Clinical Manager, Ms I

An Aged Care Facility

An Aged Care Facility Company

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC17647)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

This complaint relates to the care provided by an aged care facility to a 90-year-old man. On 18 September 2007 he was admitted for urgent respite hospital-level care for two weeks. On 21 September, he pulled out his urinary drainage catheter, and on 25 September he fell when left unattended in the shower. On 26 September, Mr D's family insisted that he have an X-ray because he had a sore throat and his partial dental plate was missing. The following day an X-ray showed that Mr D had swallowed his dental plate. He was transferred to a public hospital where the plate was removed under a general anaesthetic.

Complaint and investigation

On 3 October 2007, the Health and Disability Commissioner (HDC) received a complaint from Mr E about the service provided to his father, Mr D, by an aged care facility. The following issues were identified for investigation:

Clinical Manager, Ms I

- *The appropriateness of the care provided to Mr D by Ms I at the aged care facility hospital unit between 21 and 27 September 2007.*

The Aged Care Facility Hospital Unit

- *The appropriateness of the care provided to Mr D by the aged care facility hospital unit between 21 and 27 September 2007.*

The investigation was commenced on 16 October 2007. The parties involved were:

Mr D	Consumer
Mr E	Complainant/ Mr D's son
Mr F	Mr D's son
Dr G	Mr D's General practitioner
Dr H	General practitioner
Ms I	Clinical manager
Ms J	Registered nurse
Ms K	Registered nurse
Mr L	Registered nurse
Ms M	Registered nurse
Ms Q	Enrolled nurse
Ms N	Care assistant
Ms O	Care assistant
Ms P	Care assistant
Ms S	Operations manager, the Company
Mr R	The Facility manager

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Independent expert advice was obtained from Ms Lesley Spence, a registered nurse specialising in aged care. Ms Spence's advice is **attached** as Appendix 1.

Information gathered during investigation

The aged care facility

The aged care facility (the Facility) includes a care centre incorporating 42 hospital level and 42 rest home level beds, in a purpose-built facility. It is part of an aged care facility company (the Company).[1]

The Facility employs a number of registered nurses, including the Clinical Manager and Deputy Clinical Manager and approximately 50 care assistants. The hospital provides 24-hour registered nursing care.

Ms I

Ms I graduated as a registered nurse in 1976. She has been involved in the care of the elderly since 1988. In 2006 Ms I took up a position as the Care Manager of a 50-bed aged care facility before taking up the position of the Facility's Clinical Manager in June 2007.

The job description of Clinical Manager states that the primary objective of that role is "to co-ordinate the efficient day-to-day running of the Hospital/Rest home, to ensure excellent quality care is provided to all residents and clients, in liaison with the [Facility] Manager". The key responsibilities include:

1.1 Organise the delivery of nursing care, which is directed according to Nursing Process ensuring all care is assessed, planned, implemented and evaluated to meet the needs of individual residents.

1.2 Co-ordinate the work of Registered Nurses and Care Assistants to ensure the accurate documentation of each resident's needs and levels of care by the use of Nursing Care Plans (adherence to "Nursing Care Plan" Protocol) and the precise documentation of all other nursing records, incident reports and medication records. This includes on-going assessment of each resident's care needs/goals, and the implementation and review of the resident's written care plan at regular and appropriate intervals; resident assessment on admission, when the resident's health status or level of dependency changes and at least at 6 monthly intervals. Development and review of the resident's care plan is undertaken in consultation with the resident and family/whanau.

1.3 Provide support, guidance, assistance and direction for all Registered Nurses and Care Assistants to implement care instructions as detailed in

[1] References to the Company in this report include the Facility.

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the resident's nursing care plan, and ensure they deliver safe, effective, high quality care.

1.4 Act as an advocate for each resident and ensure each resident is aware of their rights regarding treatment offered and care and services supplied.

…

1.6 Liaise with residents' families, ensuring continuous contact and sharing of appropriate information.

…

1.14 To promote a safe environment for all residents, relatives, clients and staff and actively promote an organisational culture of pride, enthusiasm, quality and self development of employees.

Background

Mr D has a history of chronic renal impairment secondary to obstructive uropathy[2] and a bladder tumour that was excised in 2006. As a result of this surgery he has a permanent indwelling urinary catheter. At the time of these events, Mr D had been suffering progressive memory impairment and physical deterioration for about two years. This impairment and deterioration had become more obvious since about May 2007 with weight loss, reduced energy and muscular strength, and slowly progressive iron deficiency anaemia. His tendency to fall was also increasing. Mr D lived at home with his wife, who is also elderly. Mrs D's family and a part-time caregiver assisted with her husband's care, but Mrs D was becoming stressed by the increasing level of care he required.

During the weekend of 9 and 10 September 2007, Mr D had been having hallucinations which appeared to be linked to a gastrointestinal upset a few days earlier. When his GP, Dr G, called to assess him, Mr D was recovering from two fractured ribs as a result of a recent fall at home.

Admission procedure

On Friday 14 September Dr G was asked to assess Mr D urgently for short-term residential care. Dr G faxed a referral to the District Health Board requesting a Needs Level Assessment of Mr D with a view to arranging a period of respite care. Dr G noted that Mr D "has been well cared for to date by his wife who continues to do an outstanding job".

On 17 September the Facility's Clinical Manager, registered nurse Ms I, recorded on a "Potential Resident Enquiries" form that she had received an enquiry from a District Health Board Respite Care Programme co-ordinator. Ms I noted that Mr D's wife was exhausted and the family wanted Mr D to be admitted "after lunch tomorrow" for two weeks of respite care in either the rest home or hospital. Mr D was described as

[2] Blockage in flow of urine.

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having a "slight cognitive problem", needing assistance with transferring, and as having a urinary catheter.

On Tuesday 18 September the Respite Care Programme co-ordinator faxed a letter to Ms I advising that he had visited Mrs D that morning and she had agreed to complete a care plan, to provide current information about Mr D's care, for the Facility records. He included in the letter some advice about respite care admission/discharge procedures. He attached a copy of the letter he sent to Dr G, dated 17 September, to confirm that respite care had been arranged for Mr D, and a copy of the care plan completed and signed by Mrs D on 18 September.

On 18 September Mr D was admitted by registered nurse Ms J to hospital level care at the Facility. Mrs D advised Ms J about her husband's medication and daily care routines. This information, and Ms J's observations of Mr D, formed the basis of his initial nursing care plan. Ms J did not record this in the notes.

Ms J recalls that Mr D's son, Mr E, explained to her that his father required supplementary drinks. Ms J does not recall any specific conversation about Mr D's dentures. Mr D had a partial plate with several teeth.

Registered nurse Ms K completed a "Nursing Care Assessment" dated 18 September. She noted that Mr D needed either a walking stick or walking frame, and one person to assist him to mobilise. He also needed assistance to shower and dress. Under the section for continence products, she noted "Pad" and there is no mention of the catheter. Ms K ticked a box in the section related to oral care on the assessment form, indicating that Mr D had lower dentures. Beside the box she wrote the word "plate". She also noted that because of his relatively high risk of falling, cot sides should be in place when he was in bed.

A "Resident Clinical Notes (Front Page)" was completed with Mrs D and Mr F recorded as being the next of kin and family members to contact.

Mr D's records also contain a partially completed "Admission Day — Initial Progress Notes" which is dated 16 September 2007. This is the front page of the nursing progress notes. Overleaf, the heading section of the progress notes, where the patient label is fixed, also appears to have been dated 16 September, but this has been amended to "18". The first nursing entry in the nursing progress notes is dated 16 September 2007. This is a brief entry made by Ms J, which states: "Admitted from home, meds ✓ GP Nurse will send us medication list. Settled. Bell explained."

It is accepted by the parties that references to 16 September should read 18 September.

A nursing note by the afternoon shift senior care assistant dated 18 September, records that Mr D was confused and walking around looking for his wife. He was reassured, given a wash, and settled.

19 September

On 19 September, the care assistant noted that at 7.20pm Mr D was found wandering. He had been incontinent of faeces. She returned him to his room and washed and settled him.

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A Coombes assessment tool for risk of falls was completed on 19 September and it was found that he was a medium risk. A Waterlow assessment tool to gauge Mr D's skin integrity and risk of developing pressure sores was also completed. Mr D was found to be at high risk for these because he was below average weight for height, his appetite was poor and his skin was dry and tissue thin.

20 September
At 10.30pm, registered nurse Ms K recorded that Mr D was found wandering in the corridor looking for a toilet. Ms K noted, "Apparently has ?climbed over his cotsides as cotsides were up on his bed. Assisted to toilet. Cotsides to be left down."

The next entry, untimed, by registered nurse team leader Ms M, records that Mr E consented to cot sides for his father, "because he thinks it will help [Mr D] get a good night's sleep". This note also stated, "Unfortunately he still managed to get up and under with the cotsides up. Did not hurt himself but have decided for safety not to have cotsides up."

On 20 September, registered nurse Mr L completed an initial and respite nursing care plan for Mr D, noting that staff were to be aware that he was confused and wandering, and to direct him if needed. Mr L recorded that Mr D required only a walking stick to aid him to mobilise, and that he had an indwelling urinary drainage catheter, but "wears pads at all times". Mr L ticked the box "Dentures/Plate" in the section of the plan regarding oral care, to record that Mr D had lower dentures, but did not describe whether this was a partial or full plate. Mr L noted in the "Sleeping" section of the plan that Mr D "sleeps well". The plan had a section "Safety (risk) Restraint". Mr L noted in this section that Mr D had a tendency to wander and that staff were to "be aware and direct if needed". There was no mention that cot sides were being considered for his safety.

21 September — catheter
When the morning shift care assistant, Ms N, entered Mr D's room to get him up, she found him sitting in his bedroom chair. He had blood on his legs and his pyjamas, which appeared to be coming from his penis. Ms N examined Mr D and found that he had pulled out his catheter. She reported the incident to the duty enrolled nurse, Ms Q, who checked that he had no other injuries.

Ms Q instructed Ms N to shower Mr D and apply an incontinence pad. Mr F was advised of the situation and told that his father was comfortable and might pass urine without the catheter. Ms Q advised Mr F that, in this situation, she would normally notify the doctor, but she felt that Mr D was at no risk at that time. It was decided to wait and monitor Mr D until midday before calling the doctor.

Mr E visited his father at about 1.30pm. When he arrived in the ward, he was advised by one of the nursing staff that his father had pulled out his catheter. Mr E recalls that his brother had advised the staff to contact Dr G, and this had not been done. Mr E advised registered nurse Ms M that when the catheter had been inserted after prostate surgery, the family had been told by his father's surgeon that it should not be out for more than two hours because any longer would cause severe problems. The Facility subsequently advised that at no time during his conversation with staff did Mr F

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indicate that Mr D's catheter required urgent replacement or that he needed to contact Dr G.

Ms M recalls that she offered to call the Facility doctor to ask him to reinsert the catheter. Mr E told her that the district nurse generally re-catheterised his father. Ms M left him to arrange this, believing that he was happy to do so.

At 2.30pm Ms Q noted that there was minimal blood on Mr D's incontinence pad and that although he had not passed urine, when she palpated his bladder it was empty. When the district nurse called later that afternoon, she re-catheterised Mr D, draining 300mls of urine. Ms M instructed the staff on subsequent shifts to check that the catheter was draining adequately and to ensure there was no further bleeding.

The Facility advised that appropriate monitoring was undertaken at the time of dislodgement of the catheter. They stated that two nursing entries noted that Mr D's bladder was palpated, and his pad checked. It is also recorded that staff checked him two hourly during the morning shift.

Mr E stated:

> "When I arrived it was apparent that no arrangements had been made with our family GP and as there were no doctors on the ward, or nursing staff able to re-insert a catheter I was left with no option but to attend to the necessary arrangements myself. I finally managed to arrange for a district nurse … to attend and the catheter was finally replaced at approximately 4pm."

Mr E was concerned that the catheter had been out for at least seven hours. He stated that the Facility staff made no effort to attend to this matter urgently and did not call a doctor to attend to his father. The Facility advised that Mr E did not complain at this time about the management of his father's catheter, and staff were completely unaware of his dissatisfaction.

22/23 September

The only record confirming that Ms M's instruction to monitor Mr D's catheter was followed, was a brief note by Ms J, dated 22 September but not timed, noting that the catheter was draining well. There is no record of any other problems associated with Mr D's catheter. There is no record of his fluid intake or output. At 10.30pm on 23 September Ms K noted, "BO X1 (lge, loose) [?given] a shower."

25 September — Fall

On the morning of 25 September, one of the workmen at the Facility saw Mr D fall on the floor of his en suite bathroom and alerted the nursing staff. The care assistant responsible for Mr D that morning, Ms P, rang the emergency bell for assistance, and the duty registered nurse, Ms J, arrived and checked Mr D. His blood pressure, pulse and respiration rate were normal. Ms J could not detect any injury, and Mr D denied having any pain. However, Ms J decided to call the Facility medical practitioner, Dr H, to check Mr D. Ms J instructed staff to continue to monitor Mr D for pain.

Ms P filled in an Incident Report form but did not record the time of the fall. She noted that a workman had witnessed Mr D fall "between the bathroom and the

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bedroom" and called for help. Ms J, as registered nurse, also completed the incident form, noting the actions she had taken. Ms P and Ms J did not record that this fall occurred when Mr D was left unsupervised in the bathroom. The Facility subsequently stated that Ms P was "very remorseful" and apologised immediately for leaving Mr D unattended.

At about 9am, Mr E visited and was advised of his father's fall. Mr E stated that he arrived while a nurse was dressing his father after his shower. He asked his father how he was feeling, to which his father replied, "Not too good."

Mr E stated:

> "The nurse explained she had been called to the room next door while [Dad] was in the bathroom. While she was there, leaving Dad unsupervised, he had a fall onto the bathroom tiles.
>
> On further discussion with Dad he appeared to be uninjured, however, his denture (a small lower jaw partial plate with several teeth) was missing and he was complaining about a very sore throat."

He added:

> "I then went to the nurses' station to find out what had happened to the plate as it was nowhere to be found. Apart from reaffirming that Dad should not be left unattended while in the bathroom, or out of his chair, I explained that I was concerned about Dad's throat and requested that a doctor be called to examine it and if possible an X-ray be taken to rule out the swallowing of his denture. He was having difficulty swallowing and in addition I also instructed them to give him Paracetamol Liquid 1g every 4 hours for the pain. I am a qualified Pharmacist by profession."

The staff do not recall this discussion with Mr E.

Later that morning, Dr H assessed Mr D. Dr H recorded, "Had unattended fall after shower this am." He stated, "I was asked to see [Mr D] for two separate reasons: because he had had a fall that morning, and because he had been complaining of a sore throat from a period of time before the fall." Dr H recorded that Mr D was alert and his vital recordings (blood pressure and pulse) were normal. He also noted, "Moving/throat OK. No evidence of head trauma." Dr H was not informed about the missing partial plate.

The Facility stated that Dr H was not alerted to the fact that Mr D might have swallowed his teeth because this had not been considered, and the registered nurse cannot recall Mr E raising the possibility with her that morning.

That afternoon, Mrs D visited her husband. She noticed that her husband's partial plate was missing and asked the staff if they could look for it. The registered nurse team leader, Ms M, recorded that the search of Mr D's room did not locate the denture plate. She noted, "[Mr D] can't remember where he left them. Otherwise no complaints voiced. Nil complaints of pain voiced by [Mr D]."

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26 September — injury to forehead
On the morning of 26 September, two registered nurses were working together on the medication round and found that Mr D had a "minor scratch" on his forehead, which had bled. Mr D reported that he had scratched himself. The wound was washed and left to dry. Ms J completed an Incident Report form, noting the time of this incident as 8am.

When Mrs D visited that afternoon, at about 2pm, she found her husband sitting in his chair in his room with dried blood caked on his scalp from a scalp laceration. He appeared weak, drowsy and dishevelled. Mrs D went to the nurses' station, upset and crying, to ask what had happened to her husband.

Ms Q accompanied Mrs D back to her husband's room. She noted that Mr D had a "graze and noticed that the skin was hanging". Ms Q later recorded on an Incident Report form that at 2pm a "crying" Mrs D reported to her that she was concerned that her husband was "poorly". Ms Q recorded that she cleaned the graze with normal saline, Steri-stripped it and dressed it with dry gauze, but did not specify where the graze was located. She noted on the Incident Report form that she had observed this graze earlier when she was returning from lunch at 12.30pm and saw Mr D standing outside the dining room on his walker. She had wheeled him back to his room, but had forgotten to go back to attend to the graze.

The Facility stated, "Regretfully the registered nurse did not return at this time and we apologise for this."

Care assistant Ms O was rostered on from 7am until 2pm. Ms O recorded in the progress notes that Mr D said he had fallen twice during the day, and Mrs D was concerned that he was not feeling well, "can't stand up or walk by himself" and "complaining about his dentures". She noted that Mr D had eaten a little breakfast and lunch and had been shaved.

The Facility concluded that Mr D was confused about when he had fallen. He was unable to get up off the floor independently and no staff had reported that they had assisted him after a fall. There was no documentation about any other falls, although staff were aware of, and familiar with, the policy regarding the documentation of falls, and were generally prompt in reporting such incidents.

Mrs D telephoned her son, Mr E, to tell him that she was concerned about the level of care his father was receiving and his general physical condition. Mr E recalls that his mother said that the wound on his father's forehead was a deep laceration with bruising. She was also concerned that he was having difficulty swallowing food and fluids.

Phone call to Ms I
Mr E telephoned the Facility and asked to speak to the manager. He initially spoke with Ms M, who contacted Ms I between 8.15 and 8.30pm. Ms I returned his call immediately, explaining that she was telephoning from her home as she was on leave. She recalls "categorically" that she was "very apologetic and very conciliatory" and that Mr E was very angry and talking rapidly, and Ms I was unable to interrupt easily.

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Ms I has explained that she had just taken leave after working continuously for a lengthy period. This was the first time Mr E had spoken to Ms I, and he was under the impression that she had been on leave for a week. He outlined his concerns about his father's care: the lack of care and supervision, his falls, missing dentures and sore throat, injuries and general condition. It was agreed that Mr D would be closely supervised that night and re-examined and X-rayed as soon as possible the next morning. Mr E stated that he wanted his father discharged from the Facility as he believed he was at risk if he remained there, and he wanted the manager, Mr R, updated.

Ms I lives on the premises and, after the phone call, at approximately 9pm, she went to see Mr D. He was still awake and told her he had had a couple of falls. She asked if he had hit his head and he said "No". She checked him thoroughly, including examining his throat with a torch, but could see nothing.

Ms I discussed the skin graze with the registered nurses concerned, read the reports relating to this, and confirmed her own assessment that the most likely cause of the head wound was that Mr D had scratched this area as it was itching.

Ms I recorded her conversation with Mr E in the nursing progress notes:

> "[Mr D] told morning staff that he had fallen. No indication of fall having occurred. Unable to get up without assistance by staff. Son [Mr E] called concerned about his Dad's cares. Explained to me that his mother was very upset about falls and that he had a head wound. Also concerned that [Mr D] has a sore throat and may have swallowed his denture."

Following her assessment of Mr D she recorded:

> [Mr D] says he doesn't believe that he has swallowed his denture. However, I have promised son [Mr E] that we will organise an X-ray in the morning to make sure. … Please check [Mr D] every quarter of an hour throughout rest of the evening and half hourly checks throughout night.
>
> R/N [Ms J] contacted about wound on head. She dressed the wound which she believed was a scratch because he stated that it was itchy. Family believe it was from a fall but staff say that it was a scratch. Please contact [Mr D's] Doctor ASAP to follow up with X-ray. [Mr D] told me he had a fall today when walking down the corridor with his son. Have no indication of this having occurred."

An observation chart was started for Mr D, which recorded that he was observed every fifteen minutes during the night.

Ms I detailed Mr E's concerns on the back page of the Incident Report form completed by Ms P on 25 September. The back page of the Incident Report form has sections for recording any follow-up; what caused the incident; and how it could have been prevented. Ms I wrote:

> "[Mr D's] son [Mr E] rang concerned about care of Dad. Says [Mr D] has had a number of falls since coming into our care. Only one documented.

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> Also concerned about [Mr D's] wound on top of his head which he says occurred when [Mr D] fell today.
>
> 1. Could find no indication of a fall today although [Mr D] tells me he did fall in the corridor when he was with his son today.
> 2. Checked wound minimal bleeding minimal bruising.
> 3. Son has asked that we X-ray [Mr D] as he has lost his denture and it could have been swallowed and that [Mr D] has a painful throat. Checked throat which is not red or painful at present.
>
> [Mr D] has walked well today to and from dining room with no further problems from fall."

27 September

At 8.00am on 27 September, Ms J helped Mr D with his breakfast and noted that he took an average amount and all his medications. She washed and changed Mr D before emptying his catheter drainage bag of 300mls of urine. Ms J re-dressed Mr D's skin graze on his forehead, noting that there was no sign of infection and "only superficial skin grazed off".

Ms J noted the attempts she made to contact Dr G about Mr D, at ten to fifteen minute intervals between 8.30am 10.40am. At 11am Ms J was telephoned by the surgery and advised that an X-ray had been ordered and a technician with a portable X-ray machine would arrive at midday.

Follow-up of complaint

At 8.45am that day, Mr R, Operations Manager, telephoned Mr E and listened to his complaints. He told HDC that he recognised that Mr E was angry and upset, and he therefore let him talk. He said he attempted to reassure him that an investigation would be made into his concerns. Mr R was unable to provide specific answers at that time, but expressed his concern and offered to set up a meeting so that these matters could be discussed. Mr E declined the offer of a meeting and advised that he would be making a complaint to HDC. Mr R wrote to Mr E that day to formally acknowledge his complaint and attached a copy of Mr D's clinical records.

At 1pm, Mr E and Mrs D uplifted Mr D from the Facility. Mr E stated:

> "He had to be taken downstairs in a wheelchair, was very weak and drowsy. … This is in stark contrast to how he went in to the [Facility] for respite care. When he was admitted he was mobile (walking frame) but literally had to be carried out."

Identification of foreign body

The X-ray of Mr D's chest, taken at midday on 27 September 2007, showed "two metallic densities on the chest radiograph and lateral neck sitting in the hypopharnyx/upper cervical oesophagus".

Dr G was advised of the result by telephone. He immediately went to the Facility to review Mr D and look at the X-ray, but when he arrived, he found that Mr D had already left. Dr G went straight to Mr D's home and advised Mrs D of the situation.

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He examined Mr D and found him sleepy and confused. Mr D's blood pressure and pulse were normal. Dr G could not see any foreign body in Mr D's throat. He recorded that Mr D had not eaten for three days and was "choking on swallowing/gurgles even with drink".

Dr G telephoned the public hospital and spoke to the gastroenterology and ENT[3] teams and arranged for Mr D to be admitted for further assessment and treatment.

Public Hospital

Mr D was admitted to hospital at 4.35pm on 27 September 2007. Mr E recalls that his father was in an "extremely weakened" state when he was admitted. He was dehydrated and barely able to move or communicate.

A nursing note records that the family were concerned about the care provided to Mr D by the Facility and wished to report their concerns. They were advised to discuss their concerns with the medical staff. There is no indication from the notes, or the provided treatment, that the medical staff considered that Mr D was dehydrated.

Mr D had the denture removed under general anaesthetic later that evening. The postoperative order was for him to have water only overnight and then start a soft diet the following day. Mr D was discharged home later that day.

Mr E left a message at the Facility about these developments and received a follow-up call from Mr R asking if he would like to meet. Mr E stated, "At no point was there any remorse or empathy from him re the developments and at no time did he even enquire as to Dad's condition or how the surgery went."

Additional information

Mr E stated:

> "It is … clear from our observations that there was inadequate supervision than would normally be required. Having read the letter from [Mr R] and the incident reports provided, there are significant discrepancies as to what we as a family observed and what has been recorded in the incident reports. …
>
> "My motivation for providing this complaint is to ensure that there is a thorough investigation into the standard of care being provided at this facility. I believe the above incidents were preventable … if there were adequate levels of trained staff, care criteria and follow up. This being the case my parents would not have been subjected to this traumatising series of events and my father's life being seriously endangered. Obviously my concerns extend to the general well being and safety of other patients."

The Facility

The Facility said that all their care assistants receive a comprehensive induction and on-going training (provided by the Facility) that meets all Ministry of Health and

[3] Ear Nose and Throat.

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District Health Board (the funder) contractual specifications. The Facility also recognises New Zealand Qualifications Authority (NZQA) Health Education Trust qualifications and supports any untrained staff to undergo training and become qualified while they continue to work for the organisation.

The Facility stated that it is staffed in accordance with Ministry of Health and District Health Board specifications at all times. A registered nurse is in attendance 24 hours per day, seven days per week. Throughout the time that Mr D was a respite care patient, the Facility was operating with a ratio of one care assistant to four patients for the morning shifts and one to five for evening shifts. The Facility stated that this is well in excess of requirements. All care team members attend a comprehensive handover at the start of each shift, where current patients' care requirements are discussed in detail. Care assistants are trained to refer to the registered staff in charge of each shift if they have any concerns regarding the well-being or care of any patient. The care assistants are also trained to read, interpret and follow the patients' care plans, which are developed by the registered nurse in consultation with the family, the needs assessor and the patient's doctor.

The Facility stated that there is no clear evidence that Mr D had deteriorated during his time there, other than Mr E's comment that he walked in on admission and ten days later had to be carried out. It was observed that the hospital notes do not show that he was dehydrated, there was no record of a head wound as described by the family, and the hospital doctor recorded that Mr D looked well when he was discharged after the surgery to remove the dental plate.

The Facility stated:

> "We accept that [Mr D] swallowed his partial denture whilst in our care and acknowledge there are discrepancies between the timeframe given by [Mr E] as to alerting staff to his concerns and the account of the staff member involved. We believe there must have been a genuine misunderstanding as the registered nurse involved would most certainly have alerted the house doctor to [Mr E's] comments if she had heard or understood him to have said this.
>
> Staff assisted [Mrs D] in her attempts to find the denture on the evening of the 26th September but to no avail. As way of explanation, in a situation such as this our general experience would be that a small denture plate could be inadvertently thrown out with paper tissues, napkins or laundry and lost in this manner, rather than having been swallowed by the person.
>
> To this end the swallowing of the denture plate by [Mr D] was not an immediate conclusion that staff would have come to. We most certainly regret this occurred, and agree that [Mr D], would have been very uncomfortable over this period, however, the swallowing of the denture plate would not have been foreseen by the staff involved in [Mr D's] care. …
>
> We genuinely regret that we were not able to successfully meet the expectations of [Mr E] in our care of [Mr D], and we are especially

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> disappointed that our attempts to respond to [Mr E's] concerns when raised at the time, were not perceived to be constructive."

Policies

The Facility has a Management Resource Manual, which includes a section, "Determining Staffing Levels and Skill Mix". This document outlines the benchmarks that determine the staffing in the facilities, which are established by the Operations Manager in consultation with the Manager.

The Facility also provides policies to guide staff on managing challenging behaviour, and incident and accident reporting. The "Incident and Accident Report" policy states, "In the event of a skin tear the relative should be informed during reasonable hours (e.g 0800–2000hrs). It is essential to keep relatives informed at all times." The policy states that if the incident is minor, the manager or senior is to investigate, assess the situation and document on-going follow-up within 24 hours. Appropriate corrective action is undertaken to minimise or eliminate a re-occurrence of the incident. Serious incidents are to be reported to the Chief Executive or Operations Manager.

Responses

Mr D

Mr E was sent a copy of the information gathered. He stated that the facts are simple — his father swallowed his dentures, which necessitated surgery, and it happened while he was in the care of the Facility.

The Facility

A number of the Facility's comments in response to my provisional finding have been reflected through amendments to the above text. Remaining comments are outlined below.

The Facility stated that it does not wish to minimise the seriousness of the family's concerns and their personal perception of the events as they believe they unfolded, but it does not believe the family "fairly represented the situation".

The Facility also stated:

> "We wish to acknowledge that we are very saddened that the [family's] experience of our services was so negative, and have taken significant steps to avoid a situation such as this arising again. We have high expectations for our service, and we do not believe we met those high standards. However, we do believe that [Ms I] and [the Facility] took all reasonable actions in the circumstances (and in light of current aged care nursing practice) to provide [Mr D] with appropriate care. In swallowing his partial dental plate [Mr D] experienced a unique and unfortunate event, which was not foreseeable and we would not wish this on any of our residents."

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Liability
The Company advised that the owner and operator of the facility (including the rest home and the hospital) is the certified provider in this instance. The Company stated that it is a separate entity and therefore not involved directly in this complaint. The Company's aged care facilities are all owned and operated by separate companies, and each has its own local management structure in place which oversees the day-to-day operations.

The Company advised that since these events, and due to expansion, it has reviewed the clinical governance at the Facility, and has appointed another senior clinical manager into the role of Residential Care Manager (Clinical) (RCMC). Ms I remains in her position of Clinical Manager, but her role has been directed to the supervision of the rest home, and another skilled registered nurse has been appointed to the position of Hospital Manager. The two clinical manager positions are directly responsible to the new RCMC. Mr R remains the overall Manager and takes advice on all clinical matters from the RCMC.

Other changes are:

- *System improvements:* The Facility has extensively reviewed a number of its policies and procedures forming part of the Facility Accreditation Programme, which include:
  — incident reporting and communication with families
  — falls management
  — admission documentation and discharge for respite/carer support residents
  — care planning, dentures/natural teeth
  — accident and emergency services
  — nutrition and hydration.

- *Communications skills:* A new training and carer support programme entitled "Upskill Yourself" has been introduced. This initiative was introduced as a direct response to this complaint as the Facility acknowledged that its communication with families needed to be stronger, and that there was the potential for miscommunication where staff members had English as a second language. Currently 137 employees have commenced this programme and are being provided with one-on-one tutoring.

- *Communication with families:* The Facility has introduced a new "Relationship Building Programme" to strengthen relationships with residents and relatives. The changes were at a facility and company level. This initiative will ensure that managers respond urgently to any verbal or written complaints received and immediately inform the head office. A toll-free number to the head office is now available to all residents and relatives who wish to discuss any concerns they have about the manner in which a complaint has been dealt. In addition, the Chief Executive's personal assistant will telephone the next of kin of new residents four weeks following admission to ask whether they have any

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concerns. Each manager is advised of the result of this call, and a follow-up letter is sent to the next of kin.

- *Training:* Over the past year, seminars for Managers and Clinical Managers have focused on complaint management and effective communication, as well as team building and clinical documentation. The Operations Manager leads these seminars, and the Chief Executive is also involved.

Catheter care

The Facility submitted that there was no clinical reason to undertake a fluid intake record and amend the care plan to reflect the need to monitor Mr D's intake in relation to his catheter. The Facility said that it was appropriate to be reactive when the catheter became dislodged on 21 September and, other than that incident, there were no problems with the catheter. The Facility stated:

> "We consider that the nursing team acted appropriately within their scope of practice and that there was no need for [Ms I] to be actively involved in the management of the catheter."

Falls

The Facility stated that it promotes a "no blame" environment and encourages staff to document any incidents, accidents or injuries. The "no blame" environment assures that staff report every incident immediately without fear of recrimination.

The Facility said that the response to each incident is a matter of "management discretion". If there has been an error of judgement and the staff member concerned demonstrates remorse and a willingness to improve, the manager will react accordingly. Although Ms I did not record her follow-up with the care assistant on the back of the incident form, in this case the care assistant (Ms P) was remonstrated with at the time of the incident. Ms I supported the care assistant to complete her care assistant induction modules well in advance of the deadline, and ensured that she attended all the relevant in-service training in the following weeks. As a consequence of this incident, at handover meetings staff were reminded of the importance of never leaving frail or cognitively impaired residents unattended or unsupervised, and reminded to work in pairs. In addition, a falls minimisation quality improvement plan was instigated at the Facility, and staff were given training in incident documentation.

The Facility advised:

> "We have always accepted that our caregiver should not have left [Mr D] unattended in the shower, however, this was a poor decision made by our caregiver at the time, this was not due to systematic failure on behalf of [the Facility]. We acknowledge that we did not consistently meet our own 'high quality standards' on which we pride ourselves."

The Facility advised that Ms P commenced employment at the Facility on 23 August 2007 and received five full days of orientation working as an extra to the roster with a senior buddy. During this time Ms P also completed her All Employee Induction Modules. Ms P then commenced her Caregiver Induction Appendix Modules and

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completed Modules One and Two by 28 September 2007. Caregivers are required to complete this phase of their training during the initial six months of their employment.

The Facility advised that Ms P was then considered able to assume responsibility for independently showering residents, and noted that residents of Mr D's level of acuity are well within the scope of responsibility of a caregiver. This would be viewed as appropriate and acceptable throughout the entire rest home/hospital sector. The Facility stated that Ms P's error of judgement in leaving Mr D unattended in the shower was "not related to a lack of orientation, understanding of [Facility] procedures nor inability to undertake this task".

The Facility provided copies of Ms P's Caregiver Induction, Module Two. The caregiver is required to tick the correct answers in the module sections. Point 5 in the section headed "Showering/Bathing/Washing" in Module Two asks, "Is it alright to leave residents unattended while you are showering or bathing them." Ms P ticked the "No" box. The page was dated 28 September 2007, three days after she had left Mr D unattended in the bathroom.

Head wound

The Facility submitted that the provisional opinion indicated that there was an inconsistency in the reporting of the skin tear to Mr D's forehead, which raised the possibility that there was more than one injury and reinforced the need for good, consistent record-keeping. The Facility stated that the incident reports of the wound to Mr D's forehead at 8am, 12.30pm, 2pm and 9pm all describe the wound as minimal, being either a scratch or a graze. The Facility stated:

> "The actual written reports of the graze on [Mr D's] forehead written at the time by five different qualified health professionals are very consistent."

The Facility stated that the reference to a "facial injury" in the provisional opinion appears to indicate that there may have been a fresh injury related to the falls Mr D reported. They stated, "This conclusion appears to be based solely on reports from the family that appear to be based on [Mr D] saying he had fallen again." The Facility was concerned that HDC did not appear to be willing to accept that Mr D was confused and that he did not fall at all that day. The Facility submitted:

> "There were no undocumented falls, nor was there a 'deep laceration'. We consider the response was appropriate and we would not expect our staff to immediately alert the family if a resident scratches their head and aggravates a graze. We do not accept that our staff required further direction on how to manage these incidents."

General deterioration

The Facility agreed that Mr D was frail on admission, but did not accept that there was general deterioration or that it would have been picked up if the notes had been more detailed, or consistent progress notes allowed for a critical health assessment. The Facility stated:

> "We are concerned that the HDC places so much weight on the [family's] comments and having criticised a lack of documentation, then appears to place

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> little or no value on the documentation that has been recorded by the health professionals involved in [Mr D's] care that was reported in writing at the time."

The Facility noted that the provisional opinion gave undue emphasis to the report by the morning care assistant on 26 September, who noted that Mr D was unwell that morning and unable to stand up or walk by himself. The Facility stated that by lunchtime Mr D was able to walk himself to the dining room. His condition fluctuated and, as is common with dementia, he needed ongoing prompting, supervision and encouragement to eat and drink. This was because he suffered from memory loss and confusion, not significant physical deterioration.

The Facility stated that Dr G's comments about Mr D not eating and drinking for three days are inaccurate and appear to be based on the reports by the family. The Facility said that the progress notes show that Mr D was eating and drinking right up to his discharge. The Facility stated that the promotion of daily fluid monitoring in the provisional opinion appears to be directly related to the family's assertion that Mr D did not eat or drink for three days after the fall. The Facility noted that when Mr D was admitted to hospital, there was no indication that he was dehydrated.

Clinical recording
The Facility stated:

> "We do not accept Ms Spence's [expert advisor] comment that nursing progress notes should be written by RNs on a patient every day. However, our investigation has indicated that in general our RNs did, in fact, write in [Mr D's] notes on a daily basis.
>
> [The provisional opinion] has indicated that there are significant discrepancies between what staff have indicated on the incident reports, versus what the family has observed. … We acknowledge that the description of the head wound from the family ([Mrs D]) significantly differs from the description of five experienced health professionals. … At no point, did the qualified staff at [The Facility] indicate there was a deep laceration as described by [Mrs D]. To this end, we believe that appropriate standards of documentation were maintained, and that these provided appropriate direction to staff.
>
> When there was evidence of [Mr D] not being well, this was recorded in the progress note as noted by [Ms O] on 26 September. The fact that there was no documentation in respect to his decline prior to this date is due to the fact there was no decline to note."

The Facility advised that my provisional opinion that progress notes for hospital level patients require daily entries by a registered nurse is not mitigated by the acuity or wellness level of the patient/resident, and that it sets a "blanket standard that may not be appropriate for every hospital level resident". The Facility referred to the Health and Disability Support Services Part 4 — Service Delivery (extract) 4.1.4 and 4.1.5, and the Age Related Residential Care Agreement, D7.1, and noted that no detail or actual frequency is indicated in either of these documents, but rather it provides for

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detail that demonstrates the needs and frequency that is appropriate to the degree of risk. It stated that the Facility's generic policy "Nursing Care Plans" was developed in line with the above standards, in relation to hospital patients. The policy states:

> "Hospital — The recommendation is daily recording in the Progress Notes or more frequently to reflect the wellness level of the resident. Should the resident be stable and predictable, at least weekly documentation is required."

Communication

The Facility disputed that Ms I was solely responsible for liaising with the family and ensuring continuous contact to share appropriate information during the ten days Mr D was at the Facility. The Facility stated that the registered nurses met their obligations in communicating with the family over each incident and responded appropriately to each issue as it arose. On 26 September, communication was appropriately escalated to Ms I, who took control and liaised appropriately with the family. Care of any resident is a team effort, and the team of senior registered nurses at the Facility was appropriately involved in communicating with the family, and Ms I also communicated appropriately once it became apparent that she needed to intervene.

Oversight and supervision

The Facility also submitted that Ms I gave appropriate and extensive support and assistance to her staff, and fully understood and appreciated the clinical responsibilities and oversight required of her in the role of Clinical Manager. Ms I has successfully implemented initial orientation and training of all registered nursing staff, and provides regular ongoing training sessions. There are daily clinical handover meetings with senior staff in each area, and Ms I has an "open-door" policy for clinical consultation about any resident at any time. She implemented an overview of all incident reports for follow-up, analysis of trends of incidents and infections, and the development of clinical Quality Improvement Plans.

The Facility believes that it is "entirely appropriate" for a Clinical Manager to delegate nursing tasks to properly trained and orientated registered nurses. Delegated responsibilities in relation to Mr D's care were "entirely" within the scope of practice and the job descriptions of the registered nurses involved.

The Facility stated that Ms I had not played a large role in supporting the promotion of the Facility. The Facility said:

> "The development of [the Facility] was undertaken with thorough strategic consideration. … The Clinical Manager's role was developed to exclusively oversee and operate the rest home and hospital services on this site. [Ms I] was certainly aware of this and operated competently within this frame of reference for her position, which is mirrored in her job description."

The Facility stated that Ms I was given a thorough orientation to the role of Clinical Manager and was well supported in the establishment of clinical quality and risk management procedures. During the initial development and establishment of the Facility, two senior registered nurses from the company visited to provide Ms I with "high level, hands-on" support in her role. The Facility stated that additionally,

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"senior, highly experienced and well trained and orientated care staff" were flown to the Facility from other Company facilities to buddy and orientate new staff.

The Facility advised that although open days took a considerable amount of time and attention from all members of the management team, the team was supported by a national sales team and the National Sales Manager, who took full responsibility for showing visitors through the facility. Ms I's role was restricted to these to the extent that if visitors required information relating to the hospital or rest home, Ms I would show them through these parts of the facility. The Facility said, "[Ms I] was not inappropriately distracted by the opening of the Facility from her core responsibilities, [and] [she] was comprehensively orientated, supported and assisted in her position of Clinical Manager."

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Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

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

Relevant standards

The New Zealand Health & Disability Sector Standards (NZS 8134: 2001) published by the Ministry of Health state:

"Part 2 Organisational Management …

Quality and Risk Management Systems …

Standard 2.7 Consumers/kiritaki receive timely, appropriate and safe service from suitably qualified/skilled and/or experienced service providers."

Opinion

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

Summary

When Mr D was admitted to the Facility for two weeks' care, so that his wife could have a much-needed break from caring for him, his family expected that he would be safe; his needs would be carefully assessed; and he would be looked after with reasonable care and skill, and in compliance with the relevant standards.

However, during his time at the Facility, Mr D had a fall while unsupervised in the bathroom. This was despite a history of falls, having been assessed as medium risk for falls, and evidence that he could wander and become confused. He also swallowed his partial dental plate. The management of his catheter, and the responses to concerns

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about his facial injury, and his physical condition, were inadequate. The documentation relating to his care was particularly inadequate. While aspects of the care provided to Mr D were satisfactory, in some respects the care fell below reasonable standards and it is my view that Mr D's rights under the Code were breached.

Breach — Ms I, Clinical Manager

Care planning and documentation
Ms I's job description clearly states her responsibility for ensuring that resident care is appropriate to their needs and is well documented.

In my provisional opinion, I expressed concern about the brevity of the progress notes and lack of nursing notes for Mr D.

The Facility subsequently advised that although it appears that, in Mr D's case, his daily progress notes were in the main written by the registered nurses, it does not accept that nursing progress notes should always be written by registered nurses every day. It submitted that Ms I appropriately delegated care planning and documentation for Mr D to senior nurses during his stay.

My expert, Ms Spence, advised:

> "[The Facility] also identifies that it is entirely appropriate for a Clinical Manager to delegate nursing tasks to properly trained and orientated registered nurses which I agree with. However, the staff were new, the residents were new, the building was new and everyone was learning new roles and responsibilities. This made [Ms I's] clearly defined responsibilities of orientation, supervision and education of her staff more intensive and required a tight day-to-day oversight of residents. It also required her to monitor the documentation."

While I accept that Mr D was admitted for respite care, I still conclude that the overall documentation was lacking. In particular there was a lack of documented care planning and nursing direction during the first two days of Mr D's admission. It is likely that this led to poor co-ordination of care and communication, which I have commented on later.

Ms Spence advised that, for hospital level care, the progress notes "should be written by a registered nurse on a patient every day". While on most days there were entries by registered nurses, there were three occasions, on 19, 21 and 24 September, where there is no record in the progress notes by a registered nurse. This is particularly concerning when it was on 21 September that Mr D was found to have removed his catheter.

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Ms Spence observed that there is a superficial entry on 18 September (day of admission) by RN Ms J, and the next entry is not until 7.20pm on 19 September, when a care assistant noted that Mr D was confused and unsettled.

Ms Spence advised me that:

> "progress notes provide a picture of the resident's 24 hour well-being and should highlight any changes of condition or care. For example, the brief admission note contained no information about:
>
> - Family members being present;
> - Catheter care;
> - [Mr D's] level of dementia;
> - His mobility and risk of falls or any safety issues;
> - Personal likes and dislikes eg food;
> - Baseline recordings (these were not recorded in the assessment either);
> - Family relationships — or anything relevant which will assist staff to develop a trusting relationship.
>
> This information is important for the resident's safety until the care plan can be completed."

Ms Spence advised that one way to cover these issues is to have a one-page quickly recorded checklist that covers all safety issues for the first 24 hours. She was particularly concerned about the brevity of early notes where staff most needed clear directions for care until the care plan was complete. I note that some of these matters are covered in the brief nursing care assessment by Ms K on 18 September, but not all of them. These matters were not recorded in the progress notes.

Ms Spence also pointed out that the respite care programme co-ordinator had directed that on admission (for respite care) Mr D was to have a medical assessment, but this did not happen. No reason has been recorded for the failure to do this. Had there been evidence of a more comprehensive assessment, including baseline assessments, this may have been understandable, but I would expect staff to record reasons for not organising a medical assessment as soon as possible. The first medical assessment occurred one week later, and was as a result of Mr D's fall.

In response to the provisional opinion, the Facility advised that care planning and documentation is a crucial area, and staff are consistently encouraged and supported to document robustly. However, the Facility is concerned that such weight has been placed on the use of progress notes when the admission nursing assessment was comprehensive and appropriately identified baseline observations, which directed the development of the interim Nursing Care Plan.

The Facility submitted that requiring daily entries by a registered nurse in the notes of hospital level patients sets too high a standard, and the frequency of entry should

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depend on the acuity or wellness level of the resident. This was reflected in its policy covering nursing care plans.

However, I share Ms Spence's view that the provision of hospital level care to Mr D did require daily entries by a registered nurse, and that the documentation in Mr D's file was inadequate. When Mr D was admitted, he was recovering from two fractured ribs, he had chronic renal impairment with an indwelling catheter, and he was deteriorating physically and mentally. It was reasonable to expect that he would receive daily nursing assessments and that they would be documented. Moreover, it is unreasonable that there is no entry in the progress notes by a registered nurse from 18 to 20 September, when the care plan was completed.

Like Ms Spence, I am also concerned at the brevity of the nursing notes regarding Mr D's progress and care. An example is Ms K's note at 10.30pm on 23 September, "BO X1 (lge, loose) [?given] a shower."

Furthermore, there is no record by any nurse or care assistant on 24 September (which is the day before it was discovered that the partial plate was missing). In my view this is not acceptable for hospital or rest home care, particularly when a resident has needs such as Mr D's.

In his GP records for 25 September, Dr H recorded that Mr D's throat had been sore prior to the fall that day, but there is no record in the progress notes about Mr D's throat until Ms I's entry at 9pm on 26 September recording her conversation with Mr E. Nothing in the notes would tell a care assistant or a nurse that Mr D's throat was sore on or before 25 September, or whether he had his dentures in on the morning of 25 September. As noted in a previous HDC opinion:[4]

> "The purpose of the progress notes is not only to document a patient's health and well-being. The notes also pull together other documentation relating to the patient, such as fluid balance and temperature charts, to provide a clinical overview. This clinical overview can assist other health professionals to implement or review a patient's ongoing treatment and care."

On 26 September, Mr D sustained an injury to his head. Mr E described the wound as a deep laceration with bruising. The early shift nursing record, timed at 9am, describes the wound as a "small scratch". It was recorded as a "dry skin graze" at lunchtime. The afternoon nurse who cleaned and dressed the wound after Mrs D reported her concern that her husband's forehead was bleeding, noted that the "skin was hanging" and, when Ms I looked at it at 9pm, she recorded minimal bleeding and minimal bruising. From the notes I have not been able to determine the size of the wound, where exactly on the head it was, or even the nature of the wound.

In the initial assessment on 18 September, Ms K correctly noted that Mr D had a plate. However, in subsequent entries, this was referred to as "dentures". As I have commented later, this led to some confusion as to the nature of the dental prosthesis,

[4] Opinion 05HDC07285, page 38.

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and may have contributed to the delay in recognising the reality that he might have swallowed it.

In my view, more comprehensive daily notes on Mr D's care and well-being would have assisted in determining when the pain in his throat developed and whether it coincided with the loss of his partial plate, how the injury to his head may have been caused, and whether his health was declining during his time at the Facility.

The Facility submitted that my opinion about the need for daily notes does not take account of the acuity or the wellness level of the resident. I disagree. Mr D, who suffered from progressive memory impairment and physical deterioration, and was known to be a fall risk, was in an unfamiliar environment. He could mobilise independently, but his abilities fluctuated. Three days after admission, he pulled out his indwelling catheter, and two days later he fell in the bathroom while unattended. In my view it is not unreasonable to recommend that a hospital level patient with Mr D's level of acuity should have progress notes completed by registered nurses who, better than caregivers, understand the complex clinical needs of frail elderly patients.

Furthermore, it is not only the lack of registered nursing notes that is concerning. To summarise, Mr D's documentation was deficient or inaccurate in the following respects:

- inadequate nursing direction given prior to the care plan being completed on 20 September (two days after Mr D's admission), and in particular no baseline assessments
- records for 18 September entered as 16 September
- no nursing entries for 19, 21 and 24 September
- no entry at all for 24 September
- time of entry not recorded (in most progress notes and also in the incident form for the fall on 25 September)
- entries signed but designation not clear
- insufficient detail in entries
- no indication of when Mr D first complained of having a sore throat
- partial plate incorrectly referred to as dentures
- no mention in the incident form for 25 September that the fall occurred when Mr D was left unattended
- insufficient or inaccurate descriptions of the injury to Mr D's head.

It is the combination of these factors that led me to conclude that the documentation did not meet acceptable standards.

Deteriorating condition

Mr D's family have complained that his condition deteriorated significantly while in the Facility for nine days. Mr E stated that when his father was admitted to the Facility

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he was mobile with a walking frame, but by the time he left on 27 September he had deteriorated to the point that he had to be carried out. Mr E said that there were times when the family visited and found that his father had not been shaved and was still in his pyjamas. Mrs D reported that on 26 September, she found her husband weak, drowsy and dishevelled, with dried blood on his scalp. The family believe that Mr D did not eat or drink for three days, and Mr E described his father as "weak and dishevelled" when he left the Facility. Mr D's physical condition certainly distressed his family.

The Facility has challenged this and said that Mr D was frail on admission, and there is no clear evidence that he deteriorated while at the Facility.

I note that Ms O recorded that on the morning of 26 September Mr D was not feeling well and could not stand or walk by himself, and she had to help him eat. However, The Facility submitted that undue emphasis has been placed on Ms O's description of Mr D's condition on 26 September. It stated that Mr D's condition fluctuated, and by lunchtime that day he was able to walk himself to the dining room. The Facility also said that the comment that Mr D did not eat and drink for three days is inaccurate, and the nursing notes show that he was eating and drinking right up to his discharge, and that this is supported by the fact that the public hospital recorded no concerns about his hydration when he was admitted at 4.45pm on 27 September.

It was certainly the strong impression of Mr D's wife and son that Mr D was deteriorating. They, of course, knew him better than anyone. Mrs D was the person responsible for Mr D's care, and has been credited by their GP as doing an "outstanding job". She was distressed by her husband's physical condition. Mr D was confused, frail and elderly, and had been moved from his surroundings and familiar routines, and it is therefore likely he would deteriorate.

I accept that the level of deterioration may not have been as great as the family perceived, and that there was no indication when Mr D was assessed by Dr G in the early afternoon of 27 September, and later at the public hospital, that there was any concern about his general condition.

However, the Facility notes provide scant information about Mr D's food and fluid intake, and do not provide a complete picture of Mr D's state when he arrived and when he left. I accept the family's view that there was a change in his condition and that this was not sufficiently assessed or reflected in the progress notes. This failure likely stemmed from the deficiencies in care planning referred to above.

The Facility was a relatively new one and this may have contributed to these events. I acknowledge that getting a new facility up and running can be extremely difficult, and Ms I had been in her job only since June. I accept that Ms I was entitled to have some confidence that her registered nurses would have the necessary skills to appropriately plan and document Mr D's care needs. However, as Ms Spence points out, this was a new facility, with new staff and residents, where everyone was learning new roles and responsibilities. In my view, it needed time to become a cohesive unit. It certainly required careful oversight by the Clinical Manager, and Ms I was an experienced nurse with previous experience in a leadership role. It was Ms I's clearly documented

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responsibility to organise the delivery of nursing care, and to co-ordinate the work of the registered nurses and care assistants and to ensure that documentation of all nursing records met professional standards.

Catheter monitoring

While I consider that the response to Mr D's removal of his catheter was adequate, the overall management of his catheter was less satisfactory. Ms Spence noted that there was infrequent reporting of Mr D's catheter drainage. From admission, on 18 September, until 21 September when Mr D pulled out his catheter, there was no reference in his records to his catheter drainage. On the morning of 21 September, the nursing staff advised Mr F that they would monitor Mr D's urinary output until midday. There is nothing in the nursing records until 2.30pm to indicate that this was done. From 21 to 27 September there were only three references to Mr D's urinary output, despite Ms M's direction to staff to check Mr D's catheter bag for blood. On 22 September Ms J noted that the catheter was draining well, and on 27 September that she had changed the catheter bag and emptied it of 300mls.

Mr D was a frail, elderly man, who was below average weight for his height and had a poor appetite. Daily monitoring of his urinary output would have been an indicator of the adequacy of his oral intake and his general well-being, and should have been a routine task. Additionally, from 26 September, questions were being asked about whether he had swallowed his denture, causing a possible obstruction. It would have been prudent to begin a fluid intake record and amend the care plan to reflect the need to monitor Mr D's intake.

I am not convinced that Mr D's urinary drainage was monitored appropriately, and do not agree with the Facility that the nurses adequately monitored Mr D for signs of bleeding and urinary output as directed by Ms M.

Communication

By the time Mrs D visited her husband on 26 September there was good reason for the family to be concerned about the standard of care he was receiving at the Facility. Mr D had only been there for eight days. In that time, he had pulled out his catheter; he had fallen while left unattended; his throat was sore; on 26 September Mrs D had found him unshaven and with blood on his face; he was not eating and drinking well; and his dental plate had been missing for over 24 hours. This does not reflect high quality care, and I note that the Facility has acknowledged that it did not meet its own "high standards" in this case.

One of Ms I's designated responsibilities was to liaise with families and ensure continuous contact and sharing of appropriate information. She was only able to fulfil that function if she knew what needed to be discussed. Ms I told my investigator that Mrs D was very distraught to find her husband bleeding from a skin graze on 26 September, and that when she spoke with Mrs D that day Mrs D then seemed "OK". Ms I also said that she had been told that Mr D's "dentures" were missing, and it had not occurred to her that he could have swallowed them. I accept that during the course of Mr D's short admission, various staff members, including other nurses, had conversations with Mrs D, Mr E and Mr F.

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However, Mr D's confusion caused his ability to mobilise to fluctuate. He therefore needed careful monitoring and ongoing evaluation of his safety. Direction should have been given to staff, not only to accurately record the nature of any injuries and the cause if known, but also to fully inform his family. The Facility has stated that it is not usual to inform families of minor skin tears and grazes. I accept that this might be usual practice. However, Mrs D had been under great stress caring for her husband at home. He had already had a serious fall at home, and Mrs D and her family were understandably very anxious that he not fall and sustain further injury. He then sustained a fall at the Facility while left unattended, and then Mrs D found him bleeding. In my view, full discussion about all events, no matter how trivial, would have gone some way to allay the family's anxiety about his welfare, and this was Ms I's responsibility.

The Facility subsequently advised that throughout Mr D's stay, the registered nurses communicated with the three members of the family and, until the family's complaints on 26 September, there was no reason to involve Ms I. The Facility considers that it was not Ms I's sole responsibility to liaise with the family, ensure continuous contact and share appropriate information during Mr D's ten-day stay.

I accept that Ms I did not need to be in continuous contact with the family and that it was not her sole responsibility to communicate with them. Furthermore, she was entitled to have confidence in her registered nurses to have the necessary communication skills. However, it appears that the staff responsible for Mr D did not have the experience to realise soon enough that this was an escalating situation. Different family members spoke with different staff members, which made it even more difficult for the staff to recognise what was happening. One person needed to coordinate the communication and have oversight of it. Ms I had the overall responsibility for communication with families, and there is no evidence that staff had been instructed to advise her about any communication difficulties with families, or that she was monitoring concerns being raised and how they were being addressed. If Ms I had become aware of the difficulties at an earlier stage, such as on 25 September when Mr D fell and when his catheter had already become dislodged, her involvement may have altered the subsequent outcome. I acknowledge that when Ms I was advised that there was a problem, she acted promptly. It is unfortunate that she did not know earlier. I am not satisfied that, in these circumstances, Ms I sufficiently fulfilled her responsibilities.

Breach

In my opinion, Ms I should have been more vigilant in addressing documentation standards and care planning, and providing direction to staff. She did not provide the necessary clinical oversight required to ensure Mr D received services with reasonable care and skill. She therefore breached Right 4(1) of the Code.

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Breach — The Facility/Company

Vicarious liability
Under section 72 of the Health and Disability Commissioner Act 1994 ("the Act") an employer is liable for acts or omissions by an employee unless it proves that it took such steps as were reasonably practicable to prevent the employee from breaching the Code. It is therefore necessary to also consider whether the Facility is vicariously liable for Ms I's breach of the Code.

In response to my provisional opinion, the Company has argued that because Ms I was not employed by the Company, but by the Facility, the Company cannot be found to be vicariously liable. I am disappointed and surprised by this attempt to deny liability. In earlier correspondence, the Company stated:

> "[The Company] owns and operates [the Facility] and all staff working [there] are employees. Both [Mr R] and [Ms I] are directly responsible to the writer ([Ms S], Operations Manager [the Company])."

Indeed, all correspondence on behalf of the Facility and its staff has been with the Operations Manager of the Company. Clearly it was the Company that employed staff (either directly or indirectly), and to which staff are accountable. Furthermore, I note that the various actions being taken in response to these events have been led by the Company with Ms S and the Company's CEO personally involved.

As already noted, the Facility was a relatively new facility. The Open Day held before Mr D's admission meant that Ms I and other senior team members were busy handling numerous enquiries additional to their usual duties. The Facility stated that Ms I's role as Clinical Manager was not compromised by her role in promoting the newly opened facility. It stated that there was a team of sales persons specifically engaged to promote the Facility. Ms I's role was restricted to showing visitors who required information about the hospital and rest home through this part of the facility. The Facility also stated that Ms I was comprehensively orientated, supported and assisted in her position as Clinical Manager.

The majority of the staff had previous experience in caring for the elderly, but the nursing teams at the Facility were newly established. The Company advised that during the initial development and establishment of the Facility it provided senior experienced registered nurses and care assistants to augment and support Ms I and the newly appointed care assistants.

I am of the view that, despite the orientation and in-service training programmes in place, and the experienced staff brought in to support new staff in the initial period, this was a new facility that required time and careful attention to allow the staff to become a cohesive unit.

In her advice, Ms Spence concluded that:

> "the fact remains that [Mr D] had a nursing experience which was borderline in meeting safe nursing practice, and certainly did not provide a comfortable hospital stay for him.

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> I am of the opinion that whilst each individual incident would not be viewed as very serious, the collective management of these incidents did not reflect best practice and would lead peers of [Ms I] and [the Facility] to view their actions with some disapproval."

I agree with this assessment. Ms I's job description is sufficiently wide that any error can be laid at her feet but, in my view, the Company must also bear some responsibility for these events.

As previously noted, the Facility was a new facility with a new clinical manager and staff. As Ms Spence advised me, monitoring of documentation was particularly important in this early stage, as was careful oversight of staff. The Company needed to ensure that such a process was in place and being carried out. Accordingly, in my opinion, the Facility and the Company did not have adequate systems in place to prevent Ms I from breaching the Code and thus are vicariously liable for her breach of Right 4(1) of the Code.

Fall, 25 September — Ms P

On the morning of 25 September, when left unattended in the bathroom, Mr D fell. A workman saw this and alerted staff. Ms P, the care assistant who had left him unattended, immediately checked Mr D and fetched the registered nurse on duty. She then assessed Mr D and, although she found no evidence of injury, appropriately called the Facility doctor, Dr H, to examine him.

Ms Spence advised that "frail, demented, unstable hospital residents should never be left alone in a shower where the obvious hazards of hot water, slippery floors and falls exist". I agree. Furthermore, in Mr D's case, falls were a known risk, and it had been clearly recorded that he required assistance to shower and dress. In my opinion, leaving Mr D unattended in the bathroom was unacceptable.

Although Ms Spence commented that the documentation of this incident "would meet the standards", I am concerned that the incident was incompletely recorded and there was insufficient follow-up. While I accept that there was clearly no intention to cover up the circumstances of the fall, there is no mention in the incident form that this fall occurred when Mr D was left unattended.

The Facility told me that the care assistant was very remorseful and that the registered nurse remonstrated with her at the time. This was also unrecorded.

As noted above, Standard 2.7 of the New Zealand Health & Disability Sector Standards states:

> "Consumers/kiritaki receive timely, appropriate and safe service from suitably qualified/skilled and/or experienced service providers."

The Facility subsequently advised that Mr D's fall resulted from a poor decision by Ms P, not systemic failure. It advised that Ms P commenced employment on 23 August 2007 and received five full days of orientation working as an extra to the roster with a senior buddy, and that she completed her training within six months as

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required. However, the training module, which included instruction on showering and bathing, and a question regarding leaving residents unattended, was completed by Ms P on 28 September, three days after Mr D's fall. Common sense dictates that staff should have the relevant training before being left to care for someone with a demonstrated fall risk. I therefore conclude that Ms P had not received adequate training prior to her caring for Mr D on 25 September.

The service Mr D received on 25 September when left in the bathroom was neither appropriate nor safe. By allowing a care assistant with insufficient skill or experience to have responsibility for Mr D, the Company did not comply with Standard 2.7. I therefore find that the Company breached Right 4 (2) of the Code.

No Breach — The Facility/Company

Response to catheter incident
When Mr D was admitted to the Facility he had an indwelling urinary drainage catheter. Mr E recalled being instructed by his father's surgeon that if the catheter was dislodged it was to be reinserted within two hours. Any longer would cause severe problems.

On the morning of 21 September, Mr D was found sitting in his bedroom chair with blood on his legs and pyjamas. On examination, it was found that he had pulled out his catheter. Mr D's son, Mr F, was contacted and informed of the situation. The registered nurse, Ms M, informed Mr F that she would normally call in a doctor in this situation, but was satisfied that Mr D was comfortable and it was appropriate to monitor him until midday to see if he was able to pass urine. Mr E arrived after lunch to visit his father. He was concerned that there was no one at the Facility who could reinsert the catheter, and that no arrangements had been made to have it done. He discussed his concerns with Ms M. It was agreed that Mr E would contact the district nurse who normally performed his father's catheter care. She was prompt in attending to Mr D.

The Facility submitted that there was no clinical reason to undertake a fluid intake record, and it was appropriate for the nursing actions to be reactive on 21 September when the catheter became dislodged. It said that apart from this incident, there were no other problems with Mr D's catheter. The nursing team acted appropriately and there was no need for Ms I to be actively involved.

Ms Spence noted that when the district nurse catheterised Mr D, she drained 300ml of urine. This is not a significant amount to be retained in the bladder, and it would not have caused Mr D any distress. Ms Spence also advised that, as Mr D's catheter was not suprapubic, which would have required quicker re-insertion, seven hours without a catheter is not a serious concern providing there is no bladder distension. She advised that, although it is regrettable that there was confused communication with the family

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members, the proposed plan for re-insertion of the catheter met safety and comfort standards.

I agree that the actions taken by the nursing staff on 21 September in relation to replacing the dislodged catheter were appropriate. Although there was some miscommunication with the family as to the person best placed to re-insert the catheter, Mr D suffered no ill effects.

Other comment

Some other matters require further comment.

Overall care

Missing plate
There is no dispute that Mr D swallowed his dental plate while in respite care at the Facility. The fact that this occurred does not in itself give rise to a breach of the Code. How and when it happened is unknown.

I do not know whether Mr D was wearing his plate on 24 September, or at breakfast on 25 September. In the absence of any evidence to the contrary, I must assume that the first indication that it was missing was on 25 September, and that it is likely he swallowed it when he fell that morning. Although I have found that the circumstances of that fall give rise to a breach of the Code, I must separately determine whether the possibility of a swallowed plate should have been considered and acted on sooner.

Some factors may have clouded perceptions. First, Mr D had been complaining of a sore throat before the fall, and so the link between a sore throat and a lost plate was not apparent. Secondly, when Dr H examined Mr D, he looked at Mr D's throat, but found nothing untoward. When Ms I (who was aware of Mr E's concerns) looked down Mr D's throat on the evening of 26 September, she also found nothing untoward. Thirdly, the partial plate (which was accurately recorded as that in the admission record) was inaccurately referred to as "dentures" when people were discussing its whereabouts.

Mr E recalls that when he visited at 9am on 25 September and was informed about the fall, he had two concerns — that his father had been left unattended, and that his partial plate was missing. Mr E stated that he advised the staff that he was concerned that his father might have swallowed his denture, but they took no action. The staff members do not recall Mr E voicing this concern. Registered nurse Ms J, who was on duty from 7am to 3.30 pm and who assisted following the fall, recorded in the incident report: "Son visited. Informed. Seen by [Dr H]. Nil major. Second son informed at midday." She also recorded in the progress notes: "Seen by [Dr H]. Continue to monitor for pain and family informed." The registered nurse on the afternoon shift recorded in the progress notes that when Mrs D visited that afternoon she asked the nurses to help her look for Mr D's bottom dentures.

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On 26 September care assistant Ms O recorded that Mrs D had visited and was again raising the issue of the dentures.

The Facility has acknowledged that Mr D swallowed his partial plate and that there are discrepancies in the timeframes given by Mr E and those given by the staff about when he first raised his concerns about the missing plate. The Facility said that staff would not have immediately concluded that the missing plate had been swallowed, and that it was more likely to have been discarded with the laundry or rubbish.

In my opinion, the assumption by staff that the plate was more likely to have been lost than swallowed was understandable in the first instance. Furthermore, while Mr E says that he raised with the staff the possibility that Mr D might have swallowed his plate, the Facility advised that the registered nurse on duty has no recollection of this.

It is difficult for me to determine whether Mr E did in fact discuss this possibility with Ms J. Where a fact is disputed, I may consider that it happened if I am satisfied that it is "more likely than not" to have occurred. If the matter is evenly balanced, I am unable to determine the issue.

In this case, I would have expected a discussion about the size of the denture to have followed Mr D's request for an X-ray, and for Ms J to record that discussion in the notes. I would also have thought that if the family believed that Mr D had swallowed the plate, they would have followed up on that point later on 25 September. While Mr E may have told staff that he thought that his father might have swallowed his plate, I am unable to reach a conclusion, on the information before me, that Mr D mentioned this at 9am on 25 September.

Irrespective of whether or not staff should have appreciated the risk of swallowing the plate, when Mrs D visited on the afternoon of 26 September her husband still had no plate, and its whereabouts was unknown. This would not have inspired confidence.

I am satisfied that on 26 September, once Ms I accepted that there was a real possibility that Mr D might have swallowed his denture, appropriate action was taken.

Facial injury

On 26 September, Mr D sustained an injury to his forehead. Mr E described the wound as a deep laceration with bruising. However, the early shift nursing record, timed at 9am, describes the wound as a "small scratch". It was recorded as a "dry skin graze" at lunchtime. The afternoon nurse who cleaned and dressed the wound after Mrs D reported her concern that her husband's forehead was bleeding, noted that the "skin was hanging" and Ms I referred to a wound on the top of his head and to bruising. The nursing staff believed that the wound was caused by Mr D scratching rather than a fall. The inconsistency in the reporting of the skin tear to Mr D's forehead, in my view, does nothing to allay the concerns of the family that there was more than one injury. It reinforces the importance of good, consistent, record-keeping. I am not satisfied that the wound to Mr D's head was caused by his scratching alone, but I am unable to determine the cause of it.

Mr D told staff that he had sustained two falls. The staff recorded this in the notes, and appropriately assessed him. The Facility says that two falls could not have happened

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without staff being aware of it and reporting it, because Mr D was unable to get up unassisted. The Facility stated that staff concluded that Mr D was confused about when he had fallen. This was based on his inability to get up off the floor independently. I am satisfied that Mr D did not fall more than the one time that was recorded.

Lack of empathy in response to events
Mr E has said that there was a lack of empathy in response to these events.

At about 8.30pm on 27 September, Ms I returned his call. Following her discussion with him, she responded appropriately, personally reviewing Mr D, ordering half-hourly observations, documenting her actions, and arranging for an X-ray to be taken the next day. Ms I said that she told Mr D that she was sorry to hear his concerns and that she would set up a process to have his father checked half-hourly. She recalls "categorically" that she was "very apologetic and very conciliatory". However, Mr E was very angry and was talking rapidly, and Ms I was unable to interrupt easily.

The Manager, Mr R, spoke with Mr E the next morning. Mr R said that he could see that Mr D was upset and it was obvious that he did not want to be interrupted. Mr R let him talk and said that he would look into things and get back to him. Mr R prepared a letter, which he gave to Mr F when he collected his father on 27 September. In the letter to Mr E, Mr R addressed the concerns raised and invited him to meet with Ms I and himself. Mr R received a further message to telephone Mr E. Mr R returned the call and left a message that he would ring the following morning. When he rang Mr E on 28 September he said that he was sorry to hear the news that Mr D had swallowed his plate. He enquired after him. Mr R offered a meeting to discuss the family's concerns, but Mr D declined.

In my view, Ms I and Mr R took appropriate action to remedy and resolve the situation. However, I also acknowledge that Mr E felt that Mr R "at no point" expressed remorse or empathy, and did not enquire about Mr D's surgery or condition. It is impossible to know exactly what was, or was not, communicated here.

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Actions taken

The Facility and Ms I have provided written apologies to the family.

The Facility advised that changes have been made in the following areas:

- Personnel changes
- Systems improvements
- Communications skills
- Communication with families
- Management training

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Ministry of Health (HealthCert), and the District Health Board. The MOH and DHB will be asked to follow up the issues highlighted by this report and the changes made by the Facility in their next audit.

- A copy of this report, with details identifying the parties removed (except the name of my expert), will be sent to HealthCare Providers New Zealand and the Association of Residential Care Homes and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix 1

My name is Lesley Wynne Spence and I have been asked to provide a nursing opinion to the Commissioner on case number 07/17647.

I have read carefully the Commissioner 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) specialising in medical nursing.

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

I taught General Nursing for three 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 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 five years, I had the responsibility for Post graduate short courses which included courses in Gerontology (care of the Aged). It was the relevance of this knowledge that in 1996 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 care giving staff and see the benefits of their knowledge conveyed to the residents. I also developed skills in management which assisted in meeting the challenges of running a rest home.

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

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

Since then a further two rest homes, The Oaks Senior Care Centre (150 residents) and Palm Grove Senior Care Centre (118 residents) have been built and include long-term hospitals. Palm Grove was opened in December 2003.

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At this time, my role changed to Principal Nurse Manager with oversight of the three centres. Recently I resigned from this position and I am now acting as a consultant and relieving manager to Canterbury rest homes.

I am a member of:

- New Zealand Nurses Organisation
- New Zealand Association of Gerontology
- Healthcare Providers NZ (& Canterbury Branch committee 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 care assistants 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 care assistants
- Other rest homes seeking policy and clinical support.

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

EXPERT ADVICE REQUIRED

I have been asked to provide expert advice about whether Registered Nurse [Ms I] and [the Facility] provided an appropriate standard of care to [Mr D].

Background

[Mr D], aged 90 years, was admitted to [the Facility] on 16 September 2007 for two weeks of respite care. Until that time, he had been cared for at home by [his wife].

[Mr D] had a number of medical conditions. Of relevance to this matter is his frailty, cognitive impairment, history of bladder cancer with chronic renal failure and placement of a permanent indwelling catheter.

[Mr D] was resident in [the Facility] for eight days before his family took him home. During that time the family alleged that [Mr D] suffered the following:

> He pulled out his urinary catheter. This was not replaced for seven hours because none of the staff could replace it. He fell when he was left alone in the shower and swallowed his partial plate. This was not found for two days, despite the family asking about the denture and suggesting it could have been swallowed. No [X-ray] was taken.

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He had difficulty eating and drinking, became more confused and was said to have deteriorated considerably. There is no record of [Mr D's] fluid intake in his records.

He suffered several unrecorded falls, scratching his forehead, which was not treated until [Mrs D] asked for the wound to be cleaned and the dried blood removed. [The Facility] explained that [Mr D] scratched his forehead because it was itchy.

I have been asked to specifically comment on the following:

1. **The standard of care provided to [Mr D] by [Ms I] and [the Facility].**

2. **Whether [Mr D's] initial needs assessment and management plan was appropriate.**

3. **The management of [Mr D's] urinary catheter by [the Facility] staff.**

4. **[The Facility] acknowledged that [Mr D] should not have been left alone in the shower on 25 September 2007. To comment on the actions taken by the [Facility] staff after [Mr D] fell in the shower.**

5. **To comment on the actions taken by [the Facility] staff when [Mr D's] wife and son expressed their concerns about [Mr D's] missing teeth and suggested that he might have swallowed them.**

6. **To comment on the standard of documentation, in particular the accident/incident reporting and follow.**

7. **To comment on any aspects of the care provided by [Ms I] and [the Facility] that warranted additional comment.**

1. Standard of care provided to [Mr D] by [Ms I] (Clinical Manager) and the Facility.

I will comment here on the issues raised by [Mr E], one of [Mr D's] sons, in his formal complaint to the Health & Disability Commissioner.

Lack of standard of care — There are issues of lack of standard of care which are addressed in the report and summary.

Lack of appropriate supervision — [Mr D's] fall in his bathroom whilst being showered did arise from lack of supervision and this has been admitted and apologised for by Senior Management of the Facility.

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Falls — Only one fall can be definitely identified although the family believe he may have had three. I have addressed this under (4).

Missing denture and sore throat — The swallowing of the partial plate was the most significant incident in [Mr D's] hospital stay. While [the Facility] cannot be blamed for this, their follow-up response was inadequate and slow.

Injuries and general physical condition — Apart from the partial plate incident the only other reported injury to [Mr D] was the wound to his head. I have addressed this fully later in the report.

[Mr D's] presenting physical condition did cause distress to his family. It appears there were times he was not shaved. He was still in his pyjama top when visited on another occasion and the family describes him as being weak and dishevelled. Dr G, his GP, noted a significant decline when he visited him at home on the day he was discharged. While staff described him in some progress reports as "appears to be fine — nil problems" there is no doubt the family were observing a general deterioration; they state that "he walked in on admission day and 10 days later had to be carried out".

The family believes that this decline was due to [Mr D's] inability to eat and drink, although staff claim in several reports that he was eating and drinking a little and continued to take his medication. [Ms I] gave him a drink of water in the evening which he swallowed following [Mr E's] call expressing his concern.

I can also find no record in any of the [public] Hospital clinical notes that [Mr D] was dehydrated on admission which may indicate that he had sufficient fluids. An intravenous infusion was started on arrival at the hospital but this is standard practice for emergency admissions who are going to be undergoing surgery.

I believe, however, that [Mr D] did deteriorate significantly while residing at [the Facility] and this should be of concern to the Management and Clinical staff.

2. Whether [Mr D's] initial needs assessment and management plan was appropriate.

Documents provided which relate to [Mr D's] initial needs assessment and Management Plan which I have assessed.

16.09.07	Admission day progress notes	Unreadable signature
17.09.07	Potential resident enquiry	[Ms I]
17.09.07	Fax message from respite care programme with information about [Mr D] needs.	[Respite care co-ordinator]

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18.09.07	Fax message from respite care programme with an overview of the programmes management of the admission.	[Respite care co-ordinator]
18.09.07	Short overview of care form	[Mrs D]
18.09.07	Nursing care assessment including assessment for fall and pressure sore risk and nursing care plan	RN [Ms K]
20.09.07	Nursing care plan — Initial/respite	RN [Mr L]

It appears that there must have been discussions (not recorded) regarding [Mr D's] admission for respite care prior to 16 September 2007. It seems the original plan intended that he would be admitted on 18 September and most documentation begins at this point. Even [Mr E] in his complaint states his father was admitted on 18 September 2007. However, some event (not recorded) precipitated his admission on the afternoon of 16 September 2007.

The admission date has been confirmed with [Ms I] (Clinical Services Coordinator). The only evidence that the admission was on the 16th is in the very brief progress notes on that day. In a later discussion with … [HDC] [Ms I] explained that she normally does not accept admissions over the weekend as she likes to have new residents seen by the attending GP within 24 hours of admission. However, in this case [Mrs D] was stressed and tired and she needed some immediate relief so [Ms I] agreed to the weekend admission.

Curiously, the "potential resident" enquiry was not completed until the Monday, 17 September 2007. [Ms I] admits that she was extremely busy on Sunday, 16 September 2007 […] and although her memory is hazy about the events it is possible she completed and dated this form the day after admission.

Unfortunately there is no other record of [Mr D's] care on 17 September 2007, not even in the progress notes where no notes were recorded until the evening of l7 September 2007. These notes were written by a healthcare assistant and although they cover his care that evening there are literacy issues. On 19 September 2007 again there is only one entry in the afternoon, by the same healthcare assistant.

The first entry in the progress notes is by a registered nurse in the evening of 20 September 2007 — 5 days after admission; however Registered Nurses were completing assessments and a care plan during this period.

18 September 2007 — A Nursing Care Assessment was done which included risk assessments for falls and pressure sores. A full nursing care plan was developed from this information and from the respite care programme fax and [Mrs D's] report.

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20 September 2007 — A short-term care plan was completed. This plan is more concise than that for a permanent resident but is adequate for short stay residents. It is curious why this plan was completed when the full care plan was completed earlier.

Sufficient information was collected to provide good oversight of [Mr D's] care but it was collected late in his admission and one serious oversight was the lack of a clear description between a denture and a partial plate which had serious implications for [Mr D]. The assessment form did allow for this to be noted but the nurse completing this form failed to record it. It appears family were not involved in [Mr D's] nursing assessment, had they been the partial plate may have been more clearly identified as a problem. Best practice involves family or significant others in providing a health history for new admissions. However, it is fair to note that [the Facility] admitted [Mr D] earlier than they were prepared for, to meet the needs of [Mrs D] who needed urgent respite care for her husband.

[Ms I] states that residents' progress notes are not written in every day unless something extraordinary happens. I believe this is insufficient especially in the case of a new resident adapting to a new environment and at hospital care level. I also have concerns that progress notes are written by healthcare assistants for hospital level care residents. Tick lists are provided for recording daily care but [Mr D's] tick list was not included in the documents provided for my consideration.

Overall — The assessment and care plan did provide sufficient information for appropriate nursing care. However, it was not collected, collated and implemented early enough and the omission of not noting the partial plate caused serious outcomes for [Mr D]. The lack of early progress notes also did not paint a picture of [Mr D's] well-being or otherwise, or the outcomes of the nursing care being provided.

3. The management of [Mr D's] urinary catheter by [the Facility] staff.

It appears from nursing reports that [Mr D] pulled out his catheter prior to his shower time on Friday 21 September 2007. The care assistant described finding him with blood on his pyjamas probably due to the inflated balloon being pulled through the urethra — she advised the RN on duty and then showered [Mr D] and put a continence pad on him. She reported that he did not appear to be in pain and that she checked him two-hourly. He had no distension of his abdomen, but did not appear to have passed urine.

The RN on duty reported that she checked [Mr D's] pad, found minimal blood on it and no urine but called his son [Mr F] who was the Next of Kin identified on the admission form and advised him what happened.

In discussion with [Mr F] about how to proceed, the R.N. in her assessment said that [Mr D] was comfortable and may in fact pass urine without aid. I could find no directions in admission information which required the catheter to be inserted within two hours and as it was not a suprapubic catheter (which requires a quicker insertion)

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then the nurse's decision, subject to careful monitoring of [Mr D's] abdomen, which was done, seems reasonable.

The decision was made in consultation with [Mr F] to monitor [Mr D] until approximately midday and then follow up with the GP.

[Mr E], another of [Mr D's] sons states he visited at approximately 1.30pm and was told about the catheter. He states, "When I arrived it was apparent that no arrangements had been made with our family GP and as there were no doctors on the ward, or nursing staff able to [re-insert] a catheter I was left with no option but to attend to the necessary arrangements myself. I finally managed to arrange for a district nurse … to attend and the catheter was finally replaced at approximately 4pm."

The Registered Nurse on duty recalls she suggested she phone the GP but [Mr E] told her the District Nurse generally dealt with the catheter and that he would arrange for the District Nurse to do this. In the RN's report she says that staff felt that [Mr D] was not concerned about taking responsibility for this call.

It appeared that he had her cell phone number so it seemed appropriate to the RN for him to ring her.

The District Nurse was prompt and [Mr D] was catheterised by 4pm that day. 300mls of urine was drained, an amount which would not have caused [Mr D] undue discomfort. Providing no distension was evident, the seven hour period was not of serious concern and actions were being taken to remedy the problem.

The catheter remained in place and functioned well throughout the rest of [Mr D's] stay.

[Mr E] also raised the concern that the continence pad had not been changed. Staff report they checked it regularly and as there was minimal drainage, it may not have been necessary to change it in this time frame. Continence products have a wide range of absorption capacity and some can contain up to 1000mls and still keep a dry surface.

It is regrettable that there can be confused communication when several concerned family members are involved with the care of their relatives. This appeared to have occurred that day.

However, from reports given by nurses and healthcare assistants, I believe the catheter management met safety and comfort standards for [Mr D] on this occasion.

4. Comment on the actions taken by [the Facility] after [Mr D] fell in the shower.

Prior to 9am on 25 September 2007, [Mr D] had a fall in the shower. The healthcare assistant had been assisting him when she was called away. When she returned she found [Mr D] on the floor of his en-suite. She immediately called the RN who

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assessed him and found no injury. All of his vital signs were within normal ranges and he was not complaining of pain. I am unsure as to what time [Ms I] also thoroughly checked [Mr D] and could find no cause for concern (she reported that she had done so to the Health & Disability officer who interviewed her).

Shortly after the fall, [Mr E] arrived to visit his father, he was advised of the fall and the fact that [Mr D] appeared uninjured. However, on discussion with his father he said that he was complaining of a sore throat and that his partial plate was missing. The RN on duty that morning does not recall [Mr E] saying the plate was missing, only that his father had a sore throat.

Later that morning the house doctor, [Dr H], at the request of the registered nurse, assessed [Mr D] both for his sore throat and whether there were any injuries post fall.

He found [Mr D] alert, and with normal vital signs and no evidence of head trauma. His writing is difficult to read but there is a note which I have interpreted to state "throat/assessed OK". His diagnosis reads — no ill effects of fall, review as necessary.

Staff actions following fall: The RN correctly assessed [Mr D] following his fall, his vital signs were within normal ranges and he had no visible injury. Perhaps because they felt concern that [Mr D] had been unsupervised in the shower when he fell they decided to provide additional assessment and asked the house doctor also to see him.

An Incident report was written stating that a workman noticed [Mr D] on the floor between his bathroom and room and called for help. The healthcare assistant pressed the emergency bell and the R.N. came and assessed him before he was lifted on to his chair.

Mr E was informed when he visited shortly afterwards and [Mr F] at about midday by telephone.

Both [Mr E] and [Mrs D] expressed concern that [Mr D] fell on other occasions.

Staff doubted this as he was unable to get to his feet without assistance. No staff had been required to assist him. [Mr D] himself did say he fell in the corridor while he was with his son, but neither son reported this.

I can find no evidence in any reports that [Mr D] had any falls apart from the fully reported one on the morning of the 25th September 2007 and [may] have to assume that [Mr D] was confused about the number of times he fell.

In regard to [Mr D], a frail, elderly, unstable, confused man being left unsupervised in the shower, this is definitely not safe nursing practice and I do not condone the healthcare assistant leaving him alone in the room for whatever reason.

[The Facility] staff fully acknowledge this and have stated their sincere regret about this incident in their report to the Health & Disability Deputy Commissioner.

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5. Actions taken by [the Facility] staff when [Mr D's] wife and son expressed their concern about [Mr D's] missing teeth and suggested that he may have swallowed them.

A full nursing care assessment was completed on 18 September 2007 which indicated [Mr D] had a lower partial plate.

Curiously a respite care plan (a shorter version was completed on 20 September 2007), in this plan — a lower denture was recorded although as "plate" is not deleted it is not clear which artificial teeth [Mr D] had. I can only assume that this second assessment was completed because the RN on duty on 20 September 2007 was unaware for whatever reason that another assessment had been done. Staff then had a choice of either plan to refer to [which] could have caused confusion.

On the morning of 25 September 2007 following a fall [Mr D] was visited by his son [Mr E] who was understandably concerned about his father's fall but also reported that his father had a sore throat and a missing partial plate. Staff dispute that [Mr E] mentioned to missing partial plate at this time.

The R.N. on duty asked the house doctor to see [Mr D] and advised him of the fall and the sore throat.

[Dr H], the House Doctor, carried out the examination, found no injuries from the fall and stated (although his writing is difficult to read) "throat assessed, OK".

In his letter to the Health & Disability Commissioner [Dr H] has said that he was asked to see [Mr D] for two reasons; the fall, and because he was complaining of a sore throat. He was [not] informed that there was a missing partial plate.

The RN that morning reports the fall, an incident form was written. In the progress notes she states she monitored [Mr D] for pain (although she doesn't say where) and notes he said he had none.

She also asks staff to search for [Mr D's] bottom dentures at the request of [Mrs D] who visited later in the day. A search was carried out but the denture/plate could not be found.

Staff appeared not to consider it possible for [Mr D] to have swallowed his teeth. Some staff thought it was a denture therefore he could not have swallowed it.

The two assessments shortly after admission differ in the recording of teeth, one indicates a partial plate, the other indicates it could have been either.

Following the initial complaint of a sore throat on 25 September, [Mr D] was asked on several occasions whether his throat was sore and he stated that it wasn't. Staff reported that he continued to take his medication and that he was eating and drinking a little.

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Although there is infrequent reporting of his catheter drainage, what was reported appears satisfactory which may indicate he was receiving sufficient fluids to drink. [Mr D's] general decline, is of concern as is the family's statement that he was deteriorating and not being cared for and had lost the ability to walk. This prompted [Mr E] to call [Ms I] (director of Clinical Services) on the evening of 26 September to express his concerns about his father's:

- lack of standard of care
- lack of appropriate supervision
- falls
- the missing denture and sore throat
- injuries and general physical condition

Of most concern to him was the missing denture and a wound on [Mr D's] head which he felt was caused by a fall.

Although [Ms I] had commenced leave that day, she decided to return to the hospital and carry out a complete assessment of [Mr D] and his care.

She checked his throat with a torch and asked about pain and could find nothing of concern. She asked him about falls and he said he had a fall when walking down the corridor with his son. This could not be substantiated.

She telephoned RN [Ms J] to check the history of the head wound which the RN said she believed was a scratch because [Mr D] had said his head was itchy. Staff could not see how he could have fallen as he was unable to get to his feet by himself.

She had agreed with [Mr E] that an X-ray would be provided first thing in the morning and the [Facility] would pay the cost of it. She instigated 15 minute checks of [Mr D] throughout the night. This indicated that he slept almost constantly from 9.20pm to 6.45am.

At 8am he was assisted with breakfast and took an "average" amount. During the morning he was washed and changed and shaved. The dressing on his head was done, the nurse noticing only superficial skin grazed off. The portable chest X-ray was done at 12 midday and [Mr D] was discharged shortly afterwards to his home.

At approximately 2pm, [Dr G] visited [Mr D] at home and advised the family that the missing partial plate had been found by the X-ray taken lodged in [Mr D's] cricopharynx and he was immediately transferred by ambulance to [public] Hospital where later that evening an oesophagoscopy was performed and the plate extracted.

Despite pulling out his nasogastric tube inserted at the time of surgery he recovered quickly and was eating and drinking by the next morning. The doctor commented he looked well. An occupational therapy assessment was done to determine what aids might be appropriate for his care at home and he was discharged to the care of his wife.

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Additional home care had been organised previously to assist [Mrs D].

In the light of two family members expressing concern about the missing partial plate and [Mr D's] sore throat and general deterioration, I believe staff at [the Facility's] actions lacked thoughtfulness and professional insight and further investigations should have been made of the missing teeth and [Mr D's] general deterioration.

6. Standard of documentation, in particular accident incident reporting and follow up.

I have made some comment about documentation in my notes about [Mr D's] care planning but wish to add the following:

Overall [the Facility] appears to have good frameworks for collecting and conveying nursing information. However, I have the following concerns:

Progress Notes — were not written in every day. At hospital level of care I would consider at least one entry should be made even if there were no concerning incidents about the resident that day. There was a serious lack of documentation about [Mr D] for the first five days of his admission in the progress notes and two entries were made by healthcare assistants.

My opinion is that at hospital level of care, a progress note should be written by a registered nurse on each resident every day. Assessment included an overview of [Mr D's] personal care needs plus risk assessment for falls and pressure sores. This met standards apart from the omission of identifying the partial plate which may have been due to the nurse completing the form not having access to a family member as [Mr D] himself was a poor historian.

Care Plan — A short respite care plan was developed from the assessment and was adequate even if superficial in content, it is fair to comment that many providers of respite care do have a shortened form of care plan for short stay residents. A full care plan takes time to develop and by the time it is complete the short stay resident may well be nearing discharge.

The full care plan provided a good overview of care but its implementation was not timely enough.

At [the Facility], [Ms I] has now decided that in future all short stay residents will have full care plans written.

7. Accident incident reporting

Three reports were provided.

25 September 2007. Initially completed by [Mr P], a healthcare assistant, who was first on the scene after [Mr D] fell. The report describes how she reported the fall

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immediately to the R.N. on duty who assessed [Mr D] for injuries, found none and then assisted him to his chair. The registered nurse describes in her actions that she advised the house doctor and asked him to see [Mr D] and informed the family of the accident.

A follow-up report on this same form on 26 September comments on a call from [Mr E] who rang in with several concerns about his father's care:

- that he had more falls
- that he has a wound on his head
- that he has a painful throat

This report was written by [Ms I] and the progress notes describe the care she put in place following this.

26 September 2007. This report completed by an RN describes how she found [Mr D] with a small scratch and a little blood on his head at 8.00am. [Mr D] told staff it occurred because he scratched his head because it was itchy. The report states it was cleaned and moisturised, presumably the moisturising was around the site to reduce the itchiness. The wound and care was also noted by [another R.N.] who was assisting the R.N. with medication rounds.

The third report, also on Wednesday 26 September 2007, describes how the nurse at 12.30pm found the wound again needing treatment but as it was lunch time, planned to go back after lunch to clean and dress it. Unfortunately she forgot to do so and was confronted by [Mrs D] in a distressed state who had come in to visit and found her husband with dried blood on his head.

The nurse describes trying to comfort [Mrs D] and taking her back to her husband's room to clean and dress the wound, this time putting a steri-strip on it.

The incident/accident reporting in regard to the wound appears satisfactory although family members do have differing views as to how the wound occurred. Staff are consistent in their reports that it was not caused by a fall, as it would have been necessary for [Mr D] to be assisted to his feet as he could not stand up by himself. The written accident/incident report of the one known fall would meet Standards.

Overall — no documentation exists to demonstrate the nursing care [Mr D] was receiving apart from the briefest comments which were irregular in the progress notes. I have noted that tick lists are used which may indicate the personal care given but these were not included.

I am concerned about the lack of progress notes, which are useful for many reasons, but especially for painting a picture of a resident's well-being on a daily basis, and also the slowness with which the nursing care plan for a short stay resident was completed.

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8. Additional comments

Head wound — Although not asked to comment specifically on the head wound [Mr D] suffered, it was of concern to the family.

Two RNs administering medications at 8.00am on 26 September 2007 found [Mr D] with a small scratch and a little blood on his forehead. They asked him what happened and he told them that he had scratched it because it was itchy.

According to the report it was cleaned and moisturised. At 2pm that afternoon [Mrs D] visited and was very distressed by her husband's state; the bleeding head wound, his statement that he had fallen, his general debility and the lack of a shave.

The RN had noted "the graze" was bleeding again at 12.30pm but, as she was serving lunch, planned to go back and clean it later.

In responding to [Mrs D's] distress she returned to [Mr D] with her and cleaned and steri-stripped the wound. She described the skin as "hanging" and found it necessary to apply a very thin strip of sterile adhesive tape (a steri-strip) across the wound to hold the skin in position. She then covered it with dry gauze.

All this time another care assistant was shaving [Mr D].

The written incident reports (2) over the day vary in describing the significance of the head wound — a scratch, a graze and hanging skin. [Ms I] described it as being about 1 inch long. It did appear to have treatment early in the day and it may have been bumped or scratched again to cause more bleeding about lunch time.

While recognising staff are busy at meal times the staff member who observed the wound should have attended to it or reported it to the person responsible for wound care that day.

[Mr E] describes the wound as a deep laceration with a bruise but I can find no evidence that the wound could be described with this intensity.

It is likely that if it was a serious wound it would have been noted in the clinical assessment at [public] Hospital but it was not mentioned.

Head wounds do tend to bleed freely and even the blood loss from a minor head wound could cause distress to a family member especially if it was not cleaned in a timely manner.

Summarising comments

I believe there have been significant issues of omission in [Mr D's] care at [the Facility].

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1. The needs assessment and care plan was not completed in a timely manner for a short stay resident, although good quality frameworks were available to ensure this could happen.

2. Insufficient progress notes were written to record his care and well-being and for all staff to be effective in responding to his needs.

3. No frail, demented, unstable hospital resident should ever be left alone in a shower where the obvious hazards of hot water, slippery floors and falls exist.

   This lack of supervision and the resultant fall could have had serious implications for [Mr D].

4. Staff were not pro-active in acknowledging the family's concern about the missing plate/dentures, his general decline and difficulty in eating and drinking over the period of his hospital stay.

   His general decline should have triggered the staff to instigate further investigation prior to [Mr E's] insistence that something be done.

   I acknowledge that [the Facility] was new; the manager was especially busy, promoting the Centre, admitting new residents, employing staff and establishing policies and procedures. However, this [Facility] is one of a group with significant experience and understanding of the Health & Disability Standards required (and have met these standards in other [facilities]). These standards require that older people in residential care should expect safe environments and skilled care.

   Regretfully [Mr D] did not receive a satisfactory level of care in regard to documentation, protection or insightful and proactive nursing, and I would have to view [the Facility] and [Ms I's] care of him with mild to moderate disapproval.

Lesley Spence"

Further expert advice

"I have been requested to review my original advice regarding the above complaint in response to [the Facility's] letter to Rae Lamb, Health & Disability Commissioner of 25th July 2008.

There has been some delay as I have been overseas and I apologise for this.

The report is written in two parts: Part one — My response to the [Facility's] letter; Part two — Comment on the key responsibilities of the Clinical Manager and how, if at all, she departed from these responsibilities.

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Part One

I have responded to most points made in numerical order.

1. & 2. Admission Date

The admission date was confusing and was made so by two documentation of date errors and a report from [Ms I] in which she describes [Mr D] being admitted on the 16th September.

In the admission day progress notes in the date column it is clearly stated 16th September 2007. On the header on the right-hand side it appears to be changed from 16th to 18th September 2007. On the cover page of the admission day progress notes it indicates the day of admission as 16th September 2007.

i. Statement taken from [Ms I] on 6th March 2008 (see page 3 of HDC provisional report) by the Health & Disability Commissioner investigator, who after discussions with [Ms I] confirmed that [Ms I] did not normally admit residents over the weekend but some events required that [Mr D] needed care so she agreed to the admission. It now transpires that [Ms I's] memory of events is hazy, understandably so because she was particularly busy over that weekend and she was mistaken about the date of [Mr D's] admission. She now agrees it was the 18th September.

2. Discrepancy not followed up

i The discrepancy was noted and followed up by a call to the Health & Disability Investigator who I understand again clarified the date with [Ms I] and reported back to me.

3. The date on my copy of the cover page of the admission day Initial progress note is clear (not blurred) — 16th September 2007 and also in the date column — also 16th September 2007.

4. Progress Notes

The first entry in the progress notes now noted to be on admission day 18th September 2007 is signed but I found the signature unreadable and there was no designation. It was superficial and gave little information about the state of the new resident or instructions for staff so it was possible to assume it was written by a health care assistant.

The next report neatly signed and with the designation of health care assistant was not written until 1920hrs (7.20pm) the following day (19th September 2007). It did indicate [Mr D] was confused and unsettled.

The next evening, 20th September 2007 the report was written at 2230hrs (10.30pm) and described [Mr D] as wandering and had climbed over his cotsides. The registered nurse recording this also noted that the cotsides were to be left down.

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The report following this (just stated as pm) describes [Mr E] signing consent for cotsides. This report also describes [Mr D] climbing out of bed despite the cotsides and the Registered Nurse deciding it was safer to leave them down.

The reports on this day appear out of order. However, the content was important and it is better recorded even if added later.

From this point the progress notes did improve although there was no notation on the 24th September.

Progress notes provide a picture of the resident's 24-hour well-being and should highlight any changes of condition or care. For example, the brief admission note contained no information about:

- family members being present;
- catheter care;
- [Mr D's] level of dementia;
- his mobility and risk of falls or any safety issues;
- personal likes and dislikes e.g. food;
- baseline recordings (these were not recorded in the assessment either);
- family relationships — or anything relevant which will assist staff to develop a trusting relationship.

This information is important for the resident's safety until a care plan can be completed.

Another way is to have a one-page quick to record checklist which covers all safety issues for the first 24 hours. This can be displayed in a prominent place and will keep the resident safe until time allows a fuller care plan to be written.

5. The Nursing Care Assessment

The nursing care assessment contained information which could be interpreted as planning and it appeared to be duplicated. However, I did indicate that apart from the discrepancy of recording the plate and dentures inconsistently and no information about the catheter, I believe the care planning met acceptable standards having sufficient information to guide staff in [Mr D's] routine care.

There are always difficulties with short stay residents having information available in a timely manner. [Mr D's] care plan was not completed until two days after admission on 20th September 2008.

In my previous comment I have indicated a way of improving resident safety over the first 24–48 hours.

6. Re: Swallowing of Plate

The nursing care assessment completed on 18th September 2007 indicated [Mr D] had a plate. The initial respite care plan completed on 20th September 2007 only indicated lower dentures.

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While it may not have initially seemed relevant to consider [Mr D] had swallowed his plate, the fact he had a sore throat and both [Mr E] by his account on the morning of the fall 25th September 2008, and [Mrs D] in the afternoon indicated to staff that he may have swallowed his plate should have alerted the staff to investigate.

[Dr H] is clear in his letter he was not told about the missing plate.

Glaring errors

I am concerned about [the Facility's] concerns and dismay about "glaring errors" in my report. These arose from inaccuracies in their staff's documentation.

[Mr D's] general decline

My responsibility in this work is to take complaints seriously and also to take cognisance of information/documentation about the complaint from [the Facility] and to treat both thoughtfully.

I used [Mr E's] full report of incidents and summary of his feelings by the statement "that his father walked in on admission and had to be carried out 10 days later".

I also took into account [Mrs D's] concern and distress noted in [Mr E's] report and in the progress notes of 26th September 2007. If [Mr D] did not deteriorate during his stay at [the Facility], why was [Mrs D] so distressed when she visited and why did she also telephone her son [Mr E] still distressed to tell him her husband was dishevelled and unshaven, not walking or eating and drinking?

I also note in the [Facility] response to the Health & Disability Commissioner's provisional report about [Mr E's] complaint that the family perceptions were highly coloured by their dissatisfaction with [the Facility] and this influenced and intensified the nature of the complaint.

Should consideration been given to the fact that the family felt they had reason for this dissatisfaction?

7. Daily Notation in progress notes

I spent a great deal of time reading and analysing my first report and considerable time responding to your [Facility's] current concerns.

With your [Facility's] clarification, I acknowledge the progress notes did in fact start on the 18th September 2007, the date of admission. I remain concerned about their early brevity where staff needed clear directions about [Mr D's] care until the care plan was complete, and in some places where there was lack of advice to staff particularly in reminding them to monitor [Mr D] for falls. My carefully considered opinion based on experience remains the same that at hospital level care there should be an RN notation on every resident, every day. If there are few or no changes, a brief note could indicate this.

Staff can be assisted to learn to make brief notes which "paint a picture" of the resident's well-being or otherwise, eg:

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- enjoyed participating in activities this morning;
  (This short statement indicates the resident was up in time for activities, bright enough and feeling physically well enough to enjoy them.)
- noted by care assistant to be disinterested in food 12md.
  (While one notation of this type may not be of concern, daily notes may reveal a pattern for investigation.)

I encourage you [the Facility] to implement RN daily notation. It will provide your residents with safety and your nursing staff professional security.

8. [Facility] Standards of Care

   In regard to the comment that I implied that [the Facility] should meet higher standards than the norm, I did not make that comment.

   My comment "this [facility] is one of a group with significant experience and understanding of the Health & Disability Standards required".

   A copy of the Audit of [another facility] was included to demonstrate this point.

   I also note in the Clinical Manager's job description:

   In the Primary Objectives is the statement "To ensure excellent quality of care" is provided to all residents and clients.

   I believe [the Facility] would want public perception to be that of attractive facilities offering "excellent quality care".

9. An omission

   Although I noted this earlier I did not include it in my first report.

   In [the respite care co-ordinator's] faxed letter to the Clinical Manager of 18th September 2007 he clearly laid out all the conditions of admission for [Mr D]. One of these indicated that he must be medically admitted by the House Doctor. I can find no documentation to show this was done. However, I believe this to be best practice and may have had some influence on the outcomes of [Mr D's] care.

Part Two

[Ms I], Clinical Manager, [the Facility]

In the request from the Health & Disability Commissioner to review my opinions about the [Mr D] complaint I was also asked to advise on the key responsibilities of the Clinical Manager and how if at all she departed from those standards.

The Clinical Manager's job description is extensive and clearly identifies her role.

Her Primary Objective:

To co-ordinate the efficient day-to-day running of the Hospital/Rest home, to ensure excellent quality care is provided to all residents and clients, in liaison with the [Facility] Manager.

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Of the 14 key responsibilities in her independent role the following relate directly to the issues raised in the current complaint.

1.1 Organise the delivery of nursing care, which is directed according to Nursing Process ensuring all care is assessed, planned, implemented and evaluated to meet the needs of individual residents.

1.2 Co-ordinate the work of Registered Nurses and Care Assistants to ensure the accurate documentation of each resident's needs and levels of care by the use of Nursing Care Plans (adherence to "Nursing Care Plans" Protocol) and the precise documentation of all other nursing records, incident reports and medication records. This includes the ongoing assessment of each resident's care needs/goals, and the implementation and review of the resident's written care plan at regular and appropriate intervals; resident assessment on admission, when the resident's health status or level of dependency changes and at least at six-monthly intervals. Development and review of the resident's care plan is undertaken in consultation with the resident and family/whanau.

1.3 Provide support, guidance, assistance and direction for all Registered Nurses and Care Assistants to implement care instructions as detailed in the resident's nursing care plan, and ensure they deliver safe, effective, high quality care.

1.4 Act as an advocate for each resident and ensure each resident is aware of their rights regarding treatment offered and care and services supplied.

…

1.6 Liaise with residents' families, ensuring continuous contact and sharing of appropriate information.

The [Facility's] response to the provisional opinion describes in detail the support given to new staff during the establishment of a new [facility].

It also describes [Ms I's] orientation and clinical management support and workload, denying that she played a large role in support of the opening and selling of [the Facility]. It describes the Clinical Manager's support to ensure she was able to be effective in her own role. This then should have ensured that [Ms I] was free to meet the day-to-day responsibilities of her role of Clinical Manager during this busy period.

[The Facility] also identifies that it is entirely appropriate for a Clinical Manager to delegate nursing tasks to properly trained and orientated registered nurses which I agree with. However, the staff were new, the residents were new, the building was new and everyone was learning new roles and responsibilities. This made [Ms I's] clearly defined responsibilities of orientation, supervision and education of her staff more

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intensive and required a tight day-to-day oversight of residents. It also required her to monitor the documentation.

In any retirement village the development of a trusting relationship with families is paramount. In the [family's] case this trust was not established early because in their view concerns were not always acknowledged or acted upon in a timely manner.

[Ms I] herself admits she had not spoken to [Mr E] until the 26th September, nine days after admission, by which time there were serious tensions with the family's perceptions of the nursing care. I acknowledge that the records required staff contact with [Mr F] but it seems it was [Mr E] who was expressing the concerns and who [Mrs D] was referring to with her worries.

I am sure [Ms I] believed she could safely delegate many of these tasks. However, [Mr D's] nursing experience has indicated that staff were not totally ready for the responsibilities they were being given.

This was demonstrated in [Mr D's] care by:

- an unsupervised fall;
- a missing denture and sore throat;
- a wound left uncleaned and bleeding;
- lack of personal care — shaving and dressing;
- insufficient documentation — progress notes, falls reporting, description of skin tear, catheter care;
- a deteriorating relationship with family;
- his general condition in decline.

I am mindful of [Ms I's] workload (despite the support she was given) in establishing the clinical nursing requirements of this new rest home and hospital but remain concerned about the oversight of her staff and residents and in particular [Mr D] over this ten day period.

I have taken into account the errors in the admission dates and how it affected my interpretation of the documentation but believe improved progress note reporting may also have improved the outcomes for [Mr D] along with more attention to the deficiencies in care listed above.

I have given the "[Facility] response" to the incidents and issues long consideration and continue to have similar concerns to that in my first report. More support and direction from [Ms I] to her staff to provide proactive and insightful nursing to [Mr D] and his family would have had much improved outcomes.

Despite [the Facility's] response to the Spence report and the Health & Disability Commissioner's provisional report, the fact remains that [Mr D] had a nursing experience which was borderline in meeting safe nursing practice, and certainly did not provide a comfortable hospital stay for him.

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I am of the opinion that whilst each individual incident would not be viewed as very serious, the collective management of these incidents did not reflect best practice and would lead peers of [Ms I] and [the Facility] to view their actions with some disapproval.

Lesley Spence"

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