Norfolk Court Rest Home Ltd

Registered Nurse, Ms E

Rest Home Manager, Ms F

A Report by the

Acting Health and Disability Commissioner

(Case 09HDC01050)

Overview

This report examines the care provided to 73-year-old Mr A after he was placed in Norfolk Court Rest Home's secure dementia unit.

Mr A was placed in the unit on 16 December 2008 because his wife could no longer provide all his care needs. Immediately before his rest home admission, Mr A spent three weeks in hospital psychiatric care, where staff had tried to control his aggressive outbursts with medication.

In early January 2009, one of Mr A's sons phoned the rest home to speak with his father. He was advised that his father was asleep but he could speak to the nurse on duty. He did so, and was told that Mr A had exhibited threatening behaviour towards the staff and they were exploring medication options. The next day, he visited the rest home and found his father unconscious, incontinent, and strapped into a chair. He roused his father and found him to be "stupefied". He assumed that this was due to medication. He was advised at the visit that his father had fallen out of bed two or three times the previous day and had also fallen outside his room.

When Mrs A visited her husband over a few days in early January she insisted to staff that her husband's stupefaction was not the result of the new drug regime. She demanded he be seen by a doctor. After review by a doctor, Mr A was admitted to the public hospital. A computerised axial tomography (CT scan) of Mr A's head confirmed two significant subdural haematomas[1] on his brain. After discussing this with Mrs A it was decided that, given Mr A's poor quality of life and rapidly progressing dementia, he was not a candidate for surgical intervention.

Mr A was treated palliatively at the public hospital until a suitable private hospital bed became available. He died a short time later.

Complaint and investigation

On 25 March 2009 the Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided by Norfolk Court Rest Home Ltd to his father, Mr A.

An investigation was commenced on 17 July 2009. The following issues were identified for investigation:

- *The appropriateness of care provided by Norfolk Court Rest Home Ltd to Mr A between December 2008 and January 2009.*
- *The adequacy of the information provided by Norfolk Court Rest Home Ltd to Mr A and/or his Enduring Power of Attorney between December 2008 and January 2009.*

[1] A collection of blood over the surface of the brain.

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- *The appropriateness of the care provided by rest home manager Ms F to Mr A between December 2008 and January 2009.*
- *The adequacy of the information provided by rest home manager Ms F to Mr A and/or his Enduring Power of Attorney between December 2008 and January 2009.*
- *The appropriateness of care provided by registered nurse Ms E to Mr A between December 2008 and January 2009.*

On 25 August 2009 the investigation was extended to include:

- *The adequacy of the information provided by registered nurse Ms E to Mr A and/or his Enduring Power of Attorney between December 2008 and January 2009.*

The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant/consumer's wife
Mr B	Complainant/consumer's son
Mr C	Complainant/consumer's son
Norfolk Court Rest Home Ltd	Provider
Mr D	CEO Norfolk Court Rest Home Ltd/Provider
Ms E	Registered nurse/Provider
Ms F	Manager, Norfolk Court Rest Home Ltd/Provider
Mr G	Temporary manager, Norfolk Court Rest Home Ltd

Also mentioned in this report:

Mr H	Registered nurse
Dr I	General practitioner
Dr J	Geriatrician
Dr K	General practitioner

Information reviewed:

- Letter of complaint from Mr B
- Responses to complaint from Norfolk Court Rest Home Ltd, Ms E and Ms F
- Copy of Mr A's records from Norfolk Court Rest Home Ltd
- Copy of internal investigation carried out by Mr G
- Copy of Mr A's clinical notes from the DHB
- Copy of Ministry of Health (HealthCERT) audit report dated 6 April 2009

Independent expert nursing advice was obtained from Lesley Spence (general standard of care) and Jenny Baker (dementia care in particular), and these are attached as **Appendices A and B**.

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Information gathered during investigation

Norfolk Court Rest Home Ltd
Norfolk Court Rest Home is owned by Norfolk Court Rest Home Ltd, which is certified to provide rest home care services and dementia services. References in this opinion to Norfolk Court and the rest home include Norfolk Court Rest Home Ltd.

The rest home provides aged residential care (48 beds) and dementia care (11 beds). The company (Norfolk Court Rest Home Ltd) is owned by Mr and Mrs D, and Mr D is the CEO.

During the relevant period, the facility manager was Ms F. Her primary responsibility was to "maintain the continuous, smooth [m]anagement of Norfolk Court with good liaison and communication between all parties involved. To provide total health care in consultation with [registered nurse], Doctors, Residents and families."[2]

The rest home also employed one full-time registered nurse (Ms E) and one part-time (two days per week) registered nurse (Mr H). Ms E was responsible for the provision and documentation of clinical care to residents (including carrying out clinical assessments of residents, developing care plans, overseeing administration of medications, and keeping families informed). Medical support was provided by doctors at the local medical centre.

Mr H was employed to allow Ms E time to "do her paperwork" or have "additional days off". The rest home advised HDC that Mr H's duties were to administer the morning and lunchtime medications and to attend to any dressings as directed by Ms E. The rest home further advised that Mr H only carried out specific tasks as delegated by Ms E, and that he had no personal dealings with Mr A while he was a resident at Norfolk Court.

Caregivers were responsible for providing daily cares to the residents, alerting the registered nurses (RNs) to any concerns they had about the residents, and carrying out the nurses' instructions.

Mr A

Background
Mr A suffered from Alzheimer's disease and, on 16 December 2008, he was admitted to the rest home's secure dementia care unit because his mental state had deteriorated to a point where his wife was no longer able to provide care for him.[3] Immediately prior to being placed in the rest home, Mr A spent three weeks under psychiatric care at a public hospital pursuant to a compulsory treatment order.

During his admission at the public hospital, Mr A was commenced on quetiapine (12.5mg daily at 9pm) and lorazepam (0.5mg twice daily) in an attempt to moderate

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[2] An excerpt from the Manager's job description (undated).
[3] On 16 December 2008 the DHB's Needs Assessment Service Co-ordination (NASC) carried out an assessment on Mr A and identified him as requiring dementia level care.

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his aggressive outbursts. In addition to this, quetiapine (12.5mg) was prescribed PRN (as required) up to every six hours for agitation; and zopiclone (7.5–15mg at night, if required, for insomnia).

The discharge summary from the mental health service detailed Mr A's history, including recent personality changes and behaviours, the fact that he was wandering and confused, had assaulted his wife and son if they attempted to stop him wandering, and that his wife described his mood as "foul" or "black". The discharge summary also described Mr A as disoriented as to date and time, having very poor short-term memory, and poor sleep on occasions.

It noted that Mr A had participated in some activities during his admission, including relaxation techniques, painting, playing dominos, and helping with simple tasks around the ward. It also noted that if left unoccupied for any length of time he "tends to pack his belongings and bring them out to social areas".

Initial assessment

When new residents arrive at the rest home, the RN is required to carry out a physical assessment of the resident (including taking the resident's blood pressure and weight, etc). The RN is also required to formulate, in consultation with the resident's family,[4] an initial care plan covering such matters as the resident's medical history, cognition, activity, comfort, nutrition, elimination, skin integrity, allergies, and general health information. These requirements are set out in the rest home's "Guidelines on resident's admission" and its policies on care plans (these had been last reviewed in March 2008).[5]

There is no documented evidence of any physical assessment being undertaken on Mr A's admission to the rest home's dementia unit on 16 December 2008. However, on 29 December 2008 Mr A was seen by Dr I for his "admission assessment". This medical assessment did not find anything of significance.

There is also no evidence that any assessment was carried out to gain information about Mr A's behaviours, possible triggers, or known successful management strategies, or that any attempt was made to develop an individualised activities programme for Mr A.

Ms E began to develop a care plan on the day of Mr A's admission. The care plan form included the following headings: personal cleaning and dressing; mobilising;

[4] The rest home's policy on consultation with resident/family/whanau/significant others requires that any consultation with the resident's family is to be with the resident's consent (if mentally competent). As well as on admission, the policy lists the other times when consultation is to take place. These include radical changes in treatment or cessation of treatment, referral to another service, significant behavioural problems, and in the formulation of individual care plans. There were no family meetings recorded during Mr A's residency at the rest home.

[5] It is noted that, in Mr A's application form for the rest home, his son Mr B is noted as Mr A's "power of attorney". Mr B advised HDC that he held power of attorney for his father in relation to personal care and welfare; however, he was unable to locate a copy of the Enduring Power of Attorney for HDC to review. I have therefore decided to proceed on the basis that no Enduring Power of Attorney was in effect at the time of these events.

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communication; eating and drinking; eliminating; maintaining a safe environment; sleeping; breathing; controlling pain; restraint; and medication. There was a space for Mr A's family to sign the care plan but it had not been signed.

In the section headed "maintaining a safe environment", Mr A was noted not to be a falls risk, yet there is no record of a falls assessment having been completed for him beforehand.[6]

In the section headed "restraint for patient safety", the following information is recorded:

> "[Mr A] is in our secure unit and special care is needed to ensure [Mr A] does not climb over the fence [a]s he has attempted this since his arrival but seems to have refrained from doing so again."[7]

Mr A's medications were listed under the care plan's medication heading (quetiapine 12.5mg [once per day]; lorazepam 0.5mg [twice per day]; zopiclone 7.5mg at night for insomnia [when required]), and he was noted as having "no known drug allergies".

The medication instruction sheets for Mr A's regular and non-regular drug orders also noted that Mr A had no known drug allergies. The regular medication chart records his regular drugs (quetiapine and lorazepam).

The non-regular medication chart records the following:

> "quetiapine 25mg, ½ — 1 6 hourly for PRN Agitation
>
> zopiclone 7.5mg Nocte for insomnia PRN"

Mr A's bed was noted to be too small for his tall frame. Ms F advised HDC that she spoke with Mrs A shortly after Mr A's arrival, to arrange a replacement bed for him, and that Mrs A offered to bring in a larger bed and a chair from home; however, this never eventuated.[8]

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[6] There is no specific reference to falls assessments in either the rest home's falls prevention policy or the rest home's policies and procedures relating to the formulation of residents' care plans. The falls prevention policy advises staff to bring any concerns about a resident's mobility to the attention of the registered nurse immediately. The registered nurse is then required to assess the resident and consult with the doctor as to further action.

[7] The progress notes report that Mr A attempted to get out of the secure dementia unit by climbing the fence on 17 December, 18 December and 19 December. Ms E advised HDC that the date on Mr A's care plan (16 December 2008) related to the date she commenced writing it up, not the date it was completed. This explains why the care plan includes information about Mr A's behaviour that occurred after the date on the care plan.

[8] The rest home advised HDC that it was not advised, prior to Mr A's arrival, of his size. If it had been, it may have been able to resource a suitable bed for him. The family advised HDC that the larger bed "never eventuated" because it became obvious that Mr A would not be staying at Norfolk Court very long, as he was on a waiting list for a rest home closer to Mrs A.

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Behaviour charts
On arrival at the rest home, a "24 hour behaviour chart" was implemented to record information about Mr A's behaviour in his first 24 hours at the rest home. Additional "24 hour behaviour charts" were completed on 31 December, 1 January and 4 January.

Escalating agitation
On the evening of 30 December 2008, Mr A was given zopiclone to see if it would give him a good night's sleep. However, Mr A slept for only about one hour that night. He was noted to have upset quite a lot of the residents and "was stumbling around the floor nearly falling at times". The caregiver noted that she thought the zopiclone had made Mr A worse.

The following morning, on 31 December 2008, a caregiver recorded the following in Mr A's progress notes:

> "At the beginning of the shift [Mr A] had just gone to sleep in the chair. At breakfast we [tried] to wake him up & he got aggressive & angry towards us. We helped him out of the chair and he started telling me he was going to hit me … [Mr A] was sleeping at the table after breakfast & would not sit in an arm chair. After [five] minutes of asking him he fell off the chair. We went to help him up & check him over he started yelling at us & told us not to touch him, don't help him & to get away."

An accident and incident form was filled in.[9] Under the heading "Extent of injuries", it is noted that Mr A would not let the staff check him. Under the heading "Person notified of accident/incident", the name of a caregiver is written. No one in Mr A's family is recorded as having been notified.

At 10.10am Mr A was given one quetiapine tablet at Ms E's instruction.

At 11.20am Mr A was found climbing up the balcony, wanting to jump off it. Staff managed to get Mr A back inside to rest in an armchair, and another 24-hour behaviour chart was commenced.

Ms E telephoned Dr I about Mr A's escalating agitation, and Dr I revised Mr A's medication — the night-time dose of quetiapine was increased to 25mg, with a half tablet to be given the following day at midday if Mr A was still agitated. Ms E documented these instructions at 5pm on a form headed "Telephone drug order", referring to the medication by its trade name, "Seroquel". Ms E did not amend the dose on Mr A's medication instruction sheet.

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[9] The rest home's accident and incident reporting policy required all accidents and incidents to be reported and recorded on the appropriate forms as soon as practicable after the event. The accident and incident report form contains space to write a description of the accident/incident; extent of injuries; treatment given; and person/s notified of the accident/incident. The policy itself does not contain any instruction to contact the consumer's Enduring Power of Attorney or nominated contact person, and a doctor, if necessary.

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Ms E advised HDC about the other measures she had taken, but not documented, in response to Mr A's increased agitation and falls:

> "Due to [Mr A's] level of agitation and aggression throughout the day an extra staff member was brought in to sit with [Mr A] on a one on one basis.
>
> …
>
> I phoned his son [Mr C] as he had called earlier that day. I informed him of his father's condition and behaviour. He said 'not to phone his mother as she was expecting guests for new years and he would tell her after the New Year' … [Mr A's] mattress was put on the floor to reduce the risk of him falling out of bed.
>
> …
>
> The following day I was informed about [Mr A's] fall[10] and checked his right side, there was minimal bruising to his right rib area."

The night shift report on 31 December to 1 January notes that Mr A was complaining of sore ribs and pulled muscles.

Drowsiness and falls

Between 2 to 7 January 2009 there are several reports of Mr A sleeping or being described as "sleepy".

On 3 and 6 January Mr A was noted to be very unsteady on his feet. At 6am on 7 January Mr A was found lying on the floor on his right-hand side. He was noted to have a few grazes on his kneecaps and his right hip, and was described again as being very unsteady on his feet. An accident and incident form was filled out. No one was notified of this fall.

Later that morning Mr A fell out of his bed on two occasions — once at 9.40am and again at 11.45am. An accident and incident form was completed. There is nothing written on the form under the headings "Extent of injuries" or "Treatment given". Ms E and Ms F are listed as the persons notified.

Dr I's review

Dr I was asked to review Mr A that day (7 January) in relation to Mr A's drowsiness, dizziness and falls tendency. Dr I noted multiple abrasions on Mr A's right knee, leg, upper thigh and left knee. He also noted that Mr A "greets and talks, then falls asleep easily". Dr I's impression was that the drowsiness and falls could be due to the quetiapine. He therefore ordered for the quetiapine to be stopped for the rest of the day and the following day. It was to be restarted at a smaller dose (12.5mg) two days later (9 January). He also ordered the PRN quetiapine and the lorazepam to be stopped and restarted on 9 January.

[10] This is a reference to the fall on 31 December 2008.

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At the bottom of Dr I's notes from this consultation there is a warning that, according to Mrs A, zopiclone and risperidone caused Mr A agitation. Mr A's medication chart was not updated with this information at this point.

Use of enabler
Mr A's care plan was updated on 7 January. Under the heading "Maintaining a safe environment" it is noted that Mr A is "drowsy at the moment, he is a falls risk and an enabler can be used when seated in the lounge chair".

According to the rest home's "Guidelines for the Safe and Appropriate Use of Restraints" (this had last been reviewed in October 2006), the use of an enabler is a form of physical restraint and, accordingly there are formal procedures to follow, including: an assessment of the type of restraint to use; consultation with the family; and approval for the use of the restraint from the "approval group" (consisting of the manager, RN, GP, and it may also include the resident and their representative). Once implemented, the use of the restraint needs to be monitored and regularly reviewed.

There is no evidence that any of the above procedures were followed when using the enabler for Mr A.

Medication administration records and medication management policy
Mr A's medication records show that his medication was placed in trays by the RNs from 16 December 2008 (day of admission) until 6 January 2009.

On 5 January 2009, Mr A's medications (lorazepam and quetiapine) were delivered to the rest home in pharmacy-packed blister packs.

According to the medication administration records, Mr A received a total of 37.5mg (25mg tray packed and 12.5mg blister packed) quetiapine at 9pm on 5 and 6 January 2009. On both occasions this was 12.5mg more than the prescribed dose. He also received a total of 1mg (0.5mg tray packed and 0.5mg blister packed) lorazepam at 8am and 8pm on 5 and 6 January 2009. This was double the prescribed dose on all four occasions.[11]

Ms E advised HDC that it was usual practice to remove the obsolete medications when the blister packs arrived from the pharmacy. However, she recalls that in this case, the blister packs contained incorrect doses. She believes staff used the obsolete medications to access the correct dose, and recalls that the blister packs were later returned to the pharmacy to correct the packing.

The rest home's medication policy (this had been last reviewed in May 2007) states that "[t]he CEO, Manager or Registered Nurse should ensure that the storage, administration and disposal of medicines are strictly controlled". Under the heading "Administration" it states that all regular drugs are to be blister packed.

[11] It appears that these medication administration errors were not identified until the rest home's internal investigation into Mr B's complaint to HDC.

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When administering medication, staff are required to check the identity of the resident, identify the appropriate medication container and check labels against the resident's profile (noting any recent changes in therapy), administer the medication, record if medication is not taken and state the reason, record the drugs administered, and sign the drug chart. If any queries or problems arise, staff are advised to seek assistance or advice from the RN, manager or senior caregiver, and a medication error/mishap report must be filled out.

Continued deterioration

Mr A's physical ability continued to deteriorate. Between 7 January and 11 January his progress notes contained the following observations: "very unsteady on his feet"; "will not weight bear"; "Still trying to get fluids into him"; "[Mr A] vomited once this morning"; "Got [Mr A] into a wheelchair and his wife took [Mr A] outside"; "Diarrhoea accident & changed"; "took [four] caregivers for safety to get [Mr A] into the shower".

It appears that Mrs A contacted Dr J (a geriatrician at the DHB who was familiar with Mr A) on 9 January as she was concerned about her husband's drowsiness. That day the rest home received a telephone drug order from Dr J, instructing that all medications be stopped until Mr A was reviewed by Dr I on 14 January.

In the early hours of 12 January, a caregiver found that Mr A had fallen out of bed. The caregiver noted in the progress notes that Mr A had "slid off bed and onto the mattress on the floor". The caregiver filled out an accident and incident form, noting that no injuries were found and that a senior caregiver had been informed.

Mrs A telephoned Ms E on 12 January to request a doctor's visit for Mr A as she was still concerned about his drowsiness. Ms E agreed that Mr A's drowsiness was a concern, and she spoke with a nurse at the medical centre over the telephone. Ms E recorded the following in Mr A's progress notes:

> "[Doctor's] visit requested and I have spoken to [n]urse at [medical centre] … re: our concerns. If after hours, can staff please call [Mrs A] and let her know Dr has been."

Later that day Dr K, a general practitioner from the medical centre, visited and examined Mr A. Her written consultation notes contain the following:

> "[U]nable to do neurological assessment but possible [left] sided weakness."

Dr K's computerised notes from the consultation contain the following:

> "[R]emains extremely drowsy ?cause. [S]poke to wife [Mrs A] then [Dr J]. [P]ossible sub dural haemorrhage but would not undergo neurosurgery so not for CT scan. [D]o bloods. [I]f becomes agitated [Dr J] suggests giving lorazepam not quetiapine. [H]e will visit [Mr A] next week."

During Dr K's telephone call to Dr J she was advised by him that Mr A was sensitive to risperidone and zopiclone as they made his mood uncontrollable. This information

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was subsequently relayed to Ms E, who then amended Mr A's medication instruction sheet to include this information.

There is a comment by Dr J on 16 January 2009 in Mr A's notes from the public hospital, referring to his telephone discussion with Dr K on 12 January. Dr J states:

> "[Mr A] is a patient of mine who has severe dementia. When he deteriorated the question of a sub dural [haemorrhage] was raised. After discussion with GP and wife we made a decision not [original emphasis] to CT him as he is not a neurosurgical candidate."

Dr I's assessment and transfer to the public hospital
On 14 January 2009 Dr I visited Mr A as part of a planned follow-up assessment. He noted that Mr A was still very sleepy and drowsy and was not weight bearing properly. He also noted that Mr A had had a distended abdomen since the previous morning and was complaining of abdominal pain. Dr I arranged for Mr A to be transferred to the local hospital for an abdominal X-ray. Following this he was admitted to the public hospital for further investigation of his distended abdomen.

On admission to the public hospital Mr A was examined by a surgical registrar, who noted Mr A's history of possible head injury from previous falls and the relatively rapid deterioration in his level of functioning. On examination, the registrar noted that Mr A was "drowsy [but] rousable to voice with pinpoint pupils, moving all [four] limbs". Later that day the possibility of a subdural haemorrhage was raised and this was investigated further with a CT scan of Mr A's head. The CT scan revealed that Mr A was suffering from two subdural haematomas. After discussing this with Mrs A it was decided that, given Mr A's poor quality of life and rapidly progressing dementia, he was not a candidate for surgical intervention.

Mr A's distended abdomen was also investigated further and a diagnosis of intestinal pseudo-obstruction[12] was made. A flatus tube was inserted with good effect.

Mr A was treated palliatively at the public hospital until a suitable private hospital bed came available. He died a short time later.

Continence management
The family complained of an "overwhelming stench of urine" present in the rest home. An internal investigation by the rest home found that the offensive urine odour was an ongoing issue despite regular carpet cleaning using a commercial "Vex" machine, the installation of an extractor fan, and the regular toileting of residents by staff. Incontinent residents used re-usable incontinence products but these products often leak, which can lead to soiling of their outer clothing, bed linen, floor and chair

[12] A rare condition with symptoms like those caused by a bowel obstruction, or blockage, but when the intestines are examined, no blockage is found. The symptoms are caused by nerve or muscle problems that affect the movement of food, fluid, and air through the intestines.

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coverings.[13] (Residents were free to purchase their own disposable incontinence products.)

Smoking
The rest home's policy on smoking (last reviewed in December 2005) restricted the smoking areas for residents to "the outside verandas or decks (provided no other persons rights are infringed)". Staff were permitted to smoke in "[d]esignated areas as authorised by Management that comply with the [Smoke-free Environments Act 1990]".

The staff smoking veranda was positioned directly outside Mr A's room, and his family requested he be moved as they were concerned about the smoke that was drifting into his room. Mr A was moved to another room on 12 January.

Rest home staff
Ms E
Ms E completed her nursing degree in 2005. She became registered in December 2005 and, in January 2006, she commenced a graduate programme in paediatrics at a public hospital. On 18 July 2006 she began work at the rest home.

Ms E advised HDC that on her first day at the rest home she was oriented to the facility by another RN who was then working there one day a week. The orientation took four hours. Ms E worked four days a week at the rest home until she went on maternity leave on 10 November 2006. On 12 February 2007, she returned to work as the sole RN.

Ms E advised HDC:

> "I felt somewhat overwhelmed by this and requested another Registered Nurse be employed as I felt I was unable to carry out my duties effectively. I continued to request verbally to the Manager that I needed assistance and that I was finding it tiring and was not able to keep up with my work load."

The rest home employed a second RN during 2007, to assist Ms E while she caught up on paperwork. After three months, the second RN resigned. Ms E advised HDC that she requested assistance on several occasions, but when this was not forthcoming she handed in her resignation as she felt she could "not continue to carry out the duties required of [her]".

However, after a discussion with the rest home's CEO, Mr D, Ms E agreed not to resign. She was given one week's stress leave and another RN was employed to work two days per week.

Ms E advised HDC that during her employment at the rest home she was not provided with any clinical support[14] until after the complaint from Mr B was received in March

[13] It is noted that Mr A was not incontinent on admission to the rest home, but did have issues with incontinence during his stay.

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2009. At that time she "was appointed a professional mentor who has been a great help just to know there is someone I can call for advice/support".

During her employment at the rest home, Ms E attended various seminars and workshops, including a four-hour workshop on wound management; a one-day seminar on diabetes and depression; and a one-day registered nurse seminar. She also received in-house training on a variety of issues, including informed consent; restraint; risk management; residents' rights; restraint and elder abuse; and a gerontology seminar.

Ms E advised HDC:

> "I feel during the past three years I have done the best I could have with the lack of experience, support and guidance in my role as a Registered Nurse in this facility. I have taken my job seriously and I understand my short falls and am the first to admit them. My documentation has been below standard and I am now realising the importance of good documentation, even down to communications I have had with my employers. I am sincerely sorry for any wrongs I may have contributed to and my apologies go out to the family for the pain they have endured."

With regard to the care she provided Mr A in particular, Ms E advised HDC that she spoke on a number of occasions with Mr A's family members (usually Mrs A) and at all times she was "upfront and honest".

In July 2009 Ms E resigned and left Norfolk Court Rest Home.

On 11 May 2010 Ms E wrote a letter of apology to the family of Mr A. Ms E conveyed her "deepest apologies for any pain and suffering which occurred whilst [she] was involved with [Mr A's] care at Norfolk Court Rest Home". Ms E advised the family that she had been working outside her limit of expertise and had now learned "to stand firmer when asking for guidance and help with the residents under [her] care". She also advised that she has now realised that she needs to "retrain under the supervision of senior nurses within elderly care, so this does not happen again to any person [she] care[s] for".

Ms F

Ms F worked as an ambulance officer for 16 years and also as a clerk/administrator. In 2001 she was initially employed by the rest home as office manager, during which time she completed an Aged Care Education Core Programme (ACE programme). She was appointed to the position of Manager in 2002[15] and since then has attended

[14] Ms E advised HDC that both of the RNs that were employed to assist her at Norfolk Court would look to her for guidance.

[15] Ms F advised HDC that she was offered the Manager's position when the current manager left suddenly. Ms F declined the offer and was appointed to the position of "Interim Manager" while the rest home advertised for a permanent Manager. The rest home was unsuccessful in its attempts to find a permanent Manager and this resulted in Ms F "inheriting" the Manager's position.

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in-house education sessions on a variety of issues[16] and achieved various NZQA standards.[17]

Ms F's job description said she was responsible for "Managing Norfolk Court Rest Home in a manner which ensures all statutory and contractual obligations are met". The following are included in the list of "Primary Objectives" and "Performance Indicators" for the role:

- Ensuring that "all clinical and non clinical services at Norfolk Court are delivered to the Residents in a safe and dignified way … ensuring … their individual needs are met".
- Ensuring " … staff are knowledgeable of, and their work-practices reflect, the Code".[18]
- Ensuring "appropriate written information is available to residents and their representatives as required by the Code …".
- Ensuring "staff are competent to carry out assigned tasks and responsibilities".
- Promoting "positive and therapeutic resident care by a Multidisciplinary team model".
- Ensuring that "services are provided to a level and quality to ensure at least 95% Resident satisfaction with services at all times".

Ms F advised HDC:

> "When new residents are admitted, I am responsible for the administrative aspects of the admission process. I meet and greet them and show them to their room. I also ensure that the appropriate personal information and contact person is available and that an agreement for admission is signed … The Registered Nurse takes over from me and is responsible for undertaking the clinical assessment and documentation and providing instructions to the caregivers.
>
> …
>
> In practice, the registered nurse met with me at least daily to advise me of any concerns regarding clinical issues. I did not interfere with clinical matters, respecting her autonomy as a health professional. I relied heavily upon the registered nurse to work with [the contracted medical service] to ensure the health needs of residents were met in a timely and competent manner.
>
> …
>
> I believe the support I gave to the Registered Nurse [Ms E] was more than usual for a manager. I spent a lot of my time assisting her when she commenced

[16] These include: risk management; restraint and elder abuse and neglect; leadership/team building; dementia; restraint, informed consent and advance directives; and challenging behaviour.
[17] These include: managing acute cardiac events in ambulance services; treating hypovolaemic shock in ambulance services; workplace safety; wound healing — prevention of pressure sores; health and safety — employees' responsibilities.
[18] The Code of Health and Disability Services Consumers' Rights.

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employment and during her time at Norfolk Court … I also visited [the local] Hospital and approached the Nurse Educator in regard to her working with [Ms E] on education and her portfolio.

…

I did not provide any personal care for [Mr A] … On no occasion did the registered nurse or general practitioner indicate to me any concern in the management of [Mr A].”

Ms F highlighted the difficulties faced by the rest home given its rural location, noting that the rest home has always had difficulty attracting qualified staff (both registered nurses and caregivers), and being the only dementia care facility in the area, they are continually having to train new caregivers as the qualified staff leave.

With regard to support and training provided to her by the rest home, Ms F advised HDC:

“Training has been very limited. I have numerous times requested to attend the [regional] Management meetings held monthly by Healthcare Providers New Zealand Inc in [the closest main centre], plus requested that I attend Conference[s] etc. This has not been granted.[19]

…

I feel that I have not had the opportunity to increase my knowledge as I have not been given any peer support. I have progressed through the introduction of Certification by myself using the information given to me by Residential Care NZ Ltd/Healthcare Providers Inc.

…

I have spoken to the CEO, [Mr D] on several occasions in regard to Norfolk Court needing a Clinical Nurse Manager or higher qualified Manager and have offered to step down from my position to facilitate this.

…

I really appreciate having [Mr G][20] assisting us with amending and updat[ing] our policies and procedures. His expertise and professionalism is outstanding and I wish I had received support such as his earlier.”

[19] Ms F subsequently advised HDC that Norfolk Court CEO, Mr D, has now permitted her to attend the Manager’s meetings, and in September 2009 she commenced night school classes to obtain a Certificate in Small Business Management (the only course available in the area). As at April 2010 she had completed three of the six modules.

[20] Temporary manager, appointed 11 April 2009 by the DHB.

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Ms F also expressed frustration at the inconsistency of audit reports, which she believes impacted on her ability to monitor the rest home's compliance with its various obligations. She advised:

> "I would like to express my concerns about the number of different opinions given by the various auditors who have visited Norfolk Court since certification i.e. MOH, DHB and independent auditors. We have changed our systems at least three times because of comments made by them. They do not appear to be consistent."

On 30 April 2010 Ms F offered her "sincere apologies for the inadequacy of [her] performance in regard to documentation etc that led to the concerns of [the family]". She also sent a letter of apology to Mrs A and her family. Ms F apologised on behalf of herself and her fellow staff members "for any distress we may have caused" during Mr A's time at the rest home. Ms F advised the family that the rest home's documentation systems, policies, and procedures had been reviewed and, where necessary, rewritten, with the assistance of a consultant, and that all staff have undertaken "extensive" training to improve the service they deliver.

Staff orientation policy
The rest home's staff orientation policy (this had last been reviewed in October 2003) states that new staff will, in their own time, undergo an orientation programme, one hour in duration. During this hour, staff are required to familiarise themselves with:

- the building
- occupational health and safety routines
- individual routines
- policies and procedures

After orientation of the building, the staff member will be oriented to "[c]aregiving and written aspects of the position", and a checklist will be completed.

The new staff member will be oriented in the "general care of the elderly" by completing two to three shifts with a buddy.

Communication between RN and Manager
Ms E and Ms F advised HDC that they would have contact at least once a day regarding a variety of issues such as the day-to-day running of the rest home, any concerns Ms E had about staff or residents, reviewing accident/incident reports, and infection control.

Communication between caregivers and RNs
The rest home's policy on communication about residents by staff (this had last been reviewed in May 2003) contains the following information:

> "It is policy of Norfolk Court to ensure that the reporting of Residents to staff is carried out regularly, both written and orally at each shift change and as events occur which may necessitate staff being aware of that knowledge.

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> All written reporting and records of Residents will be kept up to date and reviewed regularly.
>
> …
>
> All reports are to be documented in Daily Progress Notes and documentation noted on 24hr Alert. Notes can also be written in [RN] Communication Book."[21]

The rest home's policy on written and verbal reports on residents by staff (this had last been reviewed in March 2008) includes:

> "At commencement of all shifts, Staff must read Staff Communication Book, 24 hour alert, and the daily diary … The Senior is to read the [RN] Communication Book and pass on any relevant information to carers.
>
> …
>
> At the end of every shift each Caregiver will note on the handover report any matters that need to be brought to fellow staff. This shift handover report will also be read by the Registered Nurse. The nurse is also able to document any changes to care plans etc for staff to read and refer to."

Caregivers would routinely document observations about residents in the resident's progress notes, and any specific concerns they had about residents would be documented in the RN Communication Book.

Ms E advised HDC that the caregivers were directed to verbally inform the RN on duty of anything that required addressing, or notes that needed to be read, but this did not always happen and as a consequence "things [were] missed by the RN on duty".

Ms E did not write routinely in the resident's progress notes but would document any doctors' visits and changes to the resident's medication.

DHB and Ministry of Health audits

The DHB advised HDC that it carried out a routine audit at the rest home on 28 March 2007. This audit identified some areas of partial compliance, and the rest home submitted evidence to satisfy the areas of partial compliance on 17 May 2007.

On 2 May 2007 a re-certification audit at the rest home was completed by International Certifications Ltd, an auditing agency engaged by HealthCERT.[22] The audit report identified partially attained criteria in relation to: assessment tools (policies and procedures); exit/discharge/transfer forms; medical reviews; medication management; and infection control (documentation and review of data).

[21] The rest home advised HDC that this book would be used for communication between RNs, and caregivers would also use the book to advise the RNs of any concerns they had.

[22] HealthCERT is the section of the Ministry of Health responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001.

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The audit report identified unattained criteria in relation to: integration of residents' notes and files; and policies and procedures for monitoring and re-evaluating the use, effect and impact of restraint.

A surveillance audit at the rest home was completed on 13 May 2008 by the same auditing agency. The above "partially" or "unattained" criteria was identified as being "fully attained", but further criteria were found to be partially attained in relation to: activities assessment plans for residents; storage of medication; and self-medication policy and procedure.

Subsequent events

Ministry of Health inspection report
After receipt of an unrelated complaint about Norfolk Court Rest Home Ltd, HealthCERT carried out an unannounced inspection at the rest home on 19 March 2009.

The report, dated 6 April 2009, identified a number of shortcomings at the rest home requiring corrective action, including issues relating to:

- Residents' needs assessments
- Supervision/mentoring for the RN
- Reducing exposure to avoidable risk
- Analysis of incidents, accidents and other untoward events
- Lack of involvement by residents' families in care planning
- Insufficient documentation
- Inappropriate use of restraint
- Pain assessment and management
- Falls prevention
- Medicine management
- Lack of multidisciplinary approach to care
- Care plans not reflecting goals and interventions required to meet goals

Of particular significance, the inspection report identified that the rest home was short staffed and lacked qualified staff in the dementia unit. For instance, none of the caregivers at the rest home held a certificate or unit standard in dementia care (although there was one dementia unit caregiver undergoing dementia unit standard training at the time of the inspection); and at times there were unqualified caregivers rostered on a shift together in the dementia unit without a qualified caregiver (one of the night caregivers who was rostered on regularly in the dementia unit was not qualified as a caregiver and was not undertaking training).

Appointment of temporary manager
The inspection report demonstrated that the rest home had failed to meet a number of its contractual obligations which were set out in the Aged Residential Care service agreement it had with the DHB. Consequently, the DHB appointed Mr G to the position of Temporary Manager of the rest home. His appointment was for an initial

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period of three months commencing 11 April 2009 (this was later extended for a further three months).

Mr G's role was to produce and oversee the implementation of a "Corrective Action Plan" to address the identified failures by the rest home to meet its statutory and contractual obligations.

The DHB subsequently contracted Mr G to visit the rest home monthly (until July 2010). He also attends meetings at the rest home for quality and risk management, and clinical management, and he reviews quality and risk management activities.

The DHB advised HDC:

> "HealthCERT and [the] DHB have made a commitment to keep each other informed of developments at Norfolk Court Rest Home. To date, this collaborative approach has worked in a satisfactory manner."

Re-certification audit
On 12–13 May 2009, International Certifications Ltd carried out another re-certification audit at the rest home. This audit identified many of the issues already picked up by HealthCERT's recent inspection report, in particular: insufficient staffing levels; lack of clinical support; need for analysis of accident and incident reports (quality improvement); inadequate care plans; and restraint (assessment, monitoring, re-evaluation and staff training).

The report advised that the temporary manager was in the process of employing three new staff members and was developing new staff rosters at the time of the audit.

Internal investigation and changes made
Mr G provided HDC with a copy of an internal investigation into the family's complaint. Mr G advised that:

> "[a]s a result of reviewing the services delivered, we have identified a number of shortcomings in [Mr A's] care, for which we unreservedly apologise. These shortcomings relate to systemic failures including the following:
>
> - Clinical Governance and Supervision
> - Assessment
> - Care Planning
> - Activities Programming
> - Behaviour Management
> - Adverse Event Management
> - Medication Management
> - Minimisation and Safe Use of Restraint Programme
> - Continence Management
> - Medical Services
> - Communication with Residents' Representatives."

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The rest home acknowledged that these omissions "are likely to have contributed to the rapid deterioration of [Mr A's] health status, and a more proactive approach to his management may have prevented the onset of such a rapid decline".

With regard to care planning, the rest home noted that Mr A's initial care plan did not address the risks detailed in the pre-admission information supplied by the public hospital, and the potential effects relocation would have on Mr A.

The rest home advised that it has taken the following measures to address these omissions:

- Developed a pre-admission information form to ensure appropriate information is accessed (including a history of the resident's behaviours).
- Developed an initial and ongoing care plan specific to residents entering the dementia unit. It is hoped this will allow caregivers to provide more individualised support and care interventions to residents in the dementia unit.
- Implemented a specific care plan for residents at high risk of falls and "acute on chronic" confusional states.

In light of the inadequate assessment, follow-up, and management of Mr A's reported behaviours identified by the investigation, the rest home advised:

- The RN and a senior caregiver have attended external workshops on dementia care. It is developing an in-house teaching session and self-directed learning programme called "Supporting Residents Affected by Dementia". It is following up staff in the dementia unit to ensure they complete the required Dementia Care unit standards.
- It is developing a "Clinical Incident Report" form (for use in non-accident-related changes in a resident's health status), to ensure collection and communication of relevant information to health professionals.
- It is integrating residents' clinical records to enhance access to information.
- It is involving specialist services and implementing multidisciplinary team reviews.
- It is implementing a shift handover and RN follow-up tool.

The rest home also identified, with regard to behaviour management, that the information contained in Mr A's behaviour charts was "limited to identifying episodes of escalating behaviours". They did not contain any information about possible triggers for the behaviour, or the effectiveness of strategies employed to manage the behaviour. Accordingly, the rest home advised that it was implementing a behaviour observation chart that includes identification of trigger factors and successful management strategies.

It had also reviewed and rewritten the manual on restraint minimisation and safe practice, and was developing a restraint minimisation and safe practice programme for its staff, in light of the fact that correct procedures had not been followed in the use of the enabler (a form of physical restraint) on Mr A.

The rest home advised that it had taken the following measures to address the failure to develop an individualised activities programme for Mr A:

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- Implemented an activities assessment and planning tool.
- Re-distributed dedicated “diversional therapy” hours in the dementia unit to allow a morning and afternoon session.
- Increased the caregiving hours to ensure two caregivers are on duty during waking hours (7am to 9pm).
- Taken steps to change the culture from “custodial” care to “quality of life”.

With regard to issues surrounding adverse event management, the rest home noted that its accident and incident reporting policy “poorly defines accidents and incidents”, and “serious accidents/incidents” were not defined.

It also identified, with regard to Mr A, a lack of timely and appropriate follow-up of reported accidents by a health professional; poor communication with Mr A’s family about his falls and deteriorating condition; and that no attempts had been made to analyse the accident and incident reports for trends.

The rest home advised that it has taken the following measures to improve its adverse event management:

- Introduced monthly quality and risk management meetings.
- Reviewed and revised its adverse management policy (including the principles of open disclosure), and presented the new policy to staff.
- Implemented a new accident and incident form to include evidence of appropriate assessment, immediate follow-up, family notification and review.
- Revised its policy on communication with family/whanau, including information on when the resident’s representative should be contacted, and by whom.
- Conducted an internal training session for staff on communication skills.
- Commenced analysis of reports for quality improvement data.

Regarding issues of medication management, the rest home identified “evidence of actual/potential problems related to medication prescribing and administration systems”. Accordingly, the rest home advised that it was implementing the following measures:

- Introduction of monthly clinical management team meetings (comprising the manager, registered nurse, and specialist dementia unit coordinator).
- Review and revision of the medication policy, including managing medication errors and open disclosure.
- Review of medication supply system with pharmacy to minimise, isolate, and eliminate dual systems of supply of prescribed medications.
- Development of an education programme, self-directed learning package, and competency testing programme.
- Implementation of a household remedies and standing orders policy.

As a result of its findings regarding continence management, the rest home advised that it was seeking advice from the DHB Community Continence Nurse and developing an assessment tool for urinary and faecal incontinence. It was also

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introducing the use of disposable incontinence products, and Mr G had rewritten the policy on continence management.

The rest home also advised HDC that it would be revising its smoking policy in accordance with the provisions of the Smoke-free Environments Act 1990.

Response to my provisional opinion
In response to my provisional opinion, the rest home advised that it had appointed Ms F and Ms E believing they were suitably qualified and experienced professionals and, in its view, both Ms F and Ms E "have done a reasonable job and have substantially complied with the audit reports".

While acknowledging its shortcomings and taking steps to address these, the rest home also highlighted some difficulties it faced in this particular case, and in general, as a rurally based rest home with the only dementia care unit in the area.

The rest home believes that Mr A was sent to Norfolk Court because it was the only facility in the area with a dementia bed available at the time. This was despite Mr A's medical history showing the need for "a more psychiatric based, as against caregiver based facility". The rest home advised that it was not privy to this information prior to Mr A's arrival at the rest home.

With regard to its location, the rest home advised that there are difficulties providing external training opportunities to staff. As there is no local training provider, staff are required to travel 58 kilometres by private transport to attend training sessions, and the rest home needs to ensure it has appropriate cover while the employee is away attending these sessions.

It also advised that, given its rural location, it is unlikely that all its caregivers will be fully trained at any one time. When a staff member leaves, it needs to begin training the new employee (unless a new person who is already trained moves into the area).

Code of Health and Disability Services Consumers' Rights

The relevant rights in the Code of Health and Disability Services Consumers' Rights (the Code) are attached as **Appendix C**.

Opinion: Breach — Ms E

Admission information
My expert advisor (dementia care), Ms Baker, considers that Ms E's assessment of Mr A on arrival at the rest home was inadequate. Ms Baker notes that Mr A was admitted to the rest home with a history of aggressive behaviour towards his family, including

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hitting out when they attempted to prevent him from wandering. He also had a history of falls. While a resident care plan was completed by Ms E, Ms Baker notes that Mr A was recorded as not being a falls risk, and the plan did not include "strategies for staff to use when Mr A exhibits agitated or challenging behaviour".

There was also no consultation with Mr A's family as to the suitability of the care plan. Yet, as Ms Baker observed, had Mrs A been asked to review the care plan, she may have noticed the charted zopiclone and commented about Mr A's reaction to it.

My nursing expert advisor, Ms Spence, was similarly critical about the lack of information gathered on Mr A's arrival at the rest home. She could find no documentation to indicate that a physical assessment was carried out by Ms E, nor any evidence that an individualised activities programme had been developed for him. It also appears that Ms E failed to review the information contained in the transfer note from the discharging hospital. Ms Spence advised that this information was "essential" in order to develop an individualised nursing care plan for Mr A's comfort and safety.

As Ms Spence notes, had an appropriate assessment been carried out by Ms E, this may have resulted in better management of Mr A's behaviour. For instance, an individualised activities programme may have "helped occupy [Mr A] and given him some purpose", and an appropriate assessment to find triggers for behavioural changes may have helped the caregivers to manage Mr A. Ms Baker agrees, noting that no behavioural assessment was carried out for Mr A, which would have formed the basis of a behavioural care plan.

I agree with Ms Baker and Ms Spence that there was a failure by Ms E to gather necessary information and adequately assess Mr A on his admission. Ms E also failed to effectively use the information that was available to her. As Ms Spence notes, this is a "serious registered nurse omission" and puts the accuracy and relevance of Mr A's care plan into question.

Follow-up of caregiver's reports

Ms Spence has observed that the caregivers recorded fairly accurately Mr A's behaviour, well-being, and daily progress, but Ms E was "woefully slow or didn't act at all on some communication which caregivers tried to relay". While it is accepted that there were times when caregivers should have sought advice verbally from Ms E (rather than rely on her to follow up documented incidents), it appears that Ms E took little cognisance of the caregivers' notes. Accordingly, changes in Mr A's behaviour and health were often missed.

Ms Baker was similarly critical, noting that despite the caregivers' descriptions of Mr A's continued physical deterioration in the progress notes, there is no evidence of any assessment or reassessment by Ms E, or any request for further medical assessment between 31 December 2008 and 7 January 2009.

Ms Baker noted that no goals or strategies were documented by Ms E for caregivers to use should Mr A attempt to climb the fence again (as he did soon after his arrival at

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the rest home). She also considers that Ms E failed to give appropriate information to the doctor. For instance, there is no evidence that she informed the doctor about the PRN dose of quetiapine given at 10.10am on 31 December, and that shortly after this Mr A climbed up the balcony, wanting to jump off it. Ms Baker regards this as "a very serious incident" as Mr A's safety was at risk.

While it cannot be known what was said in the verbal handovers, like Ms Spence and Ms Baker I am very concerned about the quality of the feedback and response to caregivers' reports by Ms E. The failure to proactively manage Mr A's reported behaviour, and provide accurate information to the doctor about it, is also very concerning. I consider Ms E's omissions in this respect to be very remiss.

Falls management
Mr A had four falls over a period of seven days. Ms Spence notes that some measures were taken in response to Mr A's falls. For instance, on 31 December staff had tried (unsuccessfully) to move Mr A to a safer chair, and a mattress was put beside Mr A's bed to break any falls from his bed. Ms Spence also notes that staff checked Mr A regularly throughout the night "but unless there is [one-on-one] care which is not provided at rest home level of care, it would be very difficult to anticipate when he might fall".

While bed rails may have helped, Ms Spence believes they also may have made matters worse — as "the feeling of containment behind bed rails may have made Mr A more agitated and he could have climbed over them, falling from a greater height". However, Ms Spence also considers the fact that Mr A's bed was too short for him may have made him restless and therefore more susceptible to falling out. She notes that staff did ask Mr A's family on several occasions about his bed but "if it was not forthcoming they should have sought out a longer bed for him".

Ms Spence does note that, during a period of "severe restlessness", Mr A was provided with one-on-one supervision until 2am on the night of 31 December 2008. Ms Spence believes this is "commendable as it was New Years Eve and staffing would have been difficult".

Ms Spence also notes that while no falls risk assessment was carried out, Ms E did modify Mr A's care plan on 7 January, advising that Mr A was a falls risk and, accordingly, a lap belt (enabler) could be used while he was in a chair (albeit failing to follow the correct processes in doing so).

I agree with Ms Spence that the steps taken by Ms E in response to Mr A's falls were generally adequate, and the more relevant question is whether he should have been placed in a facility where the staffing level and skill better matched his needs.

Medication management
On 5 and 6 January 2009 Mr A was given more quetiapine and lorezapam than had been prescribed. Ms E believes this error was due to the fact that the tray packed medication was not disposed of when the blister packs arrived from the pharmacy, as

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the blister packs contained the incorrect doses. It appears staff were therefore accessing the medication from the old tray packs and the new blister packs.

According to the rest home's medication policy, the RN has a responsibility to ensure that the administration of medicines is strictly controlled. The need for oversight of medication administration was even greater in this case, where there were two sources of medication (tray packs and blister packs) available for staff to use.

However, the medication errors were not noticed until the rest home carried out its investigation into Mr B's complaint. This indicates that Ms E was not adequately overseeing the administration of Mr A's medication. This is unacceptable.

Communication with Mr A's family

Ms Spence notes Ms E's advice that she spoke on a number of occasions to Mrs A and other family members, and that she was always "upfront and honest".

Mrs A also rang or visited the rest home most days from 1 January 2009, and Ms Spence believes it is therefore likely that she was "up to date (if not always satisfied) with his care".

However, I agree with Ms Spence's comment that there were "omissions in [Ms E's] communication with the family" which were of concern, in particular the poor reporting of Mr A's deteriorating condition to his family, and the failure to advise them about his falls that resulted in injuries.

Documentation

I do not consider that Ms E's documentation regarding Mr A and discussions she had had about him with caregivers and his family was adequate. Ms Spence notes that Ms E did not write in Mr A's progress notes, except to record doctors' visits and changes in medication. She was critical of this, advising:

> "I consider that RNs should be writing daily progress notes with follow up in the following shifts by caregivers when the resident's condition changes or other events required documentation.
>
> …
>
> The use of an RN Communication Book is unusual and certainly not a safe practice — many facilities do use a handover book which highlights special events eg Dr coming to see Mrs A; special dressing ordered for Mrs B will be delivered by …; Mr J out until approx 10pm.
>
> It should not be used as a method of conveying nursing intervention which is recorded in the Nursing care plan and reinforced in the progress notes where necessary."

Ms Spence notes Ms E's advice that she discussed Mr A's care with the caregivers each day, yet none of these clinical discussions were documented for all caregiving staff to refer to.

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Ms Baker believes Ms E's level of documentation was "very poor". She notes that there were only three entries by Ms E in Mr A's progress notes, despite reports from caregivers describing his challenging behaviour. She also notes that Ms E has not documented important information within the progress notes or any conversations she had with family, apart from an entry on 12 January 2009.

With regard to Ms E's use of the RN Communication Book, I accept Ms Spence's advice that this was an unusual and unsafe practice. However, this was a system put in place by Norfolk Court, and Ms E was a relatively inexperienced RN. In these circumstances I do not believe it is reasonable to expect Ms E to have recognised that her use of the RN Communication Book was unusual or unsafe.

Summary

Ms E was responsible for ensuring Mr A received appropriate and timely clinical care. This required Ms E to use the information provided in the hospital discharge notes (and request additional information if necessary), in order to assess his needs and formulate appropriate behaviour management, activity and care plans. However, no physical or behavioural assessments were carried out, and it appears that no attempt was made to use the discharge information provided by the hospital (which Ms Spence considers "essential" for formulating accurate care plans) to help formulate appropriate care plans for Mr A. Furthermore, there is no evidence that Ms E attempted to obtain important information about Mr A from Mrs A.

Once Mr A began to deteriorate, Ms E's response was inadequate. She did not implement appropriate plans or tools to assist the caregivers to manage Mr A's behaviour; she failed to relay important information about Mr A's behaviour to the doctors; she failed to provide adequate oversight in the administration of Mr A's medication by staff members; and she did not seek medical attention in a timely manner. Ms E's documentation was also well below the expected standard.

I acknowledge that Ms E was working under difficult conditions. She was very junior, with no experience in geriatric care, yet she was appointed to the position of "leader" RN, with a heavy workload and little clinical support. She was provided with some RN cover after requesting this, but it was insufficient to enable her to complete her work to a satisfactory standard. Furthermore, the rest home's policies and procedures were often deficient and lacking in detail, providing her with little guidance or support.

Nonetheless, Ms E must take some responsibility for her actions and omissions. I conclude that Ms E breached Right 4(1) of the Code by failing to ensure that services were provided with reasonable care and skill.

Opinion: Breach — Ms F

Delivery of services and organisational management
As manager of Norfolk Court, Ms F had overall responsibility for ensuring that all statutory and contractual obligations were met.[23] This included ensuring that residents received appropriate care; that staff were competent to carry out their responsibilities (and that they received extra training/support where necessary); and that residents and their families received adequate information.

Ms Baker is critical that Ms F did not appear to have any knowledge of the care being provided to Mr A. She does not believe Ms F took sufficient steps to ensure Mr A was adequately assessed on admission, that he received appropriate care during his time at the rest home, and that discussions and actions regarding his care were being accurately documented.

As Ms Baker has noted, while the RN is responsible for the clinical care delivered to the resident, Ms F is ultimately responsible for ensuring that the clinical care is delivered appropriately. To achieve this, Ms Baker believes Ms F needs to be involved with the residents, the RN, and the caregiving staff on a daily basis. She needs to be touring the facility daily to see what is happening, chatting to residents and/or family present, and discussing with the RN any concerns about residents. Ms Baker finds it surprising, as do I, that Ms F met with Ms E on a daily basis yet she was unaware of any concerns regarding Mr A.

It is acknowledged that Ms F's lack of nursing knowledge may have made it more difficult for her to accurately monitor and assess the quality of the services being delivered. It is also acknowledged that Ms F was aware of her need to educate herself further, and took appropriate steps in this regard. As Ms Spence notes, Ms F chose some relevant courses, and had requested on a number of occasions (although this was always denied) that she be granted permission to attend the monthly regional Management meetings held by Healthcare Providers NZ.[24]

Nonetheless, Ms F must bear some responsibility for the failings in Mr A's care. In my view Ms F failed to take sufficient steps to familiarise herself with Mr A and the care being provided to him. Accordingly, I conclude that she breached Right 4(4) of the Code by failing to ensure that the services provided minimised the potential harm to Mr A or optimised his quality of life.

Opinion: Breach — Norfolk Court Rest Home Ltd

Mr A was put into the rest home's dementia unit because his wife could no longer provide the level of care he required. Like Ms Spence, I question whether in fact Mr

[23] This requirement is in Ms F's job description.
[24] Now the New Zealand Aged Care Association.

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A required a higher level of care than was able to be provided by this facility. However, he was accepted as a resident by Norfolk Court.

Mr A had the right to be provided with services of an appropriate standard by Norfolk Court Rest Home, as required by Right 4 of the Code. An appropriate standard of services included appropriate assessments on admission, development of an individualised care plan that accurately reflected his needs, management of his behaviour and falls risk, and ensuring his most basic health and comfort needs (including the right not to be subject to second-hand smoke inhalation, and effective continence management) were attended to. As outlined above, Mr A did not receive such services. For the following reasons, I consider Norfolk Court Rest Home Ltd is responsible for this.

Assessment on admission and care plans

Norfolk Court staff needed clear guidance for assessing residents, particularly dementia patients such as Mr A, for planning their care, and for managing their falls and challenging behaviour. It was the responsibility of the rest home to provide this guidance.

Ms Spence advised that, at the time of these events, the rest home's policies and procedures relating to the assessment of residents, formation of care plans, falls, and incident reporting, were insufficient.

Ms Spence refers to the goal contained in the rest home's procedure for care plans, which states that:

> "Norfolk Court Rest Home is committed to providing high quality care planning, to be able to maintain competent care to meet the individual needs of all Residents."

I agree with Ms Spence that, while the goal is commendable, it is let down by superficial statements about how it will be achieved. There is no information about who will collect the resident's data; how that data will be collected; from whom the data will be collected; how the data will be recorded and within what timeframes; and how often the data will be reviewed.

Ms Spence also notes that the policy contains "only a very brief statement about assessment which suggests taking vital signs". No reference is made to falls, pain, or pressure risk assessments. Nor is there any reference to the transfer note from the discharging hospital. This information is essential to enable the rest home to assess the resident accurately and develop a corresponding care plan.

Ms Spence is also critical of the rest home's policies and procedures for assessing residents' falls risks. She notes that there is no reference to falls assessments in the care plan procedure, and the falls prevention policy "provides superficial guidelines". For instance, the policy does not mention a falls assessment "which is important to determine the resident's falls risk and, if the risk exists, a management plan to reduce

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the risk of falls". Ms Spence noted that the rest home did not have guidelines for minimising falls and the management of residents who are having frequent falls.

Ms Spence also notes that the policy does not contain the procedures to follow in the event of a fall, such as assessment; guidelines for calling a doctor; treatment; documentation (accident and incident form and progress notes); advising next of kin; and the accident and incident follow-up procedure.

Likewise, Ms Spence considers the rest home's accident and incident form is "barely sufficient". For instance, it does not advise staff to telephone a doctor if necessary, or to inform the resident's Enduring Power of Attorney or nominated contact person. There is no follow-up component (ie, investigation by an RN or Manager to identify hazards or causative factors of the accident or incident), and no requirement for staff to consider and record what corrective/preventative steps can be taken.

As I have stated in a previous case, commonsense dictates that if residents are falling or having behavioural difficulties, particularly if it is more than once, prompt action must be taken to not only ensure the resident is unharmed or appropriately treated, but also to reduce the risk of it happening again.[25]

It is clear that the rest home staff did not have adequate guidance to accurately assess Mr A's falls risk and potential behavioural difficulties. The rest home did not have appropriate systems in place to ensure that Mr A was provided with appropriate follow-up care (including introducing appropriate measures to reduce his falls risk and manage his behaviour appropriately).

Employee support — registered nurse

As Ms Spence advised, rest home owners have a responsibility to "ensure the registered nurses they appoint have the experience and skill to perform safely and, if in doubt, should ensure appropriate education and support is provided for them".

When Ms E was appointed by the rest home to the position of "leader" registered nurse, she was a new graduate and her only post-graduate experience was in paediatrics.

Ms E's position required significant education, experience and skill and, in order to succeed, she needed significant peer support from a qualified manager or a contracted professional. She also needed sufficient RN cover to allow her time away from her clinical duties to complete the significant documentation required of her.

However, Ms E was not provided with any senior mentoring or clinical support. The manager had no nursing qualifications and, although another registered nurse was appointed on a part-time basis, he would look to Ms E for guidance.

While it is acknowledged that Ms E received some support from the rest home, by way of further education, this was inadequate for someone so recently qualified and inexperienced. As Ms Spence notes:

[25] 09HDC00987.

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> "[Ms E's] needs were so great she continued to struggle to provide leadership to the caregivers, maintain the documentation and more importantly provide the nursing necessary for the safety and comfort of the residents."

Following receipt of the complaint and the subsequent internal investigation, Ms E was provided with professional mentoring, which she found to be very helpful. It is concerning that the rest home failed to recognise this need, and I note Ms Spence's comment that, had Ms E received professional help earlier she may well have succeeded in her role. It is clear that Norfolk Court Rest Home failed to meet its responsibilities to ensure the registered nurse solely responsible for clinical care of its residents had the experience and skills to perform safely. Ms E was appointed to a position beyond her level of skill and experience, and the support she received from her employers was woefully inadequate to ensure she was equipped to provide services to a safe and appropriate standard.

I also consider that Ms E's orientation was seriously lacking. It consisted of four hours on her first day with another RN who was working at the rest home one day per week, and her "orientation checklist" was only partly completed.

As Ms Spence advised:

> " … RN [Ms E] may well have tried to be familiar with the policies and procedures but pressure of work and inexperience may have affected her ability to implement them.
>
> …
>
> Regretfully the lack of a sound orientation, reasonable workload and a lack of professional support did not support success."

Ms Spence identified a number of wider deficiencies with the rest home's staff orientation policy. For instance, she believes one hour is insufficient time to cover and absorb all the information contained in the initial part of the orientation. She also believes that, while the policy mentions "familiarisation of all policies and procedures", it should identify the "essential ones which need addressing early" (eg, medication, infection control, personal hygiene, transferring and handling, food hygiene, and restraint).

Ms Spence noted that no timeframes are given with regard to completion of the "orientation checklist" or the second part of the orientation (covering caregiving and written aspects of the position). She advised that "[a] timeframe for a well planned orientation could last for up to [six] weeks with the topics to be covered each week identified."

Ms Spence has noted that the policy seems to be directed at caregiving staff (although there is brief mention of cooks, cleaners and laundry staff); there is no mention of a specific orientation programme for registered/enrolled nurses; and the differing

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orientation needs of staff (ie, those with or without previous education) have not been addressed.

I agree with Ms Spence that, while there was "an attempt to provide a policy to orientate new staff", the policy is "light in content". The policy in place was not sufficient to ensure that all staff received the introductory training they need.

Employee support — manager
Rest home managers are required to hold a "current qualification or [have] experience relevant to both management and the health and personal care of older people".[26] While the type of qualification is not specified, I note that Ms Spence considers that it should be a qualification in nursing.

Ms F was appointed to the position of Manager in 2002. She previously held an administrator position at the rest home. She held no management or nursing qualification and, other than completing the ACE Programme the year prior to her appointment, she had no experience in the personal care of older people. I accept that Ms F did not have to be an RN. Nonetheless, I am concerned about whether Ms F's background and experience were sufficient for the demands of her role, and whether she received appropriate support, particularly in a situation where the primary RN had so little nursing experience. As Ms Spence notes:

> "Experience required in the position description suggests the Manager should have experience in Management, Employment Relations and Human Resource Development, Personnel Practice and Management of Organisations.
>
> While much of this knowledge may have been gained while working at Norfolk Court, it is risky for the owners/management team to employ the leader of their team to 'learn on the job'."

Rest home owners have a responsibility to ensure the facility is in safe professional hands, part of which involves providing staff with appropriate educational and training opportunities. The rest home denied Ms F's requests to attend the monthly regional Management meetings, but, as Ms Spence notes, "[t]hese opportunities would have helped her greatly with her role identifying current issues in the rest home industry …". I also note that there is no mention in the manager's job description about compliance with the Health and Disability Services Standards; and no evidence that Ms F was given the opportunity to attend courses relating to these.

While recognising that Ms F did not need to be a nurse, I agree with Ms Spence that the rest home should have recognised Ms F's lack of relevant education and skills for the extent and challenges of her current role, and the consequent inability for her to perform her duties to the required standard without significant support and training. The rest home, in light of the failure to recognise and address the challenges Ms F faced, must therefore take responsibility for the poor care Mr A received.

[26] Clause D17.3 (d) of the National Contract for Age Related Residential Care Services Agreement between District Health Boards and aged residential care providers.

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Staffing levels

During Mr A's stay at Norfolk Court, the level of clinical support at the rest home was severely limited. All of the clinical responsibility for the complex health needs of the rest home's residents was left largely with one inexperienced nurse and a visiting doctor. As Ms Spence advised:

> "Staffing levels should … reflect the need and level of care required by the residents and no staff member should be under so much pressure of work that they can not implement care kindly and safely.
>
> …
>
> Serious consideration should be given to standards relating to nurse ratios and qualifications of nurses in these positions. The work is challenging, diverse and extremely busy as the complex and increasing needs of older people are attempted to be met."

Ms Baker had similar concerns. She notes from the information provided in the HealthCERT report (6 April 2009) that none of the caregiving staff held a certificate in dementia care (although there was one caregiver undergoing dementia unit standard training).[27] The report also described how some shifts were worked by staff who were caregivers in training. Ms Baker advised that it is inadequate to staff a dementia unit with unqualified staff, and I agree.

I note the rest home's submission that, given its rural location, it is unlikely that all its caregivers will be fully trained at any one time because of the difficulty in recruiting trained staff, and the difficulties providing external training opportunities to staff. In my view, while acknowledging the difficulties inherent in running a rest home in a remote location, the rest home did not take reasonable actions to ensure its staff were appropriately trained and skilled to provide care to vulnerable residents.

Ms Spence questioned the appropriateness of Mr A's placement at Norfolk Court:

> "While being assessed and treated at [the public hospital], [Mr A] was under the care of a highly skilled, qualified staff who, along with specialist care were able to settle his behaviour.
>
> I suspect that the level of skill of all staff at Norfolk Court Rest Home did not match his needs, and consideration should have been given to placing him at a high level dementia care facility."

However, I accept that the rest home was not privy to Mr A's medical history (showing the need for "a more psychiatric based, as against caregiver based facility") prior to Mr A's arrival at the rest home. It is also clear that there was difficulty finding a suitable facility for Mr A in December 2008, and it appears that Norfolk Court was

[27] Although Ms Baker accepts the HealthCERT report related to an audit undertaken after the complaint was made, she has reasonably assumed that, at the time of the events complained about, the level of the caregivers' education and training was similar.

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the only facility in the area with a dementia bed available at the time. Nonetheless, I consider that these circumstances highlight the need for the rest home to ensure that residents are carefully and appropriately assessed on admission, regularly reviewed, and reassessed as necessary.

Medication management

Ms Spence believes, and I agree, that the rest home's medication management policy was substandard. In particular the use of dual packaging systems is likely to result in medication errors like those that occurred on 5 and 6 January 2009 in relation to Mr A's medication. These errors were unacceptable and could have been easily avoided if only one packaging system was in use at the rest home.

If new residents arrive with different medication packs, these should be sent to the pharmacy immediately for repackaging. However, it is accepted that, while the use of one packaging system is the goal, it may not always be achievable. For instance, in the case of short stay residents, the cost of repackaging medications for a few days may not be justified.

Ms Spence advised that the rest home's medication management policy was very basic, and contained reference to outdated standards. The policy should have contained more direction to staff around the management of medication errors, guidelines, and a competency test for medication administration by caregivers, and noted that the RN must check packaging on receipt from pharmacy to check that packed supply matches the prescription.

I agree that the rest home's medication management policy was not sufficient to reduce the risk of medication errors, such as occurred with Mr A. It is pleasing to see that the rest home has acknowledged this issue and is taking steps to minimise, isolate, and eliminate dual systems of supply of prescribed medications.

Consultation and communication with family

There were a number of instances during Mr A's stay at the rest home when his family should have been contacted, and his care discussed. Ms Spence believes that, while the rest home's policy on consultation and communication with residents and their families is generally adequate, there were two important omissions. First, "accidents and incidents" are not listed as circumstances for consultation with the resident's family or Enduring Power of Attorney (EPA); and secondly, while family meetings are suggested, no time frame is given. Ms Spence advised that "[i]deally, these should be [six]-monthly at the time the care plan is reviewed to allow family participation".

In Mr A's case, his son Mr B was noted as having "power of attorney" (although he was not able to produce evidence of this during the investigation), yet there is no evidence that rest home staff kept in regular contact with him about his father's care. It is concerning that, while the rest home's application form has a space to insert the name of the resident's EPA (if he or she has appointed one), there is no requirement for staff to obtain evidence of that appointment, or even that the EPA has come into

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effect. This is particularly concerning given the fact that the rest home provides beds for 11 dementia residents.

Ms Spence also notes that there are no family meetings recorded for the "relatively short time" Mr A resided at the rest home. I agree with Ms Spence's observation that, had there been, many issues may have been resolved, and the genuine and ongoing concern expressed by Mr A's family about his care may have ensured a much safer and comfortable experience for him.

Forms generally
Ms Spence is critical of the forms used by the rest home:

> "Many forms are not well headed, some had no provision for the resident's name or for the staff completing them or making provision for signature and date.
>
> Some forms require an indication as to their purpose e.g. Short Term Care Plan — when they should be used and how they link to the Long Term Care Plan. They require a time frame and evaluation column and as earlier mentioned, date and signature columns."

I agree with Ms Spence's observation that the rest home's documentation, forms, policies, and procedures that were reviewed in relation to this investigation require significant development. I also agree with Ms Spence that the rest home should engage a consultant to carry out this work (with input from the RN), as the current manager does not have the necessary skills to do this without professional support, and the RNs do not have sufficient time.

Continence management
Ms Spence advised that the rest home's use of reusable incontinence products is not considered best practice. They do not provide dignity for the resident, as they leak, soiling clothing, bedding and the floor, and this is unpleasant for both the resident and the staff.

While carpeted floors provide a "more homely and attractive surrounding", Ms Spence believes it may be better to choose a surface that is more easily cleaned as it can be difficult to remove odour from carpets, "even with the best cleaners and chemicals".

It is disappointing to note that in an audit report from May 2008, urine odour was a documented problem. As Ms Spence commented, the rest home "should have resolved this unpleasant, unhygienic problem by the time of this complaint".

I agree with Ms Spence that the rest home requires a continence management policy that "promotes comfort and dignity; promotes continence wherever possible; manages incontinence with quality intervention; and includes a continence assessment tool".

It is pleasing to see that the rest home has already initiated appropriate steps to address this issue, including the introduction of disposable incontinence products, and

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development of a continence assessment tool, and it is seeking advice from the DHB Community Continence Nurse.

Smoking policy
Ms Spence advised that, although the rest home's smoking policy is "clear and firm", she considers the situation at the rest home, where residents' rooms open out on to the designated smokers veranda, is "fraught with difficulty" as there will be non-smoking residents (like Mr A) in these rooms and others nearby. While acknowledging that Mr A was moved into a room away from the smoking area, I agree with Ms Spence that, in a dementia facility, this is not an acceptable situation.

Ms Spence is critical of the fact that the rest home had not implemented a non-smoking policy like most other rest homes. Smoking in health-related facilities is now unacceptable for both health and social reasons, and I agree with Ms Spence's recommendation that the rest home seek ways of implementing a non-smoking policy (in accordance with the Smoke-free Environments Act 1990) which prevents any resident (or non-smoking staff member) suffering from second-hand smoke inhalation or the smoke odour from staff breath or clothes.

Summary

Following its internal investigation into the complaint about Mr A's care, the rest home identified a number of gaps in its policies and procedures and "unreservedly" apologised for the "shortcomings" in Mr A's care. The rest home advised HDC of the steps it was taking to address these shortcomings, including: improving its assessment and care planning tools and procedures; holding staff training sessions on dementia care and restraint; improving its behaviour observation charts, medication management, and accident and incident procedures; introducing activities assessments and planning tools; and implementing multidisciplinary team reviews. These changes are acknowledged and commended.

It must also be acknowledged that the rest home's policies and procedures (which my expert has criticised) met most of the criteria of HealthCERT's auditing agency following the last (surveillance) audit before the events giving rise to this investigation. However, it is important to note that the auditors assess the policies and procedures against a different and narrower set of criteria to HDC.[28]

A HealthCERT audit is an evaluation of the extent to which a health care provider meets standards and processes, based on particular audit criteria. Although a rest home may meet audit requirements, it does not follow that the services the rest home provides are consistent with the duties set out in the Code.

In my view, a number of the rest home's policies and procedures that impacted on the services provided to Mr A were inadequate. In particular, there was insufficient guidance and information provided to staff about the assessment of residents,

[28] The rest home has advised that, despite substantial compliance with the audit process, it has now appointed a new auditor. It hopes that this will improve the rest home's standards.

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development of individualised care plans, identifying and managing falls risks and challenging behaviours, medication administration and management, continence management, and smoking.

The rest home also failed to ensure it had sufficient appropriately qualified and skilled staff on duty, and it appointed staff to positions beyond their level of experience without providing adequate support to ensure services of an appropriate standard were provided to its residents. It also failed to provide Ms E with an adequate orientation to the role, policies and procedures.

I am not satisfied that the rest home took reasonable actions in the circumstances to give effect to Mr A's rights, or comply with the duties in the Code. In my view, the rest home failed to provide services of an appropriate standard to Mr A. It breached Rights 4(1), 4(2), and 4(4) of the Code by: failing to ensure services were provided with reasonable care and skill; failing to ensure services provided complied with relevant standards; and failing to ensure the services provided minimised the potential harm to Mr A and optimised his quality of life.

I am of the view that the breaches are of a seriousness that warrants the referral of Norfolk Court Rest Home Ltd to the Director of Proceedings.

Naming

I have discretion to name group providers in the final version of any breach reports that are published on the HDC website and sent to relevant agencies. Each case is considered on its own merits. In this case, Norfolk Court Rest Home submitted that it would be unfair to publish its name in my report because it considers that it took all reasonable actions and, as a provider of "an essential service to the elderly community [in the town]", it does not want the community to lose confidence in it. I have carefully considered this issue and decided that, on balance, given the seriousness of the breaches, the public interest favours publication. Accordingly, Norfolk Court Rest Home will be named in the version of this report published on the HDC website and sent to relevant agencies.

Other comment

Use of restraint and restraint policy

I have some concerns about Ms E's use of restraint on Mr A and the rest home's restraint policy which, while not directly part of this complaint, or within the scope of my investigation, I believe warrant attention.

My dementia care expert, Ms Baker, advised that the use of an enabler to ensure Mr A did not fall from his chair or get out and wander, is a form of physical restraint, not a voluntary use.

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While I have some concerns about the rest home's restraint policies (discussed below), they clearly outlined the steps Ms E was required to follow when considering restraint. These steps were not followed. For instance, there is no evidence that Ms E assessed the type of restraint to use and the risks involved, or monitored the use of the restraint. Nor is there any evidence that she obtained approval for the use of the restraint from the "approval group", or written consent from the family.

Ms E's failure to follow the restraint procedures has led Ms Baker to believe Ms E did not understand that an enabler is a form of restraint. Clearly further training and education about the rest home's restraint policies and procedures is required.

With regard to the rest home's restraint management policy, I note observations made by Ms Baker that, while the rest home's "Guidelines for the Safe and Appropriate Use of Restraints" are comprehensive and appropriate, there is a contradiction between these guidelines and the rest home's policy on consultation and communication with family/whanau. While the guidelines describe chemical restraint as an unacceptable practice, the policy on consultation and communication includes, in its list of circumstances where consultation/communication may be appropriate, "when chemical or physical restraint is indicated". Ms Baker believes this contradiction is confusing and could potentially result in staff using medication as a chemical restraint. I agree.

Ms Baker also considers the rest home's policy "Restraining of Residents" to be inappropriate. For instance, under the heading "An approved physical restraint technique" there is a detailed list of steps that should be taken by staff when physically restraining a resident. Ms Baker considers this type of restraint is "not appropriate for any level of dementia residential care ie rest home or hospital level; it may be appropriate in a mental health setting". She further advised:

> "Personal restraint should only be used if the person is at serious risk of harming themselves or someone else eg if a resident was trying to 'jump over the balcony' or being physically aggressive to another resident and the staff could not divert the resident away from the danger using de-escalation techniques."

While I acknowledge Ms Spence's advice that the rest home's policy on restraint is appropriate, I consider Ms Baker's concerns are reasonably based. Accordingly, I endorse Ms Baker's advice that the rest home's policies on Restraining of Residents and Consultation/Communication with residents/family/whanau require "immediate review" to ensure they meet the Restraint Minimisation and Safe Practice Standard.

Action taken

In addition to the actions taken following the rest home's internal investigation, the rest home advised HDC that it had taken further action in response to my provisional

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report on this complaint. With regard to my concern about the lack of RN cover over the weekend period, and my subsequent recommendation (contained in the provisional report) that the rest home provide caregiving staff with very clear guidelines on seeking medical assistance in the event an RN is not on duty or on call, the rest home advised:

> "All staff have been informed of their right to contact a doctor at any time if they are concerned about a resident's health. They do not have to contact the registered nurse, manager, or CEO for authority. Notices have been put in both nurses stations also."

With regard to my recommendation in the provisional report that the rest home ensure that "all caregivers are adequately trained and qualified for their position", the rest home advised HDC that all staff in the dementia unit now have, or are undergoing, dementia care training, and a senior caregiver is undertaking her assessors training so she can assist staff with their ACE programmes.

I also recommended in my provisional report that the rest home engage a consultant, with experience in aged care, to review and assist with the upgrading of all its policies and procedures, and check to ensure that staff are acquainted with these policies. The rest home advised HDC that it had engaged Mr G to review all of its procedures, and that the revised policies had been presented to staff.

Apologies
I note that Norfolk Court Rest Home, Ms E, and Ms F, have all apologised to the family for failing to provide an appropriate standard of care to Mr A.

Recommendations

I am satisfied that the steps taken by the rest home to address the issues raised by this complaint have addressed many of the issues identified. However, I note that on 23 April 2010 an audit agency (engaged by HealthCERT) carried out a further audit at the rest home which identified that some standards were not being achieved. I therefore ask that the rest home provide me with evidence of the further changes made in response to this latest audit report, by **30 July 2010**.

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Follow-up actions

- Norfolk Court Rest Home Ltd 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 DHB, the Ministry of Health, and the Nursing Council of New Zealand with a recommendation that it consider whether a review of Ms E's competence is warranted.

- A copy of this report, with details identifying the parties removed, except Norfolk Court Rest Home and the names of the experts who advised on this case, will be sent to the New Zealand Aged Care Association, the New Zealand Nurses Organisation, and the College of Nurses Aotearoa (NZ) Inc, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided to issue proceedings before the Human Rights Review Tribunal. Proceedings are pending.

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Appendix A — Independent nursing advice

The following expert advice was obtained from registered nurse Lesley Spence:

> "My name is Lesley Wynne Spence and I have been asked to provide nursing advice to the Commissioner on case number 09/01050.
>
> I have read carefully the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.
>
> *Qualifications and Experience*
> I am a registered general and obstetric nurse (1963) and hold an Advanced Diploma of Nursing (1981, Distinction) specializing in medical nursing. My Practising Certificate No. 019220 is current.
>
> Following graduation I worked in an acute medical surgical hospital becoming a staff nurse in a medical ward and prior to being promoted to a nurse tutor position was Sister-in-Charge of Christchurch Hospital on night duty (600 patients).
>
> I taught General Nursing for 3 years (1966–1969) and then had a period raising a family during which time I worked part-time in a hospital for the aged.
>
> In 1975, I was invited to teach in the then quite new Comprehensive Nursing programme at Christchurch Polytechnic where I was employed for 18 years.
>
> During these years, I taught most comprehensive nursing courses but in the latter 5 years, I had the responsibility for post-graduate short courses which included courses in Gerontology (care of the aged). It was the importance of this knowledge that led me to accept the offer of a nurse manager's position in a large modern rest home caring for approximately 80 seniors. There I began to apply my learning to practice — I found it rewarding to be able to teach Registered Nurses and caregiving staff and see the benefits of their knowledge conveyed to the residents. I also developed skills in management which assisted in meeting the challenges of running a rest home.
>
> From this rest home I was invited by new employers to develop a 60 bed rest home, Middlepark Senior Care Centre, from the building plans up — this gave me the opportunity to modify design, plan appropriate furniture, furnishing and equipment, write the policies and procedures, employ, orientate and educate the staff and develop trusting relationships with the residents.
>
> While challenging, this project was enormously satisfying as I was able to implement the nursing philosophies I believed in.
>
> Since then a further 2 rest homes, The Oaks Senior Care Centre (150 residents) and Palm Grove Senior Care Centre (118 residents) have been built to include long-term hospitals. Palm Grove was opened in December 2003.

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During that time my role changed to Principal Nurse Manager with oversight of the 3 centres.

In December 2007 I resigned from the position as Nurse Manager of Palm Grove Senior Care Centre. I am now working part-time for Christchurch Polytechnic, HealthCare Providers New Zealand and as an advisor to Christchurch Rest Homes.

I have recently helped set up an 18 bed hospital wing which is attached to a medium sized rest home. This involved helping with the design, purchasing all the equipment, employing and orientating staff to the new hospital policies and procedures.

I am a member of HealthCare Providers NZ (Canterbury Branch Executive Member).

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

I act as an advisor for:

- Christchurch Polytechnic Institute of Technology Post Graduate Courses for Nurses
- Health & Disability Commissioner
- Health Education Trust with input into the Aged Care Education courses for caregivers.

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

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

Health & Disability Commissioner's Request

I have been asked by the Health & Disability Commissioner to provide independent expert advice about whether Norfolk Court Rest Home provided an appropriate standard of care to [Mr A].

[At this point in her advice Ms Spence sets out the background facts to the complaint and the questions asked of her. This information has been omitted for the purpose of brevity.]

My comments on the appropriateness of care provided for [Mr A] follow:

1) Please comment generally on the standard of care provided by each of the following, in relation to their individual roles and responsibilities:

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(a) Norfolk Court Rest Home Limited

(b) [Ms E]

(c) [Ms F]

I have made more in depth comments about the above in the following advice. Briefly and in my opinion, however:

a) Norfolk Court Rest Home did not meet its legislative obligations or duty of care. The issues surrounding these have been more fully responded to in the report.

b) [Ms E] was appointed to a very busy position beyond her level of experience and as she was working without more senior professional mentoring and support, she was seriously challenged to practice safely.

c) [Ms F] had a sincere wish to lead her staff and care for the residents of Norfolk Court well but did not have the professional educational background and experience to succeed.

However, I do sense in [Ms F's] report there would have been many acts of kindness shown. [Ms E] also expresses regret and concern for any distress she may have caused.

Norfolk Court Rest Home Limited

a) Comment on the adequacies of its systems and policies in relation to:

i) Assessment of Resident on Admission

I could find no policy regarding resident assessment on admission but a form providing guidelines on resident's admission was included. This form provides brief but relevant trigger points for the admitting staff member.

There is however, only a very brief statement about assessment which suggests taking vital signs. It does also state the nurse should refer to "Admittance Forms". No reference is made to the important Support Needs Assessment which is provided by the District Health Board, or the transfer note from the discharging hospital. This is the essential information upon which the rest home assessment is built and the corresponding care plan can be developed from.

While the Norfolk Court guidelines may keep the resident safe for a short period, it is very superficial in content.

A care plan procedure has been provided with the goal that Norfolk Court Rest Home is committed to providing high quality care plans to be able to maintain competent care to meet the individual needs of all residents. The goal is

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commendable but let down by superficial statements about how it will be achieved.

The only reference to assessment is:

- Gathering information resident profile and history
- Physical information and tests
- Nursing diagnoses

No information is provided as to:

- Who will collect the data
- How and what data will be collected
- From whom the data will be collected
- How it will be recorded
- Within what timeframes
- How often the data will be reviewed

No reference is made to falls, pain or pressure risk assessments which should form part of a holistic individualised assessment and of course properly implemented would have improved the safety and comfort of [Mr A's] rest home experience.

ii) Falls Prevention

The falls prevention policy possibly written for caregivers provides superficial guidelines. It does not mention a falls assessment — which is important to determine the resident's falls risk and if the risk exists, a management plan to minimise the risk of falls.

No mention is made of the procedures to follow in the event of a fall in regard to:

- Assessment
- Guidelines for calling a doctor
- Treatment
- Documentation (Accident Form, Progress Notes)
- Advising Next of Kin

Some guidelines for minimising falls should be included and also for the management of residents having frequent falls.

A policy for reporting accidents and incidents has also been developed but it too does not include a statement to advise families if injury occurs and who is responsible.

Data should be collected from the Accident/Incident (falls) Form and referred to the Quality Improvement Committee for analysis and used as a basis for improving resident care.

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Significantly more information is required in the Norfolk Court Falls Prevention Policy to protect residents in their care.

iii) Restraint Minimisation and safe practice

At the surveillance audit in May 2008, Norfolk Court Rest Home achieved full attainment of the standards which were not fully attained at the full audit of May 2007.

The restraint policies and procedures appear to be compliant with Standards as documented by the auditing team in May 2008.

The policies and procedures are comprehensive and correct forms are available for:

- Resident Information (or Enduring Power of Attorney)
- Restraint application — which requires approval from a group which may include an RN, C.E.O., Manager, GP, Resident and family). A signature is required from an approval group representative. Clear guidelines as to how approval is given, is in the procedure for use of restraints.
- Evaluation of Individualised Restraint Use (3-monthly)
- Consent form for Use of Restraint
- Restraint Monitoring

Additional information is provided to assist staff if a resident is in danger of hurting themselves or others.

Techniques for calming residents are given and methods for physically restraining a resident as a last resort are provided.

A definition is given for an 'enabler' — usually lap belts which can be used without approval, although it is important that monitoring is continued and family/ Power of Attorney is advised. Documentation is essential.

I note [Mr B's] frustration about the limitations to the use of restraints and feel some sympathy to the family as a whole in light of the injuries sustained by his father. Unfortunately, although likely, it is not known whether the fractures were caused by a fall, or whether bedrails would have prevented the fall.

Significant research has been done into the use of restraint and the current evidence suggests that removal of or non-use of restraint does not result in increased fall rates or more serious harm related to a fall (Capezuti, Strumps, Evans, Grisso and Maislin 1998). New N.Z. research will be available soon.

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iv) Doctors' Visits to residents

There was no policy included regarding Drs' visits to residents and this does need to be clearly stated by applying the Health & Disability Standards requirements, ie:

- Regularity of visits
- Updating of notes and medication prescriptions

Doctors are required to visit monthly and as needed unless they document a Doctors visit is only required every 3 months. At the 3 monthly visit a full medical review is carried out and all medications are reviewed and re charted.

[Mr A] was seen regularly by Doctors on the following dates.

DATE	REASON FOR VISIT
29/12/08	Admission assessment
31/12/08 ([Dr I])	For [Mr A's] escalating agitation and later in day telephoned a drug order to increase quetiapine to 25mg and to give a further half at midday the following day if needed.
7/1/09 (Wed) ([Dr I])	For 2 days drowsiness dizziness and fall tendency — noted multiple abrasions. Medications were reviewed. quetiapine was stopped for 2 days and to resume at 12.5mg Friday 9th January, p.m. lorazepam also stopped until Friday 9th. [Dr I] countersigned an earlier verbal order.
9/1/09 [Dr J] .D.H.B Geriatrician	At the request of [Mr A's] wife for advice ([Mr A] was well known to [Dr J]). He also recommended stopping all medication until reviewed by [Dr I] on 14th January 2009.
12/1/09 [Dr K]	Visit at request of [Mrs A] and RN concerns. [Dr K] telephoned [Mrs A] about her findings.
14/1/09 ([Dr I])	Follow up [Mr A's] progress at routine visit. Intestinal obstruction suspected and ordered abdominal x-ray, [local] hospital.

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Drs were responsive to requests for consultation from both RN and [Mrs A] and visits were regular.

Medication was ordered or stopped as deemed necessary.

One telephoned medication change was not charted but recorded clearly on Norfolk Court Rest Home telephoned medication form. This should have been charted within 24hrs.

Although [Mrs A] felt it necessary to contact [Dr J], his advice was similar to what Dr I had ordered earlier.

Initially staff were not advised that there were drug allergies. These were advised later by [Dr J] — zopiclone & risperidone as they made [Mr A's] mood uncontrollable.

Family were not advised of changes or concerns by Doctors except on [Dr K's] visit (12/01/09), initiated by [Mrs A] when blood tests were ordered. At this visit, [Dr K] queried left-sided weakness, but because the examination was made difficult by [Mr A's] drowsiness, apparently did not feel the symptoms were significant enough to investigate further.

v) Consultation/communication with residents and their families

This policy identifies consultation and communication with families and significant others and recognises that this should be with the resident's consent.

Appropriate circumstances for consultation and communication include:

- When chemical or physical restraint is needed
- Presentation of significant behavioural problems.

An important omission is that of Accidents and Incidents.

Family meetings are suggested but no time frame is given. Ideally, these should be 6-monthly — at the time the care plan is reviewed, to allow family participation. They may be formal or informal but must be documented.

No family meeting was held for [Mr A] in the relatively short time he resided at Norfolk Court; had there been, many issues may have been resolved and the genuine and ongoing concern expressed by his family about his care may have ensured a much safer and comfortable experience for him.

vi) Accident and Incident Reporting

The policy on Accident and Incident reporting is barely sufficient as it does not advise staff to call a Doctor if necessary and to advise the family or next of kin if injuries have occurred.

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Following completion of the report by the senior-most person on duty and a review by the Registered Nurse/Manager, the report should then form part of the data taken to the Quality Improvement Committee for review and action. The comments I have made about falls reporting also apply here.

vii) Reporting of Residents to staff

Handover — this appears to have been done via a handover book with notes written by the Registered Nurse. Unfortunately it seems that the Registered Nurse took little cognizance of each resident's progress notes written regularly by the caregivers (often each shift) hence changes of [Mr A's] behaviour and health were being missed.

I do not have a full copy of the Registered Nurse Communication book and of course it is not possible to know what verbal handover was given. However, I am very concerned about the quality of reporting to caregivers and other staff at handover times and consider the Registered Nurse's action here very remiss.

The Progress note form has no column for signature and designation which is of concern as not all staff have signed correctly. [Ms E] does say in her statement that she discussed [Mr A's] care with the caregivers each day but none of these clinical discussions were documented for all shifts to use.

viii) Medication management

I have reviewed the medication policy in place at the time of [Mr A's] admission. It is a two page document which is headed by the Health and Disability Services Standard: 'The CEO Manager or Registered Nurse should ensure that the storage, administration and disposal of medicines are strictly controlled'.

Norfolk Court Rest Home medication policy contains information about: storage, the resident medication profile, records, the administration procedure, non-compliance, household remedies, telephone orders, and medication errors.

The information is fairly basic and I note the reference used was the Standards of Care for Old People's Homes (1987). This is very outdated information. A current useful reference is 'Guidelines for Nurses on the administration of Medicines' published by the NZ Nurses Organisation.

The policy I have reviewed was last updated in 2007.

More detailed content is required and should include: an explanation of the packaging system, ordering delivering and receiving, verbal orders, specialist orders, medication changes, self medication, controlled medication, medication reactions/allergies, topical and alternative medication, standing orders/household remedies, and the place of quality improvement.

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A clear statement will be required to clarify the management of medication errors. It should also include:

- Guidelines for the education programme for caregivers and competence testing for medication administration; and
- A clear list of Household Remedies and/or standing orders is required, and will require signed approval by the House Doctor.

Only one packaging system should be used in house, and new residents with different medication packs should immediately be sent to pharmacy for repackaging.

Consistency in the use of drug names is important. Nurses should only refer to the drug name prescribed by the Doctor (usually the generic name.) In several instances, quetiapine was referred to as Seroquel (the trade name) and the use of two names for a drug can lead to errors.

I note [Mr G] the temporary manager has done significant work in this area and many of the issues I have identified may have been resolved

ix) Continence Management

I could find no continence management policy.

Where frail elderly confused people are being nursed, a robust continence policy is needed which:-

- Promotes comfort and dignity
- Promotes continence wherever possible
- Manages incontinence with quality intervention
- Includes a continence assessment tool

The skills of the DHB Continence advisor should also be sought.

The resident's Doctor may also consider medical investigations and referral to specialised care.

Offensive urine odour in the building was noted by [Mr A's] son [Mr B].

The use of reusable continence products is not now considered best practice. They do not provide dignity for the resident as they leak and soil clothing, bedding and the floor. This is unpleasant for residents and for staff handling them.

Carpets can be difficult to remove odour from, even with the best cleaners and chemicals and while a carpeted floor provides a more homely and attractive surrounding, in facilities where there are a number of incontinent residents, more easily cleaned flooring may by a better choice.

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It is disappointing to note in the May 2008 audit report again indicated that urine odour was a problem. Norfolk Court Rest Home management should have resolved this unpleasant, unhygienic problem by the time of this complaint.

x) Smoking

The policy is clear and firm, however it is disappointing to see that there is not a non smoking policy as most rest homes now implement.

It appears that residents' rooms open on to a veranda where residents/staff are permitted to smoke. This is fraught with difficulty as there will be non smoking residents (as with [Mr A]) in adjacent rooms.

Smoking in health related facilities is now unacceptable for both health and social reasons and I strongly recommend that the management seek ways of implementing a non smoking policy (within the Act) which prevents any resident or non smoking staff member suffering from smoke inhalation or the smoke odour from staff breath or clothes.

At interview a staff member can be advised that the rest home is smoke free and information given to them about policies and procedures surrounding this. They then have the choice of deciding wether the workplace will be comfortable for them

I note [Mr A] was moved away from the smoking area but in a dementia facility this is unsettling and should not be necessary.

There is work to be done to ensure no resident or staff member is exposed to unwanted smoke inhalation, and to ensure this facility complies with smoking legislation.

a) The adequacy of the support/training/education provided or offered to [Ms E] by Norfolk Court Rest Home/[Mr D] in light of her experience for the position.

[Ms E] completed her Bachelor of Nursing in 2005 and registered as a nurse in December 2005.

In January 2006 she commenced her new graduate programme at [a public] Hospital.

In July 2006 she was employed at Norfolk Court Rest Home as a Registered Nurse. Her orientation consisted of 4 hours on her first day with another Registered Nurse who was working at the rest home one day a week.

An orientations checklist was partly completed but has no name, date or signature. An O.S.H. and Employment Checklist was signed by [Ms E] but again, no date.

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She worked 4 days per week until she went on maternity leave on 10th November 2006 recommencing at Norfolk Court on 12th February 2007.

At this time she was the sole registered nurse for the facility. She felt overwhelmed by this and requested the help of another registered nurse as she felt she could not carry out her duties effectively. Later that year a second registered nurse was employed to assist her while she caught up on care plans. This nurse stayed 3 months and then moved out of the area.

She again requested help and, when it was not forthcoming, handed in her resignation as she could not carry out the duties required of her. The C.E.O. then gave her one week's stress leave and advertised for another registered nurse 2 days per week.

[Ms E] states she had no other clinical support and found she was the person the other Registered Nurse turned to for guidance.

When the Temporary Manager was appointed, she felt much more supported but she has since resigned.

Education:
In the first year of her appointment, 2007, she had approximately 17 hours of relevant education. In 2008, 24 hours of appropriate education as well as 40 hours in the in-service education programme over the 2 years, some of which she taught herself. She also completed some cultural and restraint training.

In July 2009, she completed 11 hours of in-service education which included approximately 3 hours of dementia care, 1 hour continence and a restraint training questionnaire. Unfortunately, this was after [Mr A] was resident at Norfolk Court Rest Home.

Generally, the education offered to [Ms E] has been relevant and adequate however, for a new graduate, her orientation was very limited and along with a lack of professional support, this did not set the scene for the responsibilities involved.

She came to Norfolk Court as a new graduate; her only post-graduate experience was in paediatrics. To succeed, she needed significant peer support from a qualified manager or contracted professional. She also needed sufficient registered nurse staffing to allow her time from her clinical duties to complete the significant documentation required of her.

Regretfully, the lack of a sound orientation, reasonable workload and a lack of professional support did not support success.

The Health and Disability Services Standards states "New service providers receive an orientation and induction programme that covers the essential components of the service provided."

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In summary, I believe that [Ms E] did not have the experience or support from Norfolk Court Rest Home/[Mr D] to safely carry out her duties in this challenging clinical position. Her position was also made more difficult with the current manager having no nursing qualification and being totally dependent on [Ms E] for clinical decisions.

b) The adequacy of the support/training/education provided or offered to [Ms F] by Norfolk Court Rest Home/[Mr D] in light of her experience for the position.

Manager — [Ms F]

[Ms F] was appointed in 2002 and was approved by the Ministry of Health under the Old Persons Homes Regulations 1987, Regulation 3.

No documentation of her orientation from her previous administrator position at Norfolk Court to the Manager's role is known. Since then, she has achieved NZQA Standards:

2002	Manage acute cardiac events in ambulance services
	Treat hypovolaemic shock in ambulance services.
2003	Workplace safety — ACC
2006	Use Standards to assess candidate for performance
2005	A 4-hour session provided by [the] D.H.B. on Infection Control Pandemic Planning
	Wound healing — prevention of pressure sores
	Health & Safety — Employees responsibilities
	Hazard Identification and hierarchy of controls

In service education from 2001 consisted of 4–8 sessions a year of relevant Fire, Health & Safety and medical nursing topics.

Many of the topics in the last 2 years were taught by herself or the new graduate registered nurse. [Ms F] also completed the Aged Care Education Core programme and later, the A.C.E. Assessors Course.

She has also done courses in Food Safety, Team Building, Workplace and Management Practice, Risk Management, Restraint and Elder Abuse and Neglect. In September 2008 she completed an Internal Auditor Training Course.

There is no doubt [Ms F] has been aware of her need to educate herself to this important role and has chosen some relevant courses to do this. I do however

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have grave concerns about whether her early experience and education befits her for the modern, busy Facility Manager position.

When checking her job description, I find no mention in the objectives to comply with the Health & Disability Standards. There is also no evidence she has been given the opportunity to attend courses relating to these.

Experience required in her position description, suggests that Manager should have experience in Management, Employment Relations and Human Resource Development, Personnel Practice and Management of Organisations. (I Note a new position description has now been developed with the support of the temporary manager and [Ms F] is working towards achieving some of the new key performance indicators.)

While much of this knowledge may have been gained while working at Norfolk Court, it is risky for the owners/management team to employ the leader of their team to 'learn on the job'.

I noted in [Ms F's] report her request to attend the [regional] management meetings held monthly by Healthcare Providers NZ and that she would have liked to attend their conference. These opportunities would have helped her greatly with her role; identifying current issues in the rest home industry and often providing training to address these. Recently there have been excellent courses relating to the 2008 changes to the Health & Disability Standards which would be pivotal to her role.

In summary, Norfolk Court Rest Home has provided some education for [Ms F] but could have supported her to more relevant courses and conferences which would have improved her competency for her role.

Her need to understand the Health & Disability Standards in order to implement and monitor them is key to her management position at Norfolk Court Rest Home.

c) The adequacy of handover/communication amongst staff members

It appears two methods of daily resident written reporting have been in use. The first is in the resident progress notes and another book (RN Communications Book) which was written in by the registered nurse to give new instructions to the caregivers and possibly a handover report.

It is of course not possible to assess the quality of the verbal handovers which may have been adequate but documentation either via care plan — short term or long term, and progress notes was very inadequate. The registered nurse recorded only doctors visits in progress notes.

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d) The adequacy of documentation by staff generally

Caregivers wrote careful and often insightful notes regularly but these notes were often not commented on or acted on by the Registered Nurse/s.

Care planning both long and short term was superficial and not sufficiently responsive to [Mr A's] needs; the short term care plans did not indicate what their purpose was.

No clinical assessment was documented on admission and this creates doubt about the adequacy of the care plan.

I note at the top of the progress notes, a daily care sheet is issued — none of these were included with the documentation provided. If they are used they may have given an overview of the daily care [Mr A] received.

A specific care plan for behaviour management is essential to assist all staff to manage complicated and sometimes aggressive behaviour.

Generally, all of the documentation, forms, policies and procedures require significant development and Norfolk Court Rest Home will require a skilled person to assist with this. I would recommend that a consultant be employed to do this work as the current manager does not have the background to write policy without professional support. Registered nurses working in the facility would not have time free from the very busy daily care of the residents to do this.

e) The adequacy of incident/accident management and reporting

An issue of concern surrounding Norfolk Court Incident and Accident documentation is that forms require a follow up component which includes investigation by the registered nurse/manager to identify:

- Causative factors e.g. hazards involved
- Corrective/preventative action required and included in the care plan
- Additional policies requiring development
- Additional training needed
- The data from the monthly collating of accident and incident forms to be referred to the Quality Improvement Committee for benchmarking and follow up. This will improve procedures/systems.

f) The adequacy of the steps taken by Norfolk Court/[Mr D] to ensure:

i) its staff were adequately oriented/supervised/trained for their respective duties

I do not have the staff orientation policy but have read an Orientation Checklist which appears comprehensive. Providing time is allowed for it to be completed fully and signed off, staff could be safely orientated.

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[Ms E] states her orientation was inadequate.

[Ms Spence was subsequently supplied with a copy of the rest home's staff orientation policy, and her comments on this are contained at the end of her report.]

ii) Its staff were adequately educated on clinical matters

Existing staff have an in-service education programme with approximately 2 monthly education sessions which are relevant.

A number of caregivers have completed the Aged Care Education Core programmes which would provide them with good skills and knowledge for their roles.

Figures obtained form Ministry of Health's report show that of 20 care-giving staff, 9 hold accepted caregiving certificates, 10 are undertaking caregiving training and 1 has no qualification and is not seeking qualification (this is of concern).

iii) Its staff were following internal policies and procedures correctly.

Caregivers require the advice, supervision and role modelling from senior staff to implement policy. If the senior staff are not educated and supported to write and implement policy then there is a flow on effect for all staff members.

Some of the senior caregivers however demonstrated insight as they wrote in their reports and may also have been implementing knowledge from the Aged Care Education Programme as a significant number had completed the core courses.

Registered Nurses and in particular RN [Ms E] may well have tried to be familiar with the policies and procedures but pressure of work and inexperience may have affected her ability to implement them.

Her orientation was also inadequate, superficial and in most facilities this is when new staff have time to concentrate on reading, and learning policies and procedures.

She talks about being overwhelmed by her workload and responded to this by asking for more RN support. Some time later, a second RN was employed but only stayed 3 months and RN [Ms E] was again alone. She continued for a time then decided to hand in her resignation as she felt she could not carry out her duties.

At this time, the C.E.O. gave her a week's stress leave while they advertised for another RN. Eventually another RN was employed for 2 days per week to allow [Ms E] to catch up with paper work.

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She had no mentoring until the Temporary Manager was instituted and she acknowledges that the help she has had since then has been of great support. Had she had professional help earlier, she may well have succeeded in her role.

iv) If Norfolk House Rest Home Ltd was meeting its various obligations under the Code of Health & Disability Service Consumers' Rights and the Health & Disability Standards.

I consider that many of the 10 Consumer Rights were only partially met but the one of most concern was:

Right 4 Proper Standards

- Here [Mr A] had the right to expect to be treated with proper care and skill and to receive services that reflected his needs. In his behaviour and accident management, this was not achieved.

Health & Disability Standards 2001 (in place at the time of [Mr A's] admission)

Organisational Management

- The Governing body did not ensure that the services were well planned, co-ordinated and appropriate to the needs of [Mr A].
- It did not appear to have a well functioning quality and risk management system.
- The consumer information was not accurately recorded.
- Adverse events were not systematically recorded or always reported to family.
- The day to day service was not always managed in an effective manner which ensured the provision of appropriate and safe service to [Mr A].

Governance

The standard requires that the organisation is managed by a suitably qualified and/or experienced person with authority, accountability and responsibility for the provision of services. This can be interpreted that no professional qualification is required. I believe there can be serious implications from this.

While [Ms F] appeared to have a sincere motivation to provide good service to the residents of Norfolk Court, her lack of professional knowledge limited her ability to support and mentor the Registered Nurses on her staff.

Currently many District Health Boards outline in their agreements with Rest Homes the qualities and experience they require of their Managers. This should relate to better patient safety.

Service Delivery

- [Mr A] did not always receive timely and safe service from qualified and experienced service providers.

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- Service delivery plans did not always meet the requirement of assessment planning and intervention.
- Records did not always comply with regulatory requirements.

In many small rest homes, resources are limited for education and peer support and I suggest this is an area which needs addressing with the current owners and wider for the industry as a whole.

Regretfully, Norfolk Court Rest Home was not meeting all of its obligations under the Health & Disability Services Act, nor the Code of Health and Disability Services Consumer rights.

[Ms E]

a) The failure to assess (or document an assessment) of [Mr A] on his arrival at Norfolk Court.

I can find no documentation to indicate a physical assessment was done by the RN on admission, nor a copy of the self needs assessment which would have been provided by the Needs Assessor of [the] District Health Board.

There was also no transfer note included from the discharging hospital.

Both of these assessments/information and any other assessment information e.g. phone call from the RN of the discharging hospital are essential in order to develop an individualised nursing care plan for the new resident's comfort and safety.

The Care Plan procedure document (A3B) states that the individual care plan will contain:

- Assessment:
  - Gathering of information, resident's profile and history
  - Physical information and tests
  - Nursing diagnosis

I can find no physical/social assessment forms and the admission guidelines (A3) is a checklist but has no supporting information or referral to appropriate admission forms.

It would appear that the lack of a physical assessment form has meant that no admission assessment has been performed on new residents or [Mr A]. This in turn could mean that the accuracy of care plans could be questioned. The failure to assess residents on admission is a serious registered nurse omission.

b) The adequacy of the steps taken to identify the risk of [Mr A] falling and steps to reduce that risk.

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I understand [Mr B's] concerns about his father's falls and his feelings that restraint (bed rails) may have helped.

The fall when sitting at the dining table on the 31st December 2009 was seen by staff who had tried unsuccessfully to move [Mr A] to a safer chair — unfortunately he was too resistant to achieve this.

The other falls occurred during the night onto the floor and on 12th January 2009 on to a mattress (curiously, this is time he may have sustained the head injury).

Staff did check him regularly throughout the night but unless there is 1:1 care which is not provided at rest home level of care, it would be very difficult to anticipate when he might fall.

It is likely, although of course not known, whether bed rails would have helped or made worse the fall incidents. It is possible that the feeling of containment behind bed rails may have made [Mr A] more agitated and he could have climbed over them, falling from a greater height.

While not recorded or mentioned in Falls Policy, it is hoped that his bed was at the lowest possible height.

I also note the unsuitability of his rest home bed and consider his lack of comfort may have made him restless and susceptible to falling out. Staff did ask the family on several occasions about his bed but if it was not forthcoming they should have sought out a longer bed for him. Comfort in bed is a basic component of any human being's life.

I believe Norfolk Court Rest Home were remiss in this aspect of [Mr A's] care.

[Dr I] responded appropriately and in a timely way by stopping his medication and asking staff to monitor his blood pressure which may have been contributing to his unsteadiness and risk of falling.

While no falls risk assessment was done, the RN did modify the care plan on 7th January 2009 stating [Mr A] was a falls risk and advising that a lap belt (enabler) could be used while he was up in a chair. His family were not advised of this.

He was given 1:1 supervision during a period of severe restlessness on 31st December 2008 to 2am. This was commendable as it was New Years Eve and staffing would have been difficult. [Mr A] had a fall in the morning, had been aggressive, incontinent and trying to climb over the balcony.

I have considered on several occasions as I write this report that the placement of [Mr A] at this level of care may not have been appropriate. While being assessed and treated at [the local] Hospital, he was under the care of a highly skilled, qualified staff who, along with specialist medical care, were able to settle his behaviour. I suspect that the level of skill of all staff at Norfolk Court Rest Home

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did not match his needs, and consideration should have been given to placing him at a higher level dementia care facility.

c) The adequacy of the steps taken to manage [Mr A's] agitated behaviour during the relevant period.

Some policy and guidelines are available to advise staff about agitated behaviours. It appears that the dementia unit is primarily staffed by caregivers with the RN called to assist when necessary — this does not seem sufficient.

I can find no evidence of staff having specific education in managing agitated behaviour but progress reports indicated that on several occasions, caregivers appeared to understand the principles quite well.

There was some minor evidence that medication was considered first resort and did not always follow prescribed dosage.

A planned individualised activity programme may also have helped occupy him and given him some purpose. There was no evidence supplied to me that an activity programme was provided for [Mr A] although I note on the Norfolk Court Rest Home website, diversional therapy is mentioned as being provided.

An appropriate assessment to find triggers which caused behavioural changes may have helped. Progress reporting often indicated [Mr A] was incontinent when agitated.

Care plans focussed on the needs of people with dementia should be in place.

My comment relating to the possibility of inappropriate placement also applies here.

d) The adequacy of the clinical assessment of [Mr A] during the relevant period.

The RN has only made 2 entries in the progress notes. These only related to doctors visits.

The manager wrote a brief admission note and 2 on transfer to [the local] Hospital.

He had insufficient professional assessment on admission and during his time at Norfolk Court Rest Home. Clinical assessment was primarily done by the caregivers.

An example of caregivers' judgement on 30th December 2009 at RN direction, [Mr A] was given zopiclone to help him sleep. (It was not known at this time that he had sensitivity to it.) He was extremely restless and upsetting residents during

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the night. At 8 a.m. he finally went to sleep and when caregivers tried to wake him shortly afterwards for breakfast he became aggressive.

There was little follow up assessment following his falls except the falls of 7th January 2009.

A caregiver advised the RN about [Mr A's] sore ribs on the morning of 1st January 2009 but it was an afternoon caregiver who noted be had bruising on his right side. This should have been followed up by RN assessment.

[Mr A] did get one on one care instituted by the RN on the evening of 31st December 2008 which was appropriate considering it was New Year's Eve and further professional support may have been difficult to obtain.

Clinical assessment has been inadequate and rare. I could only find 2 entries from RNs in the Progress Notes and one note written by a caregiver on direction from the RN and these were relaying Doctors visit orders. Again there may have been RN clinical assessment and verbal direction to caregivers but this has not been documented.

The manager also wrote in the progress notes on 2 occasions when [Mr A] was transferred to hospital giving information about the transfer.

e) The appropriateness and timeliness of decisions to seek/not seek further medical advice from a doctor during the relevant period.

It appears caregivers primarily were responsible for care in the dementia unit and seeking advice as they deemed necessary.

While some appeared to make appropriate referral to the RN there were times this was not responded to.

While "The Haven" is only a small unit, the complexities of a dementia unit requires the services of a readily available Registered Nurse and the sharing of one with the rest home in day time hours and week days only, is not sufficient RN cover for this moderate sized facility. This may have influenced the timeliness of doctors referrals for [Mr A] however in looking at the number of doctors visits at the times of concern, they seem adequate.

f) The dispensing of [Mr A's] medication

Clearly only one packaging system should be used. Systems should be put in place for checking these by an RN on receipt from the pharmacy. This ensures the packed supply matches prescription.

However it is difficult to state categorically only one dispensing system should be used (although this should be the goal) as short stay residents may use other systems and the cost of repacking for a few days may not be acceptable. What is essential is that the management of the medications by the RN ensures that no

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duplication exists and medication approved caregivers administering medications, then have very low risk of error.

g) The adequacy of the management of pain during the relevant period

I could not find any notation which indicated that [Mr A] had suffered discomfort from pain apart from some expected soreness following his falls. Drs had not charted any analgesia and I could find no record of any being given.

The reference to the short term care plan for pain in the care plan is likely to be a standard statement to be used as necessary for residents requiring more in-depth pain management.

h) The adequacy of the incident reporting during the relevant period

Incidents were reported in a fairly timely manner but the forms used should record more information which allows for benchmarking and systems linked to Quality Improvement mechanisms.

Follow up was poor by the RN and no documentation indicated that the family were advised of any of the falls and of most concern, the falls when [Mr A] sustained injuries.

i) The adequacy of communication with other staff regarding [Mr A's] condition during the relevant period.

Caregivers recorded fairly accurately [Mr A's] behaviour, well being, and daily progress. There were times that they should have sought advice verbally and not relied on documented incidents being followed up by the RN. The RNs however were woefully slow or didn't act at all on some communication which caregivers tried to relay to them.

[Ms E] states she did discuss [Mr A's] care with the caregivers on a daily basis but none of this was recorded.

Documented communication from registered nurses to other staff was poor. The quality of verbal communication is not known.

j) The standard of documentation during the relevant period

The use of an RN Communication Book is unusual and certainly not a safe practice — many facilities do use a handover book which highlights special events e.g. Dr coming to see Mrs A, special dressing for Mrs B will be delivered by ... , Mr J out until approx 10 p.m.

It should not be used as a method of conveying nursing intervention which should be recorded in the Nursing care plan and reinforced in the progress notes where necessary.

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The short term care plans for pain, wounds, behaviour management etc require significant development.

Many forms are not well headed, some had no provision for the resident's name or for the staff completing them or making provision for signature, designation or date.

Some forms require an indication as to their purpose e.g. Short Term Care Plans — when they should be used and how they link to the Long Term Care Plan. They require a time frame and evaluation column and as earlier mentioned, date and signature columns.

While the Short Term Care Plan could be used for Pain Management, it is inadequate and a specific format should be devised. I note in Mr G's report, this is being done.

Follow up from Incident & Accident reporting was inadequate. There was no evidence that these reports were collated and referred to the Quality Improvement Committee or Health & Safety Committee for follow up and benchmarking.

In regard to the documentation for [Mr A] over the relevant period, my overall impression is that it was very inadequate for the following reasons:

- Poor reporting by RNs to caregiving staff in Progress Notes and Care Plans
- Poor recording of follow up to relatives
- Poor recording of behaviour management
- Inadequate falls risk assessment and follow up
- Inadequate recording of changes to nursing care
- No physical or social history
- Superficial care plan

There were also errors in medication recording and the medication signing sheets had dates but no year.

I consider that RNs should be writing daily progress notes with follow up in the following shifts by caregivers when the resident condition changes or other events require documentation.

It was pleasing to see the regular and descriptive reports by the caregivers. They often 'painted a clear picture' of [Mr A's] needs. Unfortunately, these consistent entries were not always responded to by the nurses leading their teams.

[Ms F]

a) The failure to assess (or document an assessment of) [Mr A] on his arrival at Norfolk Court.

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[Ms F] states she did the administrative paperwork with [Mrs A] which involved both office and telephone conversations with her.

She states in her letter to the Health & Disability Commissioner that she had no clinical role and would have delegated the assessment to the RN which was an appropriate response.

[Ms F's] role would be to ensure this was done by using a regular surveying system to check documentation quality and accuracy.

Later formal Health Cert audits found gaps in all documentation.

b) Whether [Ms F] took sufficient steps to assure herself that [Mr A] was receiving appropriate care during the relevant period.

[Ms F] admitted she relied on the RN for clinical judgement as she was not a nurse. In a moderate sized rest home such as Norfolk Court, there has to be significant concern when one new graduate nurse and a visiting doctor carry all of the clinical responsibility for the complex health needs of the 50 plus residents.

[Ms F] appears sincere in her account of the events that she believed she was working effectively in her role however despite her best attempts to educate herself to this responsible position, I have very serious concern that her educational background did not fit her for this management role.

While recognising she was employed under earlier legislation, the owners (CEO) should have recognised her lack of skill for the extent and challenges of her current position. Many DHB Agreements with rest homes now require that the rest home must engage a Manager who is either a General Practitioner or a Registered Nurse with a current Practising Certificate.

It is a significant responsibility of owners to ensure that their certified facility is in safe professional hands and to provide support to ensure they succeed in providing safe and considered care.

While [Ms F's] motivation may have been sincere, I do not believe she was able to make the clinical judgements necessary to ensure [Mr A] was receiving appropriate care and to delegate this to a very inexperienced RN was also hazardous.

c) Whether [Ms F] took sufficient steps to ensure discussions and action around [Mr A's] care were being documented accurately.

[Ms F] states she did discuss [Mr A's] care on numerous occasions with the Doctor and the RN but these were not documented. Her lack of nursing knowledge may have made it difficult for her to assess the quality and accuracy of the documentation.

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If the audit programme was being carried out in accordance to the accepted Standards, she may have been able to respond to the outcomes of these despite her lack of nursing knowledge.

Again the in-house surveys if carried out regularly would have assisted [Ms F] in her responsibilities around documentation — but I could find no evidence this was being done.

3) The adequacy of information provided by Norfolk Court Rest Home to [Mr A] and/or his Enduring Power of Attorney and/or his family between December 2008 and January 2009.

Generally the information provided by Norfolk Court Rest Home Limited did not meet Standards and is discussed more fully in the following comments about senior staff who had the delegated responsibility to communicate with family.

Of real concern is the statement made by a staff member (unknown) in relation to [Mrs A] telling them that [Mr A] (who was by now transferred to [the public] Hospital) was dying. "Well we can't be held responsible for that can we." This statement is defensive, insensitive and totally unacceptable.

4) The adequacy of information provided by [Ms F] to [Mr A] and/or his Enduring Power of Attorney and/or his family between December 2008 and January 2009.

Again I only have reference to documentation and there may have been more verbal communication with family.

Amongst other things, the policy on consultation with family identifies the need to provide information to families about:

- Change of treatment
- Change of medication
- Change of behaviour
- Implementation of restraint
- Formulating care plans

It should also include accidents and incidents.

There were 18 documented entries of contact with family, via a telephone or during visits between 18th December 2008 and 14th January 2009. While it is not known what was discussed, it would be fair to assume [Mr A's] care was focussed on at this time by staff.

[Ms F] states she also did the administration paperwork with [Mrs A] which involved both office and telephone conversations; this included asking about a replacement bed. She also supported [Mr A's] son when he came from [another region] to see his father. He was upset and [Ms F] took him outside and gave him

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coffee. She also spent time with [Mrs A] on the day [Mr A] was X-rayed and returned possessions for [Mrs A] back to her accommodation.

It would be fair to assume that [Ms F] conveyed some appropriate information about [Mr A's] condition at this time. What wasn't conveyed well was:

- Accidents and incidents
- Some behaviour changes
- Some changes in condition
- Medication change

All of these are very important to the family.

5) The adequacy of information provided by [Ms E] to [Mr A] and /or his Enduring Power of Attorney and/or his family between December 2008 and January 2009.

In [Ms E's] account of [Mr A's] care she describes that at all times when communicating with the family she was upfront and honest. She says she spoke on a number of occasions to [Mrs A] and other family members.

She also states she had daily discussions with the staff who worked in the dementia unit.

On 31st December 2008 following [Mr A's] fall, [Ms E] did speak to his son [Mr B] about his father's condition because she was concerned about him but she is unsure whether she mentioned the fall.

He asked her not to phone his Mother as she was expecting guests for New Year's Eve and he would tell her about her husband after the New Year.

Because she was concerned about [Mr A's] agitation, [Ms E] directed a caregiver to stay on duty to sit with him until he settled. She stayed until 2 a.m. Unfortunately [Mr A] became unsettled again after this.

A check of the Progress Notes shows [Mrs A] rang or visited most days from 1st January 2009. While it is not always reported who spoke with her, it is likely she was up to date (if not always satisfied) with his care. However, there were omissions in [Ms E's] communication with the family, primarily in reporting accidents and incidents and in reporting [Mr A's] deteriorating condition to them.

These omissions are of concern.

6) The adequacy of the changes made by Norfolk Court since these events.

Since the Temporary Manager has been in place the following has been implemented:

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- Professional mentoring for the manager and registered nurses
- Enhanced handover reporting
- Clarification of when and who should communicate with the family
- Revision of protocols and tools for the management of accidents and incidents.
- Education of all staff on managing escalating behaviours
- Safe medication management and pain management policies implemented
- Reviewing restraint minimisation and safe practice
- Up-skilling staff in dementia care
- Implementation of an auditable multi-disciplinary team review
- Development of more up to date continence management practices
- Review of the infection control programme
- Updating of Manager and RN position descriptions

All of the above address the concerns that I have identified apart from the need to consider more professional supervision of the dementia unit over weekends and some courses on communication skills could be helpful. Professional assistance for the Manager and RNs to upgrade all of the policies, procedures and auditing requirements are also needed.

All registered nurses require knowledge of clinical assessment, some may require a full course and others at least an update to ensure new residents are adequately assessed on admission and when their health needs change.

7) Are there any aspects of the care provided by Norfolk Court, [Ms E] or [Ms F] that you consider warrants additional comment.

Qualifications for Managers: In both the 2000/01 and the later additions to the Health and Disability Standards 2008 it is stated that managers for retirement facilities must be qualified/experienced. In the organisational management standard [it states] 'consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.'

My interpretation of this is that the qualification should be in nursing preferably with some advanced nursing studies and the experience should include management and administration.

Facility owners should also ensure the registered nurses they appoint have the experience and skill to perform safely and if in doubt should ensure appropriate education and support is provided for them.

Staffing levels should also reflect the needs and level of care required by the residents and no staff member should be under so much pressure of work that they cannot implement care kindly and safely.

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It appears there is no Registered nurse cover for the residents over the weekends. On checking the Norfolk Court rest home website I note that it provides 48 rest home beds and 11 beds for people with dementia.

I would consider this number of residents should not be left in the care of caregivers for weekends even if they had education and experience and had access to a nurse on call.

While there are no formalised requirements at present for rest homes of this size to have a Registered Nurse on duty at weekends, in my opinion many responsible managers would see that in order to provide a safe environment for the complex and varied needs of residents in this rest home (which includes a dementia unit) that a registered nurse over 7 days would be a necessity.

In my opinion a registered nurse should be employed on duty to cover weekends. A weekend registered nurse would continue to monitor residents' well being, ensure rosters were filled and caregivers were giving appropriate care. He/She would also maintain professional communication with families and visitors, a busy part of weekend work.

Orientation systems should be developed for all staff and audited to ensure that each staff member receives the introductory training they need.

Investigation into the workload of RNs in rest homes — many of whom alone have direct supervision and clinical care of 40+ residents.

Serious consideration should be given to standards relating to nurse ratios and qualifications of nurses in these positions. The work is challenging, diverse and extremely busy as the complex and increasing needs of older people are attempted to be met.

[Mr A's] family believe had there been closer supervision, their father may not have met such an untimely death.

I have some empathy with the plight of [Ms E] — her responsibilities far outweighed her experience and skill; like many young nurses, she is working full-time with a young family, her workload appeared to be unrealistic and she had no mentoring to assist her with her responsibilities.

Her role shared between the moderately large rest home and dementia unit was challenging. As her time was extremely limited between the two, to develop and maintain the documentation alone for 50+ residents is almost a full-time job.

In summary and in my opinion, Norfolk Court Rest Home did not meet its legislative obligations or duty of care in the following:

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- All staff require significant up-skilling in medication administration, accident and incident reporting and management, pain management, infection control, and communication.
- Registered Nurses require courses in physical assessment and time to perform it well.
- Clinical Governance — the selection and education of its manager did not enable her to perform her duties to the necessary standards and there appeared to be insufficient support and good role modelling by the owner [Mr D].
- The orientation, peer support and clinical guidance of its lead RN was also inadequate and the employment of a new graduate to this responsible position could be questioned.
- Communication with the family lacked some insight, kindness and responsiveness.
- I believe good role modelling from owners and senior staff must be implemented to assist staff in appropriate communication with families.
- Regular multi-disciplinary family meetings should be instigated.
- The use of re useable continence products should cease.
- New continence policies require formulating and the support of a continence advisor sought.
- Documentation in assessment, care planning, intervention and evaluation was inadequate and while reporting in the progress notes was done well by the caregivers, it demonstrated a serious lack of professional observation and clinical guidance by the RNs.
- Activity / diversional therapy plans should be in place for all residents.
- Carpet cleaning programmes require establishing.

While I understand the interpreting of signs and symptoms can be difficult in residents who cannot communicate well, following [Mr A's] fall when he caught his head between the bed and the wall, his condition deteriorated fairly rapidly which should have been a signal for further investigations being necessary.

I have concern also that [Mr A] was placed at Norfolk Court Rest Home dementia unit inappropriately. Towards the end of his stay in the psychiatric unit at [the public hospital], his behaviour was more socially appropriate but he was being treated and monitored by a psychiatrist and nursed by skilled RNs. To place him in a small unit, where the staffing was primarily caregivers and with minimal inexperienced RN oversight, may well have led to some of the sad scenarios he experienced.

I am very sympathetic to [Mr A's] family about the attitude to smoking at Norfolk Court Rest Home. If staff must smoke, it must be in designated areas well away from residents' rooms and shared areas and there must be policy which reminds staff about the offensiveness of smoke smell on breath and clothes. This is important because of the close contact necessary from staff moving and transferring residents and when doing personal care.

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I also understand [Ms F's] frustration at the variability of the auditing teams' assessment and reporting. To achieve an early report with few partial compliances and then this to be followed by a negative surveillance report is very difficult for a manager to cope with. There are some issues surrounding the variability of the work of auditing agencies at this rest home which may need addressing.

Overall I believe that Norfolk Court CEO [Mr D], [Ms F] and [Ms E] did not provide the standard of care [Mr A] had the right to expect under the Health & Disability Act and I believe their peers would view their conduct with severe disapproval.

Lesley Spence

3rd November 2009"

On 24 November 2009, Ms Spence provided the following further advice:

"ADVICE ABOUT ORIENTATION POLICY

I have now been provided with the Norfolk Court orientation policy and have been asked whether I wish to review or change any of my initial advice re staff orientation.

Were Norfolk Court Staff adequately orientated/trained for their respective duties?

My comments in the initial advice were based on an orientation checklist included in the documents sent to me. This checklist is comprehensive and if implemented fully and checked off as required, would ensure that staff were safe to practise clinically.

However the checklists I reviewed were not completed fully.

Norfolk Court policy on orientation for new staff was reviewed annually from 1996 to 2004 and then to be reviewed as necessary.

The policy is general and mentions a 1 hour orientation programme to be undertaken in the new staff member's own time.

During this hour staff will be familiarised with:

- The building
- Occupational Health & Safety routines
- Individual routines
- Policies and procedures

A checklist will be completed but no timeframe is given.

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A further orientation to cover caregiving and written aspects of the positions will follow after orientation of the building. No timeframe is given.

Following this the new employee will be orientated in the general care of the elderly completing 2 to 3 shifts with a relevant buddy.

There is no statement identifying the differing orientation needs of staff with or without previous education.

An appraisal is carried out after 3 months by the Manager.

Comment:

This policy appears to apply mostly to caregiving staff although there is a brief mention of cooks, cleaner & laundry person.

There is no mention of an orientation programme for Registered Nurses/Enrolled Nurses.

There is no payment for orientation until after 6 months of continuous employment and while some facilities adopt this, it is harsh and does not engender warm relationships at the beginning of a new staff member's employment.

The initial orientation contains far more information than could ever be covered or absorbed in 1 hour.

While the policy mentions familiarisation of all policies and procedures it does not identify the essential ones which need addressing early for new employees eg medication, infection control, personal hygiene, transferring & handling, food hygiene, and restraint.

A statement needs to be included about how to access information.

A timeframe for a well planned orientation could last for up to 6 weeks with the topics to be covered each week identified.

The facility's organisational philosophy and mission statement should also be discussed along with the quality improvement programme.

IN SUMMARY

There is an attempt to provide a policy to orientate new staff, however it does not:

- address all staff needs
- provide a structured process for the content to be covered or the timeframe required
- allow sufficient time to ensure safe practice

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- allow for caregivers' varying levels of education, or identify the requirement for them to achieve an approved aged care education programme within a prescribed period
- encourage warm relationships as it withholds payment for the orientation period for 6 months

I do note in the Ministry of Health audit report, significant numbers of caregivers have achieved their ACE Core Programme or were working towards it. Only 1 staff member at that time was not actively involved.

The manager [Ms F] is an ACE assessor and appears to have worked well with her staff to ensure they gained appropriate education. However the orientation policy is light in content and requires significant development. This may well have affected the performance of staff at Norfolk Court.

The Registered Nurse [Ms E] has stated her inadequate orientation affected her practice and stress levels.

While well written policies guide best practice, it is of course the implementation which counts. This is dependent on competent leadership, good role modelling, a sound education policy and sufficient staff and time to perform best practice. Significant work is required by Norfolk Court owners and managers to achieve this.

Lesley Spence

Nurse Advisor

22 November 2009"

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Appendix B — Independent (dementia) nursing advice

The following expert advice was obtained from registered nurse Jenny Baker:

> "I have been asked to provide an opinion about the standard of dementia care on case number 09/01050. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.
>
> **Professional Profile**
>
> I registered as a Registered Nurse in 1978. From 1978 to 1981 I worked as a Staff Nurse in Oncology. From 1981 until 1995 I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital.
>
> In 1995, I was Clinical Nurse Co-ordinator in an Assessment, Treatment and Rehabilitation Ward (A, T & R) before taking up the position of Unit Manager, A, T & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents.
>
> From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract. I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors.
>
> From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. From 2006 to 2007, I worked as a Care Manager in a rest home and rest home dementia, from 2007 to 2008 I worked in a generalist medical ward for a DHB public hospital and from 2008 to 2009 I worked as a Practice Manager for a very large General Practice.
>
> I currently work in an acute orthopaedic ward and trauma unit which involves caring for patients with dementia and/or delirium. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

[At this point in her advice Ms Baker sets out the questions asked of her. This information has been omitted for the purpose of brevity.]

> **Supporting information supplied to me:**
>
> <u>Information particular to this complaint</u>
>
> - Letter of complaint from [Mr B] dated 24 March 2009 (pages 1–3)

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- Information from Norfolk Court Rest Home Ltd in response to the complaint dated 3 June 2009 (pages 4–89)
- Response from Norfolk Court Rest Home Ltd to complainant dated 19 June 2009 (pages 90–94)
- Response from [Ms F] dated 14 August 2009 (pages 95–97)
- Response from [Ms E] (pages 98–101)
- Copy of [Mr A's] clinical notes from [the] DHB (pages 102–234)

Generic information relating to Norfolk Court Rest Home Ltd

- Information relating to Norfolk Court Rest Home Ltd (pages 235–446)
- Correspondence from [the] DHB (pages 447–476)
- Audit reports from the Ministry of Health (pages 451–476)

[At this point in her report Ms Baker sets out the background facts to the complaint. This information has been omitted for the purpose of brevity.]

Norfolk Court Rest Home Ltd

Norfolk Court have a Restraining of Residents Policy, Procedure for Use of Restraints, Resident information for Use of Restraints, Guidelines for Safe and Appropriate Use of Restraints, Restraint Application Form, Individual Restraint Evaluation and Consent Form for Use of Restraint available for staff to follow.

The Guidelines for the Safe and Appropriate Use of Restraints is comprehensive and sets out the following: definitions, approval process, assessment, application, chemical restraint, training, cultural recognition, risk management, dignity and privacy, consumer support and communication, monitoring of resident during restraint use, evaluation and review of restraint use and quality review of restraint use.

There is a restraint co-ordinator; an approval group consisting of the manager, registered nurse, GP and may also include the resident, their welfare guardian or family advocate.

Chemical restraint is defined and is not condoned in the rest home: *'The use of medication as a form of chemical restraint does not fit with the philosophy of our home and is therefore not considered acceptable practice'.* (Pages 0 029–0 034).

The Guidelines are appropriate and acceptable, however, I note that the Policy on Consultation/Communication Resident/Family/Whanau/Significant Others is contradictory to the chemical restraint in the Guidelines as follows: *'Consultation/Communication is to take place in any of the following circumstances:....When chemical or physical restraint is indicated'.* (P 0 027).

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The contradiction between the Consultation/Communication policy and the Guidelines for the Safe and Appropriate Use of Restraints is confusing to staff and there is potential for staff to use medication as a chemical restraint. The Restraint Minimization and Safe Practice states: *'Medication. The term chemical restraint is often used to imply that rather than using the above methods to restrain a consumer at risk of harm to their self or others, various mediations are used to ensure compliance and render the person incapable of resistance. Use of medications in this manner as a form of "chemical restraint" has been a hallmark of abuse and is not supported in this Standard'.*

The Restraining of Residents Policy is not appropriate. It confuses personal restraint and physical restraint by implying that personal restraint is a form of physical restraint: *'The following are situations where physical restraint may be appropriate. Personal restraint.....AN APPROVED PHYSICAL RESTRAINT TECHNIQUE. Personal Restraint'.* (Pages 0 037 & 0 038). The Restraint Minimization and Safe Practice Standard defines the differences in personal and physical restraints as the following: *'Restraint can be divided up into distinct categories. These are: Personal. For example service providers physically holding a consumer; Physical. For example the use of equipment and furniture'.*

The Restraining of Residents Policy describes Personal Restraint in detail including: *'4. When the signal is given the restraint team will initiate the approved restraint technique. 5. Restraint will be effected by immobilising the upper and/or lower limbs of the individual....7. Should restraint prove difficult to effect, the patient may be put to the floor in as controlled a way as circumstances allow. The restraint could be applied with the individual lying on his/her back or abdomen, but ideally the individual should be placed in the prone position with their head to one side'.* (P 0 038).

This type of personal restraint is not appropriate for any level of dementia residential care i.e. rest home or hospital level; it may be appropriate in a mental health setting. Personal restraint should only be used if the person is at serious risk of harming themselves or someone else e.g. if a resident was trying to 'jump over the balcony' or being physically aggressive to another resident and the staff could not divert the resident away from the danger using de-escalation techniques. It is usual to remove the other residents and the staff from the area in which a resident may be acting out and where there is potential for inflicting harm to other residents or staff; this reduces the need for personal restraint and allows the resident the space and time to settle. If a resident continued to present with this type of challenging behaviour, then it would be more appropriate for the rest home to have the resident urgently seen by the GP who may engage the appropriate services of the DHB's residential dementia community health professionals.

I believe that the Restraining of Residents Policy and the Policy on Consultation/Communication Resident/Family/Whanau/Significant Others requires immediate review and changes made to the policies to ensure that they meet the Restraint Minimization and Safe Practice Standard.

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Norfolk Court Rest Home Ltd's Registered Nurse and Manager Job Descriptions requires the RN to assess and plan the residents' care and the Manager to ensure this occurs, however, Norfolk Court has failed to provide a behavioural assessment and care plan for this to occur.

RN [Ms E's] experience was mainly in paediatric nursing prior to commencing employment with Norfolk Court Rest Home on 16 July 2006; this experience was inadequate for residential care, particularly dementia care.

RN [Ms E's] Staff In-service Education Record outlines the education received by RN [Ms E], but does not state the length of time for each education session. She received education on informed consent, restraint, risk management, residents rights, restraint and elder abuse, and gerontology seminar prior to [Mr A's] admission on 16/12/08. RN [Ms E] partially completed a Restraint Training Questionnaires on a resident using restraint dated 8/5/07; this was signed off by [Ms F] as the trainer. (P 00402). It is difficult to determine if RN [Ms E] had read and was familiar with the Restraining of Residents Policy, Procedure for Use of Restraints, Resident information for Use of Restraints, Guidelines for Safe and Appropriate Use of Restraints, Restraint Application Form, Individual Restraint Evaluation and Consent Form for Use of Restraint as there is no written proof supplied to demonstrate she had read them.

I believe that the support/training/education provided or offered to [Ms E] was inadequate in view of her lack of gerontological experience, particularly dementia care and the use of restraint.

[Ms F's] experience prior to commencing as manager in 2002 was: Paramedic Ambulance Officer, Office Manager at Norfolk Court and Temporary Manager when the manager was away (P 0 096). [Ms F's] education record outlines the following: Risk management, restraint and elder abuse and neglect; Leadership/team building; dementia, Alzheimer's Society; restraint; restraint, informed consent, advance directives; and challenging behaviour. [Ms F] had also completed the ACE (Aged Care Education (NZ) Ltd) Core Programme in 2001; this programme is a very good educational programme for residential care but does not cover dementia which is a separate programme.

[Ms F] had appropriate training in residential with some training in dementia, restraint and challenging behaviour. She had no experience as a manager and leader prior to this position and did not appear to receive sufficient support/training/education as a manager; however [Ms F] had been in this position for 6 years and I would have expected [Ms F] to have learnt skills during this tenure and have been proactive in obtaining any training/education she required to meet her job description. It is unclear whether [Ms F] had any performance reviews during her tenure which would have been a forum for both [Ms F] and Norfolk Court Rest Home to establish any training requirements related to managing residents and staff in the dementia unit. [Ms F] was the trainer for [Ms E] in restraint; I believe she did not have enough understanding or experience to sufficiently train [Ms E].

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It is difficult to determine the adequacy of handover/communication amongst staff members as no written documentation has been provided. I note that the HealthCERT report 6 April 2009 (page 00469) refers to a registered nurse hand over book. I do not know if there was a registered nurse hand over book at the time of this complaint. It is common for rest homes to have verbal handovers and registered nurse hand over books or staff communication books; however it would be inappropriate to put resident information in the registered nurse/staff communication book. Resident appointments are often documented in diaries which is appropriate. I believe that communication from staff about residents should be documented in the resident's progress notes when it relates to what is occurring to the resident clinically; communication was documented well by care giving staff but not by RN [Ms E] in the progress notes.

Documentation in [Mr A's] progress notes by the caregivers was appropriate and outlined his behaviour including any concerns. The level of documentation was very good for a rest home as the caregivers documented every shift. The level of documentation by RN [Ms E] is very poor and unacceptable. There were only three entries by RN [Ms E] in the progress notes during [Mr A's] stay, despite caregivers describing challenging behaviour that [Mr A] was exhibiting. She had not documented important information within the progress notes or any conversations with family she may have had apart from the three entries on 7/1/09 and 12/1/09.

I have not been provided with any records of the staff's education in dementia. I note the HealthCERT report 6 April 2009 (page 00468) describes that none of the care giving staff held a certificate in dementia care although there was one dementia unit caregiver currently undertaking dementia unit standard training. The report also describes shifts where staff are unqualified but are training and a night caregiver was not qualified and not trained. Although this report was for an audit undertaken after this complaint, I can only assume that at the time of the complaint the staffing education was similar; it is inadequate to staff a dementia unit with unqualified staff in residential care, let alone dementia care.

Norfolk Court Rest Home Ltd is obliged to meet its various obligations under the Health and Disability Standards. Part 4 Service Delivery states: *'Service Provision Requirements. The criteria required to achieve this outcome include the organization ensuring each stage of service provision (assessment, planning, provision, evaluation, review and exit) is: 4.1.1 Undertaken by suitably qualified/skilled and/or experienced service providers who are competent to perform the function. 4.1.2 Developed in partnership with the consumer/kiritaki, and/or their family/Whanau or other representatives as appropriate. 4.1.4 Documented to the level of detail required to demonstrate the needs of the consumer/kiritaki are met. Assessment. The criteria required to achieve this outcome include the organization ensuring: 4.2.2 The needs, outcomes and/or goals of consumers/kiritaki are identified via the assessment process and are documented to serve as the basis for service delivery planning. Planning. The criteria required to achieve this outcome include the organization ensuring: 4.3.2*

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

It is clear from my comments under RN [Ms E] that the above standard was not achieved and that the organization failed to ensure it met its obligations under this standard.

In conclusion, I believe that Norfolk Court Rest Home Ltd did not ensure that its systems/policies; support/training/education provided or offered to [Ms E] and [Ms F]; staff handover/communication; staff education on clinical matters; staff followed internal policies and procedures correctly; and that they met their various obligations under the Health and Disability Standards. I believe that the providers' peers would view the conduct with moderate disapproval.

[Ms F]

[Ms F's] Job Description states: *'Key Task 3: Clinical and Non Clinical. To ensure that all services (including Care and Support) are provided safely...and where appropriately, therapeutically. These are also performed as set out in the facility's Manuals and Guidelines which aim at providing client focused and appropriate support and care. ...Ensures the assessment and planning of care is carried out consistent with the facility's policies. Ensures clinical documentation is maintained in line with the facility's policies. Ensures all services are monitored against our standards of care'.* (pages 00416 & 00417).

[Ms F's] letter in response to the complaint dated 14 August 2009 states: *'In practice, the registered nurse met with me at least daily to advise me of any concerns regarding clinical issues. I did not interfere with clinical matters, respecting her autonomy as a health professional. I heavily relied upon the registered nurse to work with the contracted medical service...to ensure the health needs of residents were met in a timely and competent manner....On no occasion did the registered nurse or general practitioner indicate to me any concern in the management of [Mr A].* (pages 0095 & 0096).

[Ms F] has a background of a Paramedic Ambulance Officer and Officer Manager. She has also completed the ACE Core Programme in Aged Care Education (2001). (P 0096).

[Ms F] did not appear to have any knowledge of [Mr A's] assessment or the appropriateness of the clinical care being delivered to him, nor whether accurate documentation of discussions and action around his care occurred.

In my experience, the manager of a rest home, although not an RN, is involved with the resident, RN and the care staff on a daily basis. I would expect the Manager to tour the facility daily to check out what was happening, chat to residents and/or family present and to discuss with the RN any concerns for residents. I note that [Ms F] stated she met with RN [Ms E] on a daily basis but find it surprising that she was unaware of any concerns regarding [Mr A]. If that

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is the case, then there is a serious deficit in communication with the RN. The RN is responsible for the clinical care delivered to the resident, but [Ms F] is ultimately responsible to ensure that the clinical care is delivered appropriately under her Job Description.

[Ms F's] interaction with [Mr A's] family appears to be restricted to the admission administration paperwork on admission and when the son visited from [out of town]. I believe that [Ms F] did not provide [Mr A], his Enduring Power of Attorney and/or his family any information between December 2008 and January 2009.

In conclusion, I believe that [Ms F] did not ensure [Mr A] was adequately assessed on admission, she did not take sufficient steps to assure herself that he received appropriate care nor did she take sufficient steps to ensure discussions and actions around [Mr A's] care were documented accurately. [Ms F] did not ensure that [Mr A], his Enduring Power of Attorney and/or his family were provided with information. I believe that the provider's peers would view this conduct with mild disapproval.

[Ms E]

[Mr A] was admitted to Norfolk Court Rest Home on 16/12/08 with a history of aggressive behaviour towards his family, including hitting out at his wife, when they attempted to prevent him from wandering. His history also including difficulty in getting [Mr A] to shower and then obsessively showering several times a day: *'[Mr A] leaves the house on numerous occasions both day and night. When either herself or her son (who is currently living with them) attempts to stop him, he becomes physically assaultative — hitting out at her often....he would not shower for 5 or 6 weeks as he was worried about running out of water....he now showers several times during the day and most of the night to a point where it has become an obsession'.* (P 0198). [Mr A] also had a history of falls: *'Last Friday he went out in the car to pick his son up at the bus station, but fell over and was brought back by the Police with a black eye'.* (P 0198).

A Resident Care Plan was completed by RN [Ms E] on 16/12/08. The care plan covers ADLs (Activities of daily living), wandering (under mobilisation) and falls (under Maintaining a safe environment). The plan states 'no' for the falls risk P 0 046. The plan does not cover behaviour, including strategies for staff to use when [Mr A] exhibits agitated or challenging behaviour. The plan does not document strategies for staff to use to manage [Mr A's] nocturnal wandering or encourage [Mr A] to settle in bed.

There is no behavioural assessment of [Mr A], which would be the basis of a behavioural care plan. There are four 24 hour behaviour charts dated: 16.12.08, 31.12.08, 1.1.09 and 4.1.09. There is a copy of [the public hospital's] Psychiatrist Initial Assessment and progress notes about [Mr A] and the medication chart (ward 6) within the information supplied from Norfolk Court Rest Home (pages 0082–0088).

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The restraint section of the care plan states: *'Restraint Review: [Mr A] is in our secure unit and special care is needed to ensue [Mr A] does not climb over the fence. As he has attempted this since his arrival but seems to have refrained from doing so again'.* There are no strategies documented for the caregivers to use if [Mr A] attempted to climb the fence. There is no goal documented.

The care plan states: *'Medication Side Effects: NKDA* (this means none known). *Medications:....zopiclone 7.5mg At night for insomnia PRN'.* (P 0 048). The care plan was approved by RN [Ms E] and dated 16/12/08. There is a space for the Patient Family to sign the care plan; the family has not signed the care plan. (P 0 048). [Mrs A] did not accompany [Mr A] to Norfolk Court Rest Home on the day of his admission; she came two days later on Thursday 18/12/08: *'16-12-08 [Mr A] arrived at approx 12-30 pm. from [the public hospital]....Wife [Mrs A] coming on Thursday from […].* (P 0049).

There is no documentation in the progress notes by RN [Ms E] on the day of [Mr A's] admission or two days later when [Mrs A] visited; in fact the first documentation by RN [Ms E] in [Mr A's] progress notes is recorded on 7/1/09. There is no evidence that RN [Ms E] spoke with [Mrs A] in order to obtain information relating to [Mr A's] dementia, behaviour and any concerns [Mrs A] had about him. There is no evidence that RN [Ms E] discussed the care plan with [Mrs A] to establish if she was in agreement with it, had any concerns about the care plan and had offered suggestions for the care plan to ensure it met [Mr A's] behavioural needs.

On 30th December 2008, [Mr A] was given a trial of zopiclone to see if he would settle. *'30.12.08 Pm...Add. Trial. [Mr A] on Zopiciove PRN for tonight to see if he has a good night sleep'.* (P 0 051). He had one hours sleep over night then fell asleep at the beginning of the morning shift on 31st December. The staff attempted to wake [Mr A] for breakfast when he became aggressive. He fell asleep at the table and fell off the chair. [Mr A] was given one tablet quetiapine at the request of [an RN] at 1010 (P 0 052). At 1130, [Mr A] was found climbing up the balcony wanting to jump off. (pages 0051 & 0052). The Medication Instruction Sheet Non-Regular Drug Orders states: *'quetiapine 25mg, ½–1 6 hrly for Prn agitation'* (page 078).

RN [Ms E] states in her response to the complaint: *'On the day shift of the 31-12-2009.....The rest home doctor was called and he said to increase [Mr A's] Seroquel dose from 12.5mg at night and if still agitated the next day to give him an extra 12.5mg at midday on the 1-1-2009. Due to [Mr A's] level of agitation and aggression throughout the day an extra staff member was brought in to sit with [Mr A's] on a one on one basis'.* (P 0098 & 0099).

The Telephone Drug Order dated 31.12.08 states: *'Residents Name: [Mr A]. Date 31.12.08. Time 1700. Seroquel increase 25mg night time only. Still agitated in morning give half @ midday. Signed [Ms E]'.* RN [Ms E] has documented the Telephone Drug Order at 1700; this is several hours later following [Mr A] climbing the balcony and wanting to jump off. There is no evidence that the rest

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home doctor was informed of the PRN dose of quetiapine given at 1010 on 31/12/08 and [Mr A's] climbing up the balcony and wanting to jump off. There is no documentation in the progress notes from RN [Ms E] about the telephone discussion with the rest home doctor, the increase in the night time dose of quetiapine or the PRN quetiapine to be given on 1/1/09 if [Mr A] remained agitated in the morning. There is no documentation in the progress notes to substantiate that [Mr A] had a one on one staff member with him. There is no documentation in the notes that the family were contacted and informed of the fall and that [Mr A] had climbed the balcony wanting to jump off.

[Mr A] appeared to react to the Zopiclone by becoming more unsettled instead of going to sleep. Just after he eventually fell asleep he was woken and reacted aggressively; he would have been extremely tired at this stage and it would have been more appropriate to leave him to sleep and give him breakfast later. He clearly fell off his chair because the tiredness had caused him to fall asleep. [Mr A] had finally settled in an armchair after his fall and was then given PRN quetiapine; there is no mention whether [Mr A] was still agitated, awake and settled or asleep when the PRN quetiapine was given at 1010. This additional quetiapine would have the potential for [Mr A] to become more tired and unsteady increasing the risk of falling, however, [Mr A] climbed up the balcony and wanted to jump off one hour and 10 minutes later.

[Mr A] was noted to be very unsteady on his feet on 3rd January 2009 (page 053) and again on 6th January (page 054). [Mr A] was found on the floor during the night on 6th January and was seen by Dr I on 7th January (page 054) re the falls and sleepiness; this was put down to ? secondary to quetiapine. The progress notes state: *'Seen by [Dr I] this morning — re falls and sleepyness ? secondary to quetiapine — to stop all meds and restart Friday am. Check BP 2 hrly please — through out the rest of the day and 4 hrly tomorrow please — please document accurately any changes in behaviour [Ms E] RN'* (P 0054).

The progress notes for the morning shift on 7th January states: *'2 x falls today. Very sore has not eaten today.....[caregiver] (cg)'* (P 0 054). The Accident/Incident Report dated 7/01/09 describes two falls; 0940am and about 11.45am (P 0060).

[Mr A's] physical ability appeared to continue deteriorating as evidenced in the progress notes: *'7.01.09 Nocte. Very unsteady on his feet two people to change etc; 8.1.09 am. Will not Weight Bear; 8.1.09 pm. Very unsteady on feet needs two people to do his cares. Still trying to get fluids into him; 9.1.09 am. [Mr A] vomited once this morning; 7.1.09 pm Got [Mr A] into a wheel chair and his wife took [Mr A] outside; 10.1.09 Nocte. Diarrhoea accident & changed; 11.1.09 am. Took 4 caregivers for safety to get [Mr A] into the shower. But did quite well with taking his weight on his feet....Wife will ring R/N tomorrow. She has a few concerns; 11.1.09 pm. Still will not weight bear'*.

There is no evidence of any assessment or reassessment from the Registered Nurse or a request for further medical assessment between 31/12/08 and 7/1/09.

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Following a phone conversation with [Mrs A], RN [Ms E] contacted the Nurse at the Medical Centre requesting a doctor's visit; this was at [Mrs A's] request: *'11.1.09 am Wife will ring R/N tomorrow. She has a few concerns....12.1.09 Nursing: Spoke to [Mrs A] (wife) re requesting Drs visit — She is concerned @ how long he has been drowsy for as am I — has been 1 week today that he has been drowsy ? is there something going on more than the increase of quetiapine.'* (P 0056). The Doctor did not appear to visit [Mr A] as the progress notes (P 0056) states: describe a phone call with instructions: *'12.1.09 Nursing. Spoke to [Mrs A] (wife) re requesting Drs visit request.... and I have spoken to Nurse @ med centre re our concerns if after hours can staff please call [Mrs A] and let her know Dr has been. Cont 1125hrs. [Dr K] phoned — She has spoken to [Mrs A] and […] to continue withholding meds — only to give Lorazapine ½ for agitation PRN. Bloods taken @ 1125hrs...[Ms E] (RN)'*.

The complaint letter from the family page 0902 states: *'A day or so later, my brother visited the rest home to find our father unconscious, incontinent and strapped into a lazyboy chair'.* The Resident Care Plan (page 0 046) Maintaining a safe environment was evaluated on 7/1/09: *'As [Mr A] is drowsy @ the moment he is a falls risk and an enabler can be used when seated in the lounge chair.'*

The Restraint Minimization and Safe Practice standard's definition of restraint states: '*Restraint is the implementation of any forcible control by a service provider that: (a) Limits the actions of a consumer in circumstances in which the consumer is at risk of injury and/or injuring another person; (b) Intentionally removes a consumer's normal right to freedom. Restraint can be divided up into distinct categories. These are: (b) Physical. For example the use of equipment and furniture; (d) Enablers. For example, the voluntary use of equipment by a consumer to assist them in maintain independence i.e. lap safety belts used by independently mobile wheelchair users to minimize the risk of them falling.'*.

[Mr A] was a falls risk. He had significant dementia and had been wandering unsafely, falling. It appears that the 'enabler' was used to ensure that he did not fall from the chair or get out and wander; this is physical restraint, not voluntarily use of an enabler. There is no evidence of any assessment or documentation by RN [Ms E] of [Mr A] being assessed for restraint. There is no evidence of any restraint monitoring. There is no evidence of RN [Ms E] contacting the family and discussing the concerns about [Mr A] falling and the use of the restraint.

Conclusion

RN [Ms E] did not adequately assess [Mr A] on his admission. Although the caregivers completed the 'on arrival' 24 Behaviour Chart dated 16.12.08 which RN [Ms E] could have used as part of her initial assessment, RN [Ms E] should have completed a specific behavioural assessment and documented this. She also apparently had access to the information from [the public hospital] (pages 0082–0088) to assist the assessment.

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RN [Ms E] did not reassess [Mr A] as his behaviour became more challenging, including the episode when he climbed the balcony and wanted to jump. RN [Ms E's] Job Description states: *'Performance Criteria: Ongoing assessments are undertaken and documented appropriately and accurately in a timely manner. Performance Indicator: Undertakes/delegates initial assessments on day of admission.'* Although the Job Description requires initial and ongoing assessments, Norfolk Court did not provide a behavioural assessment form or care plan for RN [Ms E] to use.

RN [Ms E] completed a care plan on the day of admission as required under her Job Description; however, there was no behavioural care plan. The restraint care plan describes [Mr A] had attempted to climb over the fence but there are no strategies or goals documented.

The enabler used to prevent [Mr A] falling was documented in the Maintaining a Safe Environment section of the care plan. RN [Ms E] clearly does not understand that an enabler is a form of restraint and should be documented in the restraint section and does not appear to understand the restraint definitions as she had used physical restraint on [Mr A] with no assessment of the type to use, risks involved, approval from the approval group and written consent from family documented on the restraint form. RN [Ms E] had the following documentation available to her: Restraining of Residents Policy, Guidelines for the Safe and Appropriate Use of Restraints, Procedure for Use of Restraints, Restraint Application Form, Individual Restraint Evaluation, Consent Form for Use of Restraint and Restraint Monitoring (pages 0029–0042) which clearly outline the steps RN [Ms E] was required to follow when considering physical restraint or an enabler; she clearly did not follow the documentation.

The care plan was not signed off by the family and it appears that RN [Ms E] did not consult with the family regarding the care plan. The medication chart from Ward 6 had Zopiclone 7.5–15mg nocte for insomnia charted (P 0088). Had [Mrs A] been asked to review the care plan and make suggestions, [Mrs A] would probably have noticed the Zoplicone and commented about [Mr A's] reaction to it. This may have prevented [Mr A] from being commenced on a trial of Zoplicone on 30/12/08.

I believe that RN [Ms E] did not seek medical advice appropriately during this time. It does not appear that she gave the appropriate information to the doctor e.g. the climbing the balcony and wanting to jump episode, which I view as a serious incident and concern for [Mr A's] safety.

RN [Ms E's] communication with the staff appeared to be verbal as she has not documented instructions herself in the progress notes; this is not adequate as she should document any instructions to the staff within the progress notes and on the care plan as [Mr A's] condition changed, with any changes in management, including medication. RN [Ms E's] standard of documentation is very poor.

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Information provided by RN [Ms E] to [Mr A], his family and Enduring Power of Attorney appears to be inadequate. There are only three entries in the progress notes made by RN [Ms E]: 7/1/09, 12/1/09 (pages 0054 & 0056). The 12/1/09 entries related to phone calls received from [Mrs A] and [Dr K]. There is no other evidence of any information provided to the family and Enduring Power of Attorney. The Policy on Consultation/Communication Resident/Family/Whanau/Significant Others (p 027) states: '*Consultation/communication is to take place in any of the following circumstances; On admission, ... When chemical or physical restraint is indicated, Presentation of significant behavioural problems, Failure to settle into Norfolk Court/Norfolk Haven, To formulate an individual Care Plan.'*

In conclusion, I believe that the standard of care RN [Ms E] gave [Mr A] does not meet the standards required under the Health Practitioners Competence Assurance Act 2003 and the Nursing Council of New Zealand Code of Conduct for Nurses and Midwives January 1995. Although I have taken into consideration of the absence of a behavioural assessment and care plan, I believe the provider's peers would view the conduct with moderate disapproval.

Report compiled by:
Jenny Baker
RN (RGON) Lead Auditor
15 October 2009"

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Appendix C

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.*

…

(4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

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