

• Details about the incident and any harm, the disclosure, and any subsequent action should be fully documented in the consumer's records.

• It is important that health professionals and other personnel involved also have access to support. Numerous studies have shown that most errors are made by well-

[22] M Bismark and R Paterson, "'Doing the right thing' after an adverse event" (2005) 1219 *NZMJ* 55.

[23] *Disclosure of harm 'Good Medical Practice'*, New Zealand Medical Council, December 2004 (available at www.mcnz.org.nz).

trained people who are trying to do their job, but are caught in a flawed system that predisposes towards mistakes being made.[24]

• DHBs need to take steps to ensure that the policy is applied in practice. Ongoing staff training on open disclosure needs to take place so that staff are able to respond promptly and confidently when things go wrong. Staff, health practitioners with independent access agreements and relevant contractors also need to be aware of the policy, and adequately trained and supported in its implementation.

• Training in communication is especially important.[25] An adverse event or incident is emotionally charged for all parties, and specific skills are required to deliver bad news in a sincere, compassionate and thoughtful way. Effective communication and empathy is pivotal to the open disclosure process.[26]

RELEVANT RIGHTS UNDER THE CODE

• Right 1 provides that consumers have the right to be treated with respect. Respect requires a truthful and sensitive discussion about any harm or incident affecting the consumer.

• Under Right 4(1) a DHB has an obligation to provide health services with reasonable care and skill. This organisational duty of care includes the need to have a policy on open disclosure that is well understood and implemented by all personnel.

• The provision of information in a form, language, and manner that enables the consumer to understand the information provided is required by Right 5(1). Right 5(2) also applies as it requires an environment supporting open, honest and effective communication.

• Right 6(1) affirms the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. It is seldom reasonable to withhold information about a consumer from that consumer.

• A health practitioner has a professional and ethical duty of open disclosure under Right 6(1)(e).

• Right 6(3) gives consumers the right to honest and accurate answers to questions relating to services, including information about the identity and qualifications of providers and how to obtain an opinion from another provider.

• Right 6(4) gives consumers the right to receive, on request, a written summary of information provided.

• Right 8 — the right to have a support person(s) present — is particularly relevant in distressing situations and when people receive bad news or a shock.

• Right 10 also applies as it is important for the DHB to ensure that consumers are made aware of their right to complain and provided with information about the complaint process and their options.

[24] L Leape, "Preventing Medical Accidents: Is 'systems analysis' the answer?" (2001) 27 *American Journal of Law and Medicine* 145.

[25] See Massachusetts Coalition for the Prevention of Medical Errors, *When things go wrong: responding to adverse events* (2006) 19.

[26] See Australian Council for Safety and Quality in Healthcare, *Open disclosure: health care professionals handbook* (2003) 13.