Capital and Coast District Health Board

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00187)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. In 2016, Mrs A was transferred to Hospital 1 for the ongoing treatment and management of lymphoma.[1] Numerous staff provided care to Mrs A, including specialists and nurses.

2. A Patient Admission to Discharge Plan (PADP) was not completed for Mrs A on the day of her admission. Some parts of the PADP were completed on Day 3[2] but other parts were incomplete. A PADP includes risks assessments for falls and delirium[3] and an individualised Patient Care Plan.[4]

3. From Day 4 to Day 8 Mrs A's condition deteriorated. There were a number of indicators that Mrs A was at risk of falling, including a falls risk assessment, references to fatigue, breathlessness and disorientation, and a need for assistance. This information was recorded in various documents, but the Patient Care Plan and falls and delirium assessments were not completed regularly.

4. At 6.20am on Day 9 Mrs A fell and hit her head. There were no visible injuries apart from redness on the back of her neck. She was reviewed by a doctor at 7.40am but did not have a full assessment until 9.40am. During this assessment the haematology registrar noted a small skin laceration and bruising, and ordered a CT scan.

5. At 12pm a physiotherapist recorded that Mrs A was displaying some confusion and that her neurological condition was worsening. The house officer agreed that there were new symptoms.

6. At 1pm a CT scan was performed, and at 1.30pm Mrs A was examined by a consultant haematologist. Mrs A's fall and her condition were discussed with her family for the first time since the fall. The family were advised that it was likely that Mrs A had central nervous system (CNS) lymphoma and that her prognosis was poor.

7. Mrs A's neurological status continued to deteriorate, and at 2pm she was recorded as "virtually unresponsive". Neurological observations were taken during the afternoon and she was reviewed by a number of health providers. Apart from a brief entry by the nurse who took Mrs A for the CT scan, there were no nursing entries in the progress notes until 4.05pm.

8. Mrs A received ongoing care at Hospital 1, and died on Day 12.

[1] Lymphoma is cancer of the lymph nodes.
[2] Relevant dates are referred to as Days 1–12 to protect privacy.
[3] Delirium is a state of mental confusion.
[4] A Patient Care Plan is "an individualised plan to guide the care required by the patient each shift. This plan must be updated each day or more frequently if the plan of care changes".

Findings

9. Capital and Coast District Health Board (CCDHB) did not complete a PADP on the day of Mrs A's admission, and subsequently did not update the PADP accurately. In addition, following Mrs A's fall, full assessments of her condition were not completed adequately, her changing condition was not monitored accurately, and there was an unacceptable delay in communicating with the family regarding the fall. Accordingly, CCDHB failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

10. In response to the provisional decision, CCDHB advised HDC that it has conducted regular audits of staff compliance with PADP documentation, and that significant improvements have been made to staff training on the completion of PADPs.

11. CCDHB also advised HDC that it will review the way in which the use of the PADP documentation can support staff to assess an individual patient's needs and recognise deterioration.

12. The Deputy Commissioner recommended that CCDHB provide HDC with the outcome of its review, and provide a letter of apology to Mrs A's family.

Complaint and investigation

13. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her late mother, Mrs A, by Capital and Coast District Health Board (CCDHB). The following issue was identified for investigation:

- *Whether Hospital 1 (Capital and Coast District Health Board) provided Mrs A with an appropriate standard of care in 2016.*

14. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

15. The parties directly involved in the investigation were:

Ms B	Mrs A's daughter/complainant
Capital and Coast District Health Board	Provider

Also mentioned in this report:

Dr C	Haematologist

16. Further information was received from the Coroner.

17. Independent expert advice was obtained from a nurse consultant, Dr Jane Hardcastle, and is included as Appendix A.

Information gathered during investigation

Admission to Hospital 1 — Day 1

18. On Day 1, Mrs A was transferred to Hospital 1 from Hospital 2 for ongoing treatment and management of lymphoma. She was admitted to the ward and placed under the care of the haematology team. Mrs A received specialist care from the haematology, medical oncology, radiation oncology, radiology, pathology, and physiotherapy teams. In addition, from Day 1 to Day 9, 14 nurses provided care to Mrs A.

Handover documents

19. Hospital 2 did not provide any formal handover documents to Hospital 1. However, Hospital 2 did provide its admission notes, which document that Mrs A was lightheaded and that she had "fatigue++". The Hospital 2 Discharge Summary was also provided and included a patient transfer summary from the Intensive Care Unit (ICU) to the ward, which stated that Mrs A had a high falls risk. Nursing notes from Hospital 2 were also provided, and these record that Mrs A had a high falls risk.

20. The CCDHB Serious Adverse Event Report (SAER)[5] stated:

> "[A] copy of [Mrs A's nursing] notes from her admission to [Hospital 2] plus the discharge summary were supplied at the time of transfer and it can be suggested that this could have been referred to, to ascertain the patient's state of health prior to transfer."

Patient Admission to Discharge Plan Policy

21. CCDHB's Patient Admission to Discharge Plan (PADP) Policy (the Policy) states that a PADP consists of a number of risk assessments and a Patient Care Plan. The Policy states that a PADP is a "comprehensive tool to assess, plan and evaluate care and is aimed at achieving agreed outcomes and goals of the patient". The Patient Care Plan is described as "an individualised plan to guide the care required by the patient each shift". The policy states that the "plan must be updated each day or more frequently if the plan of care changes".

22. The Policy also states that a risk assessment for falls is to be completed within one hour of admission to the ward, and a delirium risk assessment and a Patient Care Plan are to be completed within eight hours of admission.

[5] Following the receipt of a complaint, CCDHB conducted a review of Mrs A's care. A Serious Adverse Event Report (SAER) was completed.

PADP on Day 3

23. On Day 3, a PADP for Mrs A was started but not completed. The incomplete PADP recorded that Mrs A was assessed for the risk of falls and delirium, and that a Patient Care Plan had been completed.

Falls risk assessment

24. The falls risk assessment tool in the PADP contains 10 items. Four of the items in Mrs A's PADP were ticked clearly: (1) Slipped, tripped leading to near miss fall in the last 3 months, (2) Mental status — agitated, confused, signs of delirium, depression or dementia (3) Fear of falling and (4) Sensory deficit — vision or hearing impairment, altered peripheral sensation.

25. A fifth item — "Neurological changes or condition" — was also ticked. However, underneath the entry there is a cross, followed by the annotation "medical weakness and [shortness of breath]". CCDHB has not provided an explanation of this entry.

26. A further item in the falls risk assessment tool — "[m]obility and gait problems or use of mobility aids" — had been ticked, but the tick box had two horizontal lines through it. CCDHB has not provided an explanation of this entry.

27. The item "medication effects" was not completed despite the fact that Mrs A was receiving six medications at this time. The box next to the item "No risk identified" had a cross through it. The SAER stated that "No risk identified" meant that there was "no risk" of a fall.

Delirium risk assessment

28. In the delirium risk assessment, the "aged 65+" item was marked with a tick, and the "Severe illness (a clinical condition that is deteriorating or is at risk of deterioration)" was marked with a cross. The other items, including the "No risk of delirium" item, were not marked.

29. Other sections of the PADP, including resuscitation status, health passport, advanced care plan, family violence screening, and estimated date of discharge, were not completed.

Patient Care Plan

30. The Patient Care Plan entry for Day 3 records that Mrs A required the assistance of one person to carry out the activities of daily living, and supervision for mobility. A section of the Patient Care Plan enabled the person filling it out to identify whether there was a falls risk, by ticking "Yes" or "No". However, this section was not completed on Day 3.

Assessment and documentation between Day 4 and Day 8

Day 4

Progress notes

31. The progress notes dated Day 4 record that during ward rounds Mrs A was lethargic and short of breath. Frusemide[6] was administered, but a fluid balance chart was not completed.

Patient Care Plan

32. The Patient Care Plan, completed on Day 4, identified that Mrs A required "assist x 1" to meet activities of daily living and mobility, and that she was "weak +++". The falls risk "Yes" section had been ticked, but had a horizontal line through the tick. CCDHB has not provided an explanation of this annotation.

Day 5–Day 8

33. On Day 5, the progress notes state that Mrs A required assistance with mobility and activities of daily living, and that she was short of breath and felt dizzy when she was walking.

34. Over the next few days, Mrs A was noted to be unsteady when she was mobilising.

35. On Day 8, Mrs A commenced chemotherapy.

Fall — Day 9

36. At 6.20am on Day 9, Mrs A got out of bed to go to the bathroom. She fell and hit her head. The fall was unwitnessed.

37. A registered nurse heard Mrs A calling out and found her lying on the floor near her bed. At 7.15am, the nurse recorded in the progress notes that Mrs A said that she had been feeling light-headed. The nurse noted that Mrs A appeared to be orientated and alert, and that she reported no pain. Mrs A's observations were stable, and there were no visible injuries apart from redness on the back of her head.

38. A falls sticker was completed and attached to the progress notes. The sticker recorded that Mrs A's next of kin had not been notified.

39. At 7.40am, Mrs A was reviewed by the night medical house officer. The doctor recorded: "[Mrs A] hit [her] head on the floor, but [suffered] no loss of consciousness. Nil other obvious lacerations." A full assessment was not completed because the doctor was required to attend to an emergency.

40. At 9.40am, a haematology registrar performed a thorough examination and recorded his findings in the progress notes. A small skin laceration and bruising in the occipital[7] area

[6] Frusemide is a medication that increases the volume of urine output to remove excess fluid from the body.
[7] The occipital area is at the back of the skull.

were noted, together with a lower limb strength deficit. A CT scan was requested and an instruction given to continue neurological observations.

41. At 12pm, a physiotherapist noted in the progress notes:

> "[Mrs A is] displaying some confusion on answering questions about sensation. There was left facial droop, loss of power throughout left upper and lower limbs. Worsening neurological condition noted due to ? stroke ? bleed. Review post CT head [scan] recommended."

42. A house officer was also asked to see Mrs A at this time because her condition was deteriorating. He recorded in the progress notes that there were "new neurology and progressive symptoms", and recommended an urgent CT scan.

43. At approximately 1.05pm, Mrs A was taken for a CT scan. The CT scan report stated that "[i]n the setting of trauma and progressive neurology" an acute intracranial haemorrhage[8] was likely but that there was a possibility of a central nervous system (CNS) lymphoma.

44. At 1.30pm, Mrs A was examined by a locum consultant haematologist, Dr C, and Mrs A's condition was discussed with her family. Dr C advised the family that Mrs A had fallen and had undergone an urgent CT scan as a result. Dr C explained that it was likely that Mrs A had a CNS lymphoma, and that the prognosis was poor and the main goal was to attend to Mrs A's comfort. This advice was recorded in the progress notes.

45. Dr C told HDC:

> "I endeavored to offer [Mrs A's] daughter and son the most up to date interpretation and information as changing radiological and clinical information became available. Unfortunately this resulted in the family receiving mixed explanations that evolved over time. I appreciate that this will have added to their distress, as it did to the medical team."

46. CCDHB's policy is to notify next of kin if a patient falls. Mrs A's family was not notified until 1.30pm. CCDHB stated:

> "I apologise this did not happen in a timely way when [Mrs A] fell and for the distress this has caused the family. The night nurse did indicate in the medical file that the next of kin had not been informed but unfortunately it was not recognised by morning staff."

47. By 2.00pm, Mrs A's neurological status had deteriorated significantly. The progress notes state that Mrs A was alert, orientated, and obeying commands at 7.20am, but that "progressively throughout the shift developed drowsiness, confusion … [and that] [m]ild, moderate, severe weakness developed progressively throughout [the] shift on [left] side

[8] Intracranial haemorrhage is acute bleeding inside the skull or brain.

[and] [a]t [2.00pm Mrs A was] virtually unresponsive". The progress notes record that Mrs A was to have palliative care.

48. Apart from a brief entry by the transit nurse at 1.05pm, the progress notes contain no further entry by a nurse until 4.05pm, when the entry covers the period from 7.00am to 3.30pm.

49. GCS[9] and neurological observations were undertaken during the day at 7.35am, 9.20am, 9.50am, 12.05pm, and 1.15pm, and were recorded in the neurological vital signs chart.

50. The Patient Care Plan was updated, and noted that neurological observations were required and that Mrs A's care was palliative.

51. At 5.30pm, the haematology registrar recorded in the progress notes that it was likely that Mrs A had a CNS lymphoma but that a haemorrhage could not be excluded.

Day 10–Day 12 — "Last days of life" cares

52. On Day 10, the progress notes record that Mrs A was mostly unresponsive.

53. On Day 11, the haematology registrar discussed the role of palliative care with Mrs A's family.

54. Mrs A died at 2.40am on Day 12, with her daughter in attendance.

Information provided by CCDHB

55. CCDHB conducted a review of the care provided to Mrs A and completed a Serious Adverse Event Report (SAER).

56. The review team concluded: "[There were] two root causes to [Mrs A's] fall: lack of recognition for [the] deterioration of [her] general condition and insufficient risk assessment."

57. In relation to the initial assessments between Day 1 and Day 5, the SAER stated:

> "The review team found that the initial assessments required as part of the CCDHB policy … to be carried out within one hour of admission, were not completed until two days after the patient's transfer to [the ward]."

58. In addition, the SAER stated:

> "[T]here were lengthy periods between review and reassessment of the Patient Care Plan. The lack of regular reviews of her falls and delirium risk led to a lack of recognition of the rapid progression of the patient's condition and the risk associated with this."

[9] The GCS (Glasgow Coma Scale) assesses a person's level of consciousness in response to defined stimuli.

59. The review team was "concerned that there were no further reviews and updates of the patient's admission to discharge plan for five days".

60. CCDHB told HDC that "the failure to adequately complete the PADP, during the time of Mrs A's admission to the timeframes expected by the policy, represents a departure from the acceptable practice".

61. In relation to clinical assessment and subsequent care planning by the nursing staff, CCDHB told HDC that "while the individual instances of documentation lapses may be considered as minor, when viewed as a whole they represent a departure from accepted practice". CCDHB said that the documentation of Mrs A's care following the fall was "inconsistent with best practice".

Changes made by CCDHB

62. CCDHB told HDC that it has made the following changes:

- In September 2017, a new guideline was introduced. On each morning shift the coordinator of the ward is required to check the PADP of every patient admitted in the previous 24 hours and assist with the completion of the PADP.
- The CCDHB Audit Schedule now stipulates that all PADP documentation will be audited for compliance every six months, and the results will be reported to staff.
- In March 2017, a monthly falls report was introduced. The report records each fall and identifies whether a falls sticker was placed in the notes, whether a falls assessment was completed prior to the fall, and whether the family was informed. The results are discussed with the registered nurses and reported to staff.
- The CCDHB Audit Schedule now stipulates that the Falls Prevention and Management documentation will be audited for compliance every month, and the results will be reported to the Health Quality & Safety Commission.
- Half-hourly neurological observations for the four hours following a strike to the head will be added to the Falls Prevention and Management documentation audit template. The Early Warning System and Fluid Balance documentation will be audited for compliance every three months, and reported to staff.
- CCDHB is developing a new e-learning tool to be used as part of the orientation process for new staff. The tool will teach staff how to complete a PADP and how to write a care plan.

Responses to provisional opinion

Ms B and her brother

63. Ms B and her brother were given an opportunity to comment on the "information gathered" section of the provisional opinion.

Capital and Coast DHB

64. Capital and Coast DHB was given an opportunity to comment on the provisional opinion. It advised HDC that the provisional decision was consistent with its internal review, and that in response to the proposed recommendations in the provisional opinion, the following steps have been taken:

a) Regular audits of the falls prevention documentation show that compliance with the completion of the documentation has improved from 30% at the time of these events to 95% in December 2018.

b) A Nurse Educator has been appointed to educate all staff on the completion of admission assessments and a PADP within the patient's first hour on the ward.

c) There are more nurses on the ward for patient care.

d) Education sessions on the completion of assessments are included at handover times, and posters outlining the expectations are on display.

e) Ward co-ordinators (who include the Charge Nurse Manager and Associate Charge Nurse Managers, the Clinical Nurse Educator, and some registered nurses) have guidelines to assist them with the day-to-day running of the ward. The guidelines enable them to identify all new patients, and prompt them to complete PADPs for those patients. An audit conducted in November 2018 showed that 100% of new patients had had falls assessments completed.

65. CCDHB stated that it intends to conduct a review to identify how the increased use of the PADP, as outlined above, can be used to support staff to assess an individual patient's needs and to recognise deterioration.

66. CCDHB apologised for the shortcomings in the care provided to Mrs A, and stated that it will provide a letter of apology to the family, via HDC.

Opinion: Capital and Coast District Health Board — breach

Admission document — PADP

67. Mrs A was transferred from Hospital 2 to Hospital 1. Hospital 2 did not provide Hospital 1 with any formal handover documents, but it did provide a copy of the discharge summary and the nursing notes. These documents recorded Mrs A's condition and identified her as a high falls risk.

68. CCDHB's PADP Policy states that a PADP must be completed upon admission to Hospital 1. The section relating to falls assessment is to be completed within one hour of admission, and the section relating to delirium is to be competed within eight hours of admission.

69. A PADP was not completed for Mrs A on the day of her admission. The falls assessment and delirium assessment sections of the PADP were completed on Day 3. Other parts of the PADP were left incomplete.

70. CCDHB told HDC that the failure to complete a PADP for Mrs A at the time of her admission to Hospital 1 was a departure from its practice.

71. Expert nursing advisor Dr Jane Hardcastle advised that she would have expected the nursing staff to undertake a preliminary assessment at the time of admission, and devise and document a plan for Mrs A's care.[10] Dr Hardcastle noted that the documents provided by Hospital 2 recorded that Mrs A was at an increased risk of falling. Dr Hardcastle concluded:

> "[T]he absence of [a] preliminary assessment on [Mrs A's] admission to [Hospital 1] was detrimental to her care and overall outcome. In my opinion the failure of nursing staff to ensure that [Mrs A's] health status was assessed and documented at the time of her admission to [Hospital 1] is a severe departure from the accepted standards of practice."

72. I am critical that a PADP was not completed on Day 1, and that CCDHB did not ensure that its staff complied with the PADP Policy. At least 14 nurses provided Mrs A with care from Day 1, but a full and accurate assessment of Mrs A's condition was not undertaken at the time of her admission. When Mrs A transferred to Hospital 1, she was entitled to expect that her condition would be assessed and monitored appropriately, and that her care would be planned accordingly. The discharge documents from Hospital 2 identified Mrs A as a high falls risk, and this should have alerted the nursing staff to the need for a full assessment. The failure to assess and document Mrs A's condition appropriately on admission to Hospital 1 in a manner compliant with the Policy meant that a clear baseline for her condition was not established. As a result, it was difficult for staff to monitor whether Mrs A's condition was improving or deteriorating, and to provide the appropriate care.

73. I am also concerned that when the PADP was commenced on Day 3, the results of the assessments were not clear. Some assessments were not completed or updated at all, and the meaning of other assessments was difficult to interpret because the marks in the boxes appear as both a tick and a cross.

Nursing assessment from Day 4

74. From Day 4 to Day 9, the progress notes, patient care plan, and falls risk assessments all record that Mrs A was a high falls risk. However, on multiple occasions during this period these documents were either not completed at all or not completed accurately and in accordance with policy.

[10] Based on the NZ Nursing Council Registered Nurse Scope of Practice NCNZ 2007.

75. Dr Hardcastle identified a number of indicators recorded at the time of Mrs A's admission that suggested that Mrs A was at risk of falling. These indicators include the documents from Hospital 2 that recorded that Mrs A was a high falls risk, the multiple medications being administered to Mrs A, and Mrs A's weakness and fatigue. Dr Hardcastle also identified a number of relevant clinical indicators that were recorded following Mrs A's admission. These include the falls risk assessment, the Patient Care Plan identifying Mrs A's need for assistance, and the nurses' references in the progress notes to fatigue, breathlessness, and disorientation. Dr Hardcastle advised that the nursing staff failed to appreciate the significance of these indicators.

76. Dr Hardcastle concluded:

> "Clinical assessment and subsequent care planning by the nursing staff involved in [Mrs A's] care failed to identify indicators of the severity of [Mrs A's] deteriorating condition and her risk of falling. In my opinion, whilst each individual omission in assessment, planning and written communication represents a mild departure from expected standards when considered in isolation, the cumulative effects of missed, incomplete, or incorrect nursing assessment in this case were detrimental to [Mrs A's] care. I consider this to be a moderate departure from expected standards."

77. I agree with Dr Hardcastle that the incomplete nursing assessments prior to Mrs A's fall were detrimental to her care. During this period, Mrs A's condition was deteriorating and her risk of falling was increasing. The Patient Care Plan should have been completed at least once per day, and the PADP falls and delirium risk assessments should have been updated regularly to reflect Mrs A's changing condition. I am critical that Mrs A's falls and delirium risks were not assessed adequately during this period, and that the severity of her condition based on the available information was not appreciated by the nurses. As a result, Mrs A's risk of falling was not identified adequately.

78. Mrs A's fall on Day 9 occurred at 6.20am and was recorded in the progress notes by a nurse at 7.15am. Over the course of the day, Mrs A's condition deteriorated rapidly, and by 2.00pm she was described as virtually unresponsive.

79. During the day, Mrs A was reviewed by a number of health providers, including a physiotherapist, a haematology registrar, two house officers, and a consultant haematologist. These health providers recorded their notes in the progress notes.

80. However, apart from a brief entry by a transit nurse at 1.05pm, no progress notes were made by any of the nurses until 4.05pm. The 4.05pm entry covers the period from 7.00am to 3.30pm, and records Mrs A's deterioration.

81. CCDHB told HDC that the documentation of Mrs A's condition following her fall was "inconsistent with best practice".

82. Dr Hardcastle reviewed the progress notes made at 4.05pm, and advised that "[t]his represents a significant period of time in which a nursing assessment of [Mrs A] and the deterioration that ensued were not documented".

83. Dr Hardcastle advised:

> "In situations where acute deterioration leads to change in the plan of care or treatment the need for accurate assessment and documentation are paramount … I consider the lack of apparent framework and consistency of clinical assessments, observations and nursing documentation to be a moderate departure from expected standards."

84. I am highly concerned that in a situation where Mrs A's condition was deteriorating rapidly — to a point when at 2.00pm she was described as "virtually unresponsive" — no nursing notes were made during the day. The first entry in the progress notes by the morning nursing shift was made at 4.05pm, and there were notable gaps between the neurological assessments. There were significant periods of time when Mrs A's condition was not assessed and her deterioration was not documented, and, as a result, her care could not be planned accurately.

Delay in notifying family of fall

85. Mrs A fell at 6.20am but her family was not advised of the fall until 1.30pm, some seven hours later.

86. Dr Hardcastle advised:

> "Whilst the delay in communication is extremely unfortunate in the context of [Mrs A's] rapid decline [the family] appear to have received truthful and open communication following this event."

87. I am concerned that Mrs A's family were not advised of her fall earlier in the day and that, as a result, Mrs A and her family were deprived of an opportunity to spend this time together, particularly as Mrs A's condition deteriorated rapidly, and by 2pm she was virtually unresponsive.

Conclusion

88. Accurate health assessments are the foundation of good nursing practice and clinical decision-making. CCDHB is responsible for ensuring that its staff provide appropriate health assessments and care. A number of staff provided care to Mrs A over several days, but there was a lack of accurate preliminary and ongoing risk assessments and care planning by the nursing staff. This meant that it was not clear that Mrs A's condition was deteriorating and that her risk of falling was increasing. In addition, the assessments by the nurses caring for Mrs A on the day of her fall were inadequate, and did not reflect or record her rapidly deteriorating condition. There was also a delay in notifying the family of the fall. By failing to complete a PADP on admission and to update it accurately on the

days following Mrs A's admission, and by failing to complete adequate nursing assessments on the day of her fall, CCDHB did not undertake a full assessment of Mrs A's condition or monitor her changing condition accurately. Accordingly, CCDHB failed to provide Mrs A with services with reasonable care and skill, and, as result, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[11]

Recommendations

89. In response to the provisional decision, CCDHB advised HDC:

a) CCDHB has conducted regular audits of staff compliance with PADP documentation, and compliance has increased from 30% at the time of these events to 95% in December 2018. Accordingly, I consider that my recommendation that CCDHB conduct audits of the PADP documentation has been met.

b) Improvements have been made to staff training in the completion of PADP assessments. A dedicated Nurse Educator has been appointed, and staff now have guidelines, checklists, and education sessions to ensure that the PADP documentation is completed. Accordingly, I consider that my recommendation to provide training on the completion of PADP documentation has been met.

c) CCDHB will review the way in which the use of the PADP documentation can support staff to assess an individual patient's needs and recognise deterioration. I recommend that CCDHB provide HDC with the outcome of the review, within three months of the date of this report.

d) CCDHB will provide a letter of apology to Mrs A's family. I recommend that CCDHB send this letter to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

Follow-up actions

90. A copy of this report with details identifying the parties removed, except the expert who advised on this case and CCDHB, will be sent to the Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[11] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from nurse consultant Dr Jane Hardcastle:

"**Independent Advisor report to the Health and Disability Commissioner**

Submitted by Dr Jane Hardcastle

14 July 2017

Initial advice

Introduction
I have been asked to provide an opinion to the Health and Disability Commissioner (the Commissioner) regarding investigation C17HDC00187.

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

I am a Nurse Consultant working at St George's Hospital, Christchurch. My qualifications are RN, ENB 100 (General intensive care nursing), BSc (Nursing studies), MEd (Adult education), EdD (Dr of education).

I have 25 years' clinical experience in general and cardiothoracic intensive care, cardiology, high dependency and surgical nursing and over ten years experience as a principal lecturer in post graduate nursing (critical care and acute nursing). I currently practise as a nurse consultant in education and practice development for various specialties in private surgical hospital practice (nursing, midwifery, anaesthetic technician).

Instructions

Purpose:
To provide independent expert advice on the care provided to [Mrs A] (dec) by Capital & Coast District Health Board (CCDHB).

Advice requested:
To review the documents provided and advise whether the nursing care provided to [Mrs A] by Capital & Coast District Health Board, between [Day 9] and her death on [Day 12], was reasonable in the circumstances. I was also asked to comment on the Serious and Sentinel Event review report and recommendations set by the DHB.

Expert Advice Required:

I was asked specifically to comment on the following points:

1. […]
2. The management of [Mrs A's] falls including assessment of risk, interventions to manage her falls and care following the event.

3. The Serious and Sentinel Review Report and recommendations set by the DHB.
4. Any other issues that I consider important to this complaint.

Interpretation of instructions
I have been asked to provide expert advice regarding the nursing care provided to [Mrs A]. I will focus on the nursing care, assessment, documentation and clinical decisions made within the episode of care ([Days 9–12]). In order to provide the advice requested I have reviewed all the documentation provided to me. This includes the clinical records pertaining to the episodes of care preceding [Day 9]. Review of all clinical records was required in order to address the specific questions asked of me by the Commissioner's office, however I will not comment on aspects of care that are not relevant to the instructions that I have been given. I am aware that the care provided within an acute environment is influenced by the ability of the whole institution to respond to acute care demands. This extends to communication within, and from, the organisation. Communications with [the family] regarding [Mrs A's] health status and investigative reporting have contributed to this complaint, and subsequent investigation. I will therefore provide my opinion on multidisciplinary patient care management where it is appropriate to do so.

Information reviewed
Letter of complaint to the Health and Disability Commissioner's Office from [Mrs A's] daughter dated […].

Response letter from Capital & Coast District Health Board to The Health & Disability Commissioner dated 19 April 2017.

Clinical records from Capital & Coast District Health Board.

Clinical records from [Hospital 2].

Capital & Coast District Health Board Serious & Sentinel Event Review Report.

Coroner's report dated 27 May 2016, and associated correspondence.

Factual summary of the case

- [Mrs A] was admitted to [Hospital 2] with a 6 month, progressive history of vomiting, loose bowels, bloating, anaemia, light-headedness and fatigue++
- Investigations during admission to [Hospital 2] led to a primary diagnosis of 'possible lymphoma' and secondary diagnoses of 'excisional biopsy lymph node R axilla' and 'allergic reaction — likely to be iodine'
    - Intraoperative iodine reaction of 'Rash/Welts during surgery' [date] resulted in IM Adrenaline administration and 6 hours HDU (high dependency unit) monitoring postoperatively (excision biopsy of the lymph node — right axilla)
- [Mrs A] was transferred to [Hospital 1] for further investigations (bone marrow biopsy) on [Day 1] under the care of [the haematologist]

- Medical & surgical discharge summary details all care and events during [Mrs A's] admission to [Hospital 2]
- There was no evidence of a nursing transfer summary to detail the time of [Mrs A's] transfer, condition during transfer, condition on arrival or nursing handover from [Hospital 2] to [Hospital 1] RNs
- Prior to transfer, nursing and physiotherapy notes indicated that [Mrs A] was considered to be at high risk of falls, requiring a frame and assistance to mobilise due to 'unsteadiness on feet' and 'fatigue' ([clinical records])

- [Mrs A] was admitted to [Hospital 1] at 1430 ([Day 1])
  - The Admission checklist Patient Admission to Discharge Plan (PADP) and Patient Care Plan were not completed at the time of admission ([Day 1]), or the subsequent day ([Day 2])
  - There is no documented evidence of admission health assessment, evaluation of [Mrs A's] condition or risk assessment on admission
- [Day 1]; 1700 — Bone marrow biopsy performed
- [Day 1]; Nursing notes entry written retrospectively for the time period 1430–2300. The time at which the notes entry was made was not documented. Reference is made to [Mrs A's] vital signs post bone marrow biopsy, pain score of 8/10, administration of Sevredol (morphine tablet), oxygen therapy, drain presence and TED (thromboembolic deterrent) stockings. No reference made to mobilisation.
- [Day 2] 1020 PICC line inserted
- [Day 2]; 1130 family meeting — provisional diagnosis of aggressive lymphoma, steroid and chemotherapy treatment plan discussed. Medical notes entry states that if [Mrs A] does not improve 'we may not be able to give Rx' (medical prescription).
- [Day 2]; Nursing notes entry written retrospectively for the time period 0700–1500. The time at which the notes entry was made was not documented. [Mrs A] was noted to have shortness of breath with exertion, an early warning score (EWS) of 6 due to tachycardia, low oxygen saturations and oxygen therapy requirement. 'pt needs supervision when mobilising' was documented. No falls risk assessment or care plan was documented at this time.
- Registrar reviewed by telephone (call from RN) regarding oxygen saturations and increased oxygen requirements (3l/min). Nurses instructed to monitor.
- [Day 3] preliminary assessment details added to the Patient Admission to Discharge Plan (PADP) by morning shift RN (resuscitation status, health passport, advance care plan, family violence screening, estimated date of discharge & EDD discussion with family components were not completed)

- Falls risk assessment (1135) identified 6 risk factors by the presence of a tick. A cross and tick are present alongside the 'neurological changes or condition'* (the meaning of this is unclear). 'mobility and gait problems or use of mobility aids' has a tick with 2 horizontal lines through it (meaning is unclear). A cross is present beside 'no risk'. The associated care planning statements are blank (there is no indication as to the care required). 'Medication effects' was not identified as a risk factor. [Mrs A] was receiving 6 medications, including morphine at this time.
- *The words 'medical weakness++' and 'SOBOE' are present, the word condition is underlined.
- Delirium risk assessment identified 'Aged 65+' as a risk (by the presence of a tick) — leading to confusion assessment method (CAM) tool assessment completion. The clinical record appears to show a cross beside severe illness (a clinical condition that is deteriorating or is at risk of deterioration). This would indicate that this was not considered to be a risk factor for [Mrs A]. [Mrs A] had a severe illness, evidence of deterioration is present in the [Hospital 2] clinical record.
- The CAM result documented on [Day 3] (time of entry is not documented) appears* to identify a negative assessment score by the presence of ticks in the 'No' columns. This indicated that [Mrs A] was not considered to have any delirium features present at the time of assessment. There is, however, a tick beside the CAM score positive and a cross beside the 'or Negative'.
- *there is also an entry that identifies a positive CAM score in relation to features 1, 2, and 3. There is a tick beside the 'presence of features' statement but the 'delirium present/indicated' statement has not been circled. There is an additional date entry and RN initials for [Day 9]. It is not clear, from the PADP, which assessment occurred on which date.

- [Day 3] Patient Care Plan completed by morning shift RN identified that [Mrs A] required 'assist x 1' to meet ADLs (activities of daily living), 'assist PRN (as required)/supervise' for mobility. The falls risk Yes/No section was not completed.
- [Day 3] 2 x units of RBC (red blood cells) transfused.
- [Day 3] pm & night shift nursing notes include reference to shortness of breath and requiring assistance 'x 1' to mobilise.
- [Day 4] 0905 ward round notes — antibiotic for 'R) CAP', 'lethargic & SOB today', 'ongoing chest infection & O2 requirements', 'RR 22' (respiratory rate raised) & 'sat 94' (oxygen saturation 94%) noted.
- [Day 4] 1140 nursing notes make reference to [Mrs A's] condition from 0700; '++ fatigued', difficulty with independent washing, increasing breathlessness, 'dizzy when changing positions' and increase in weight. Dr informed.

- [Day 4] 1355 nursing notes refer to audible wheeze & crackles on chest auscultation, pitting oedema & 'confusion?' RN commented that she heard pt 'wheezing this am too' documented. Dr informed re. wheeze & reviewed [Mrs A] at 1420 — no wheeze, '? pleural effusion'. CXR (chest X-ray) planned, IV (intravenous) Frusemide (diuretic) prescribed & administered.
- The delirium assessment and associated CAM were not documented at this time.
- [Day 4] 1505 nursing notes in reference to Frusemide administration 'pt aware to call for assistance to toilet'. Falls risk assessment (on the PADP) for medication effects was not updated at this time.
- Patient Care Plan completed by morning shift RN identified that [Mrs A] required 'assist x 1' to meet ADLs (activities of daily living), 'weak ++' & 'assist x 1' for mobility. The falls risk 'Yes' section has what appears to be a tick with a horizontal line through it. Meaning is unclear.
- [Day 4]; Nursing notes entry written retrospectively for the time period 1500–2300. The time at which the notes entry was made was not documented. Reference made to SOBOE (shortness of breath on exertion), oxygen requirement, presence of wheeze and 'up to bathroom with assistance'.
- [Day 5] 0420 nursing notes entry; 'Incontinent of urine x 1, woke up distressed which caused incontinence'. Right arm swelling on PICC arm noted. Falls risk assessment for incontinence (as an underlying issue) was not updated at this time. Patient Care Plan elimination/output section was not updated at this time.
- [Day 5] ward round notes. The time at which the notes entry was made was not documented. Notes include reference to SOB (shortness of breath), 'gets dizzy when walking', right arm swelling, MUGA (multigated acquisition scan) & chemotherapy plans.
- [Day 5] nursing notes am & pm shift note that [Mrs A] requires assistance with mobility and 'ADLS' (activities of daily living). Referred to physiotherapist for chest physio (pm shift).
- [Day 6] 1350 physiotherapy notes; include assessment of respiratory and mobility function. Requirement for close supervision if walking without an aid, 'Antalgic gait' (to avoid pain), 'lateral swing walking & frame' supervision & 'prompts to stay within frame', '↑ speed reciprocal gait'. Physiotherapy assessment notes 'unsteady mobilising — requiring frame'. Plan to mobilise with supervision + frame short distances.
- [Day 6] 1830; Nursing notes entry written retrospectively for the time period 0700–1830. Reference made to physiotherapy assessment. Falls risk assessment for mobility and gait problems or use of mobility aid was not updated at this time. Patient Care Plan was not updated at this time to include the requirement for a walking frame to mobilise.

- [Day 6]; Nursing notes entry written retrospectively for the time period 1900–0700. The time at which the notes entry was made was not documented. Reference made to Sevredol administration (morphine), use of walking frame and supervision. Falls risk assessment and care plan for use of mobility aid were not updated at this time.
- [Day 7] nursing notes pm shift make reference to increasing pain and analgesic requirements (sevredol dose increased).
- [Day 8] 1550 nursing notes include reference to 'severe middle back/abdominal pain' at 0800 requiring sevredol and panadol. [Mrs A] was noted to require assistance and walking frame to mobilise. Falls risk assessment and care plan for medication effects and/or use of mobility aid were not updated at this time.
- [Day 8]; Nursing notes entry written retrospectively for the time period 1500–2330. The time at which the notes entry was made was not documented. [Mrs A] was noted to have 'diarrhoea x 1' and 'pad in situ', 'very tired this duty. Sleeping most of the day'. Reference to commencement of cycle # 1 of chemotherapy (RCHOP). Falls risk assessment for medication effects and/or use of mobility aid was not updated at this time. Patient Care Plan elimination section was not updated at this time.

Episode of care [Day 9]–[Day 12] — factual summary of events

- [Day 9] 0230 nursing notes entry. [Mrs A] was noted to be short of breath on exertion, 'sats 89% on RA' (oxygen saturation levels low on room air), 'improved to 93% on 3L' (3 litres per minute oxygen delivery).
- [Day 9] 0400 nursing notes entry. Reference to blood results 'seen by night float'. [Mrs A's] condition was noted to be stable on oxygen therapy and that the 'call bell within reach. Advised to call for help as needed'.
- [Day 9] 0620 [Mrs A] had an unwitnessed fall.
- [Day 9] 0715 nursing notes entry (night shift) written in retrospect; at 0620 [Mrs A] was heard to be calling out 'help help' by the RN on duty. [Mrs A] was found on the floor 'near bed 36' and reported to have 'gotten up to go to the toilet felt lightheaded and fell'.
    - 0624 vital signs are recorded. EWS (early warning score) 3. There is no record of neurological observations undertaken at this time.
    - Nursing notes 0715 detail 'Alert & oriented Obs stable. Assisted onto chair & bed. Informed med night float & requested review'.

      Continuous nursing notes entry 0715; [Mrs A's] PICC line was noted to have been pulled out during the fall. Notes entry included 'nil visible injuries seen' [Mrs A] 'reported hitting her back & head on the floor' and 'redness noted on the back of the head'. There is no specific comment regarding loss of consciousness. There is no further record of physical assessment at this time.

Continuous nursing notes entry 0715; [Mrs A] was noted to 'remained alert, oriented to place, date & person. Reminded to call for assistance'.

The notes entry includes 'been incontinent of stool' — it is not indicated whether this happened before, or after the fall.

- The DHB *Serious and Sentinel Event Investigation Report* indicates that 'The patient had been incontinent of faeces' — the notes are written in present tense reflecting the time of assessment which may suggest that incontinence had occurred prior to [Mrs A's] discovery — it is not, however, clearly indicated whether incontinence occurred before, or after the fall.
- [Day 9] 0730 vital sign and neurological observations recorded — GCS 15 (Glasgow Coma Score — level of consciousness assessment tool), pupils equal, 3mm, ++ reaction, normal limb strength. EWS (early warning score) was not documented on the neurological observations chart.
- Identification of fall sticker present in the clinical notes following the above (0715) entry. Information includes the time and date of the fall, patient name and NHI reference number. Reportable event for completion is ticked 'yes', notify next of kin is ticked 'no', notify medical staff is ticked 'yes'. The reportable events number and injury sustained yes/no section is blank. The RN's details are provided and indicate that falls reassessment and prevention strategies were reviewed and amended (placement of a tick in the yes box). The falls reassessment is documented to have been completed at 1620 by a different (morning shift) RN. The Patient Care Plan was updated on [Day 9] (time not documented) by the morning shift RN.
- The DHB *Serious and Sentinel Event Investigation Report* indicates that a reportable event form was completed on [Day 9].
- [Day 9] 0740 [Mrs A] was reviewed by the OCHO (on call house officer) re unwitnessed fall. It is noted that [Mrs A] had 'no LOC' (loss of consciousness), PICC dislodged but 'nil other obvious lacerations/bony abnormalities'. Time of fall noted to be 0620. The notes entry includes 'MET — must go apologies' indicating that the Dr was called away to respond to a medical emergency team call.
- [Day 9] 0920 vital sign observations (RR, O_2, O_2 saturation, temp, BP, HR) recorded on the neurological vital sign chart — GCS, pupillary assessment and limb strength assessment were not documented. EWS (early warning score) was not documented.
- Oxygen therapy recorded as 4L/min — previously 3L/min — there was no explanation provided in the clinical record.
- [Day 9] 0940 full medical review re: unwitnessed fall reports that [Mrs A] 'attempted to get out of bed, felt dizzy & collapsed. Hit back of head. PICC came out'. Examination and assessment of vital signs, orientation to place & time, limb strength and reflexes are recorded showing reduced tone and muscle strength in

the lower limbs with external rotation of the left leg, clonus (R), lower back pain, small skin lacerations + bruising occipital area'. Impression is recorded as 'head injury. weak lower limb' and a plan documented to 'CT head, XR pelvis/hip and continue neuro obs'. [Mrs A's] pupillary responses were not documented at this time.

- [Day 9] 0950 vital sign and neurological observations recorded — GCS 15, pupils equal, 3mm, ++ reaction, normal limb strength R (right) arm and leg. Mild weakness L (left) arm, severe weakness L leg. EWS (early warning score) was not documented.
- [Day 9] 1115 vital signs and GCS of 12 recorded (deficits in eye opening — score 3, verbal response — score 4, and motor response — score 5), pupillary assessment, limb strength assessment and respiratory rate (RR) were not documented. EWS (early warning score) was not documented. There is no documentation of the actions taken following GCS deterioration from the last observations recorded at 0950.
- [Day 9] 1200 physiotherapy notes entry makes reference to the RN reporting '↓ing muscle strength on L) side, GCS maintained at 15/15 through morning'. The 1115 documentation of GCS (45 minutes earlier) was recorded as 12 (see above deficits).
- Physiotherapy assessment is documented to include recent history review, orientation, limb strength, alertness, sensation, air entry. Physiotherapist noted 'smile droop on L) side' 'dozing off to exam' 'confusion when answering questions about sensation'. The plan was documented to review post CT head and liaise with neuro team.

  There is no documentation of any communication undertaken following this assessment and the identification of [Mrs A's] facial droop.
- [Day 9] next entry (time not recorded) CT examination complete stamp & MRT (medical radiation technologist) initials. Subsequent nursing notes (1605) indicate that this was undertaken at 1230.
- [Day 9] 1305 transit care RN notes entry indicating [Mrs A's] return to the ward at 1305 'remains drowsy'.
- Retrospective medical notes entry for [Day 9] 1200 re request to review [Mrs A] in view of 'worsening neuro obs'. There is no documentation of this request by the attending RN or physiotherapist. Assessment notes an increase in drowsiness from this morning, facial droop, [Mrs A's] ability to follow instructions and orientation to time & place. Pupils equal and reactive to light, L) arm strength deterioration. Impression recorded as 'new neurology'. Plan for [Mrs A] to be NBM (nil by mouth), urgent CT and discussion with haematologist.
- [Day 9] 1330 medical notes entry outlining a discussion with [Mrs A's] son to explain the fall earlier that morning and urgent CT result. 'likely CNS (central

nervous system) lymphoma — explained likely outcome + she may die — given acute deterioration, could be very fast'. It is noted that [Mrs A's] 'son will ring daughter to come in'.

Continuous medical notes entry 1330 (2 styles of handwriting are noted with only 1 signature — [Dr C]) note [Mrs A's] increased drowsiness and deeper breathing. Notes make reference to [Mrs A] being informed of 'poor prognosis + main goal is comfort'. Impression note includes 'unrecoverable situation' and plan to move [Mrs A] to a private room and hold a family meeting when the family are present.

- [Day 9] 1405; subcutaneous infusion of morphine 10 mg & midazolam 10 mg commenced at 0.68 mls/hr & documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart.

- A 24 hr continuous subcutaneous infusion prescription for morphine 10 mg, midazolam 10 mg and Levomepomazine 12.5 mg is located on the medication chart. A prescription for the infusion dilutent and volume was not included. Evidence of drug administration is documented x 2 as '10 mg' at 1405 with 1 initial. There is an illegible mark on the last row for [Day 9] column. It is not clear if this refers to administration of morphine and midazolam and the omission of Levomepomazine from the infusion. There is no explanation for the placement of the illegible mark in the clinical record or medication chart. The corresponding *CPP MED-15* chart documents the syringe contents as morphine & midazolam (not Levomepomazine).

  A Q 1 H (1 hourly administration) prescription for these medications is also located on the medication chart. Time of administration is recorded on the medication chart as 1440 morphine 2.5 mg PO (oral), 1400 midazolam 1 mg SC (subcutaneous).

- [Day 9] (time not documented) *Resuscitation Status Form* indicates 'Do Not Attempt Resuscitation' (DNAR) with no review date required. The form indicates that the decision was 'Not discussed' with the patient, family or other.

  Completed by [the haematology registrar].

- [Day 9] 1605; Nursing notes entry written retrospectively for the time period 0700–1530. A summary of [Mrs A's] condition, and progression in condition, is provided for the time period 0720–1600 noting decline in pupillary responsiveness, increase in drowsiness, confusion 'etc', decline in L) sided motor strength, virtual unresponsiveness (at 1400) and 'severely deteriorating neurological function throughout shift'.

  Reference is made to the decision for palliative care, provision of 'full cares' and the presence of 'family'. There is no reference to the subcutaneous infusion or additional injections documented on the medication chart, or rationale for their introduction.

- [Day 9]; Patient Care Plan updated — time of update is not documented. Signature is consistent with morning shift nurse. Care plan additions include 'confused', 'end of life cares', 'disorientated', 'Q4h + prn neuro obs', 'palliative', 'full cares' for ADLs, reference to physiotherapy review & assistance with mobility, 'fall o/n L weakness', 'diarrhoea, P.U. incontinent, pad', references to hydration & nutrition intake are not legible. There is no reference to the requirement for subcutaneous morphine and midazolam infusion.
- [Day 9] 1730 medical notes entry (Haematology registrar) makes reference to the likelihood of 'intracranial haemorrhage' and 'CNS lymphoma' on [Mrs A's] CT scan. Decision not to undertake a contrast CT scan to provide a definitive diagnosis is documented with rationale (unlikely to change outcome).
- [Day 9] 1915 vital sign and neurological observations recorded — GCS 12 (deficits in eye opening — score 3, verbal response — score 4, and motor response — score 5), pupils equal, 4mm, ++ reaction, mild weakness L (left) + R (right) arm, severe weakness L leg, mild weakness R leg. O_2 saturation and supplemental O_2 delivery not recorded. EWS (early warning score) was not documented.
- [Day 9] 2000; new syringe of subcutaneous morphine 10 mg & midazolam 10 mg infusion documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart, running at 0.68 mls/hr. There are no administration details documented on [Mrs A's] national medication chart for these medications.
- [Day 9] 2015 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 9] 2220 Haematology consultant notes entry re summary of discussion with '[Mrs A's] daughter and work colleagues x 4'. Comprehensive documentation includes presentation of various opinions on the CT scan findings (neurosurgery, radiology and haematology). Documentation includes 'there is a bleed, likely contributed by low platelets & fall'. The clinical record states 'most likely outcome is still that [Mrs A] will die. First 24 hrs are important'. It also includes reference to [Mrs A's] daughter reporting that it would be [Mrs A's] wish not to have life prolonging treatment if she was not going to recover.
- The clinical record also states that [Mrs A's] daughter 'expressed her sadness and concern that she was not called earlier in the day and that she felt the fall had contributed to the decline'. [Dr C's] apology for both is documented 'on behalf of staff'.
- [Day 9]; Nursing notes entry written retrospectively for the time period 1500–2300. The time at which the notes entry was made was not documented. GCS 12/15 PEARL 4 R + L reported. [Mrs A] was noted to be 'unresponsive to swallow' at this time. Reference is made to 'no IV fluids at present' and 'has not taken any oral fluids'. Reference is made to passing urine ('Has PU'd x 3'). There is no reference to continence management or mobility associated with this statement.

Reference is made to 'Pt turned x 3 this shift'. Reference is made to discontinuation of subcutaneous infusion (morphine & midazolam) according to the documented medical plan 'to see if improvement in pts condition'.

- The *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult inpatients)* chart 2000 hrs entry includes 'Discontinued (W/H at present)' — there is no indication as to the time that this was written. It is not clear when (time) the infusion was discontinued.
- [Mrs A's] family were noted to be 'in attendance'.
- [Day 10] 0030 vital sign and neurological observations recorded — GCS recorded as 9 (deficits in eye opening — score 2, verbal response — score 1, and motor response — score 5), pupils equal, 3mm, ++ reaction, mild weakness R arm, severe weakness L arm, mild weakness R leg, severe weakness L leg. Respiratory rate and temperature were not documented. EWS (early warning score) was not documented.
- At this time the GCS score was recorded incorrectly (actual score was 8).
- [Day 10] 0320 nursing notes documented retrospectively from 2300; Reference made to vital signs, requirement to increase O_2 to 4L/min & change to Hudson mask delivery. Comments documented concerning absence of verbal response, 'some movements' on right hand & leg. 'none in left side'. [Mrs A] was noted to grimace 'when turned'. 'pu'd x 1 cleaned & linen changed pad in situ'. Additional note 'checked regularly — nil distress noted'. There was no reference to the decline in GCS (4 points) between 1915 and 0030 observations.
- [Day 10] 0445 vital sign and neurological observations recorded — GCS 9 (deficits in eye opening — score 2, verbal response — score 2, and motor response — score 5), pupils equal, 3mm, ++ reaction, mild weakness R arm, severe weakness L arm, mild weakness R leg, severe weakness L leg. EWS (early warning score) was not documented.
- [Day 10] 0500 administration of morphine 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 10] 0550 administration of morphine 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 10] 0640 nursing notes documented retrospectively for 0445; noted mild agitation & the requirement for subcutaneous morphine (2.5 mg) x 2 due to possible pain (detected by grimacing). Reference made to [Mrs A's] daughter being upset at seeing her mother like this.
- Continuous 0640 nursing notes documented retrospectively for 0500; [Mrs A] is reported to have been incontinent of urine requiring pad change. LOC (level of consciousness) reported as unchanged as a consequence of SC infusion pump (morphine & midazolam) discontinuation. [Mrs A's] GCS was 12 at 1915, 8 at 0030 and 9 at 0445 (as documented on the neurological observation chart). Reference

made to discussion of infusion pump recommencement with the 'night float' & decision to wait until am medical team review.

Additional note included 'difficult neuro obs due to being mostly unresponsive'.

- [Day 10] 0700 Haematology ward round notes entry (by registrar); no significant change in LOC overnight. [Mrs A's] daughter's reports of agitation and restlessness are noted, as is the wish for [Mrs A] not to have life prolonging treatment if her quality of life is going to be poor.

  Examination documented to show localisation of R arm, absence of eye opening to voice, absence of verbal response.

  [Dr C's] discussion with [Mrs A's] daughter is documented with reference to [Mrs A's] stroke and intention to talk with the coroner if [Mrs A] were to pass away — due to the fall.

  Plan to discuss [Mrs A's] situation with 'neuro', restart syringe driver if agitated/restless, and continue IV steroid.

- [Day 10] 0900 vital sign and neurological observations recorded — GCS 9 (deficits in eye opening — score 2, verbal response — score 2, and motor response — score 5), pupils equal, 3mm, ++ reaction, mild weakness R arm, severe weakness L arm, mild weakness R leg, severe weakness L leg. EWS 8.

- [Day 10] 1035 administration of morphine 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.

- [Day 10] 1230 vital sign and neurological observations recorded — GCS 7 (deficits in eye opening — score 1, verbal response — score 1, and motor response — score 5), pupils equal, 3mm, ++ reaction, mild weakness R arm, flexion L arm, mild weakness R leg, flexion L leg. EWS 8.

- [Day 10] 1230 subcutaneous infusion of morphine 10 mg & midazolam 10 mg commenced at 0.74 mls/hr & documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart. Evidence of drug administration is documented x 2 as '10 mg' at 1230 with 1 initial.

- [Day 10] 1430 Haematology registrar notes entry re neurologist opinion that raised ICP from intracerebral haemorrhage (intracranial pressure) may explain [Mrs A's] decline in GCS. Plan for supportive/palliative approach with slow supplementary fluid administration (SC or IV), maintenance of systolic blood pressure ≤ 160.

- [Day 10] 1530 1000 mls normal saline commenced IV (over 12 hours) — documented on national medication chart with 1 x initial.

- [Day 10] 1730 vital sign and neurological observations recorded — GCS 7 (deficits in eye opening — score 1, verbal response — score 1, and motor response — score 5), pupils equal, 2mm, + reaction, mild weakness R arm,

flexion L arm, mild weakness R leg, flexion L leg. EWS not recorded. [Mrs A] was febrile (38°), tachycardic 128 bpm with oxygen saturations of 91% on 4L/min O_2.

- [Day 10] 1815 nursing notes documented retrospectively for 0700–1930 shift; notes that [Mrs A] was not rousable to voice, 'obs as charted' (the neurological observation form indicates that [Mrs A's] GCS had dropped from 9 to 7 between the observations recorded at 0900 and those recorded at 1230). Reference made to a discussion with the registrar re. EWS & a 'not for resuscitation or MET call' decision.

  A 'do not attempt resuscitation' order had been previously documented on the 'resuscitation form' on [Day 9]. 'Not for CPR' (cardiopulmonary resuscitation) & 'Not for MET' (medical emergency team) was documented & signed by a registrar on the neurological observations chart but no date is provided.

  The above nursing notes make reference to 'incontinent' & a discussion with the medical team regarding urinary catheterisation 'team happy as long as daughter is happy for IDC insertion'. Reference is made to [Mrs A's] restlessness and the recommencement of the morphine & midazolam infusion pump (subcutaneous). There is no reference to the additional subcutaneous injection of midazolam (see entry below). [Mrs A's] daughter is noted to have gone home with a request to be contacted if [Mrs A] acutely deteriorates.

  Reference to the insertion of a urinary catheter could not be located in [Mrs A's] clinical file.

- [Day 10] 2000; subcutaneous morphine 10 mg & midazolam 10 mg infusion check documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult inpatients)* chart, running at 0.74 ml/hr.

- [Day 10] 2030 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.

- [Day 10] 2130 vital sign and neurological observations recorded — GCS 7 (deficits in eye opening — score 1, verbal response — score 1, and motor response — score 5), pupils equal, 4mm, + reaction, mild weakness R arm, flexion L arm, mild weakness R leg, flexion L leg. EWS recorded as 8 (correct score was 9).

- [Mrs A] was febrile (37.6°), tachypnoeic (rapid resp rate 22), tachycardic (fast heart rate) 132 bpm with oxygen saturations of 96% on 5L/min O_2.

- [Day 10] 2200 administration of morphine 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.

- [Day 10] 2240 vital sign and neurological observations recorded — GCS 7 (deficits in eye opening — score 1, verbal response — score 1, and motor response — score 5), pupils equal, 4mm, + reaction, mild weakness R arm, flexion L arm, mild weakness R leg, flexion L leg. EWS not recorded (actual score was 9).

- [Day 11] 0015; subcutaneous morphine 10 mg & midazolam 10 mg infusion check is documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult inpatients)* chart, running at 0.74 mls/hr.
- [Day 11] 0140 vital sign and neurological observations recorded — GCS 7 (deficits in eye opening — not clearly recorded, verbal response — not clearly recorded, and motor response — score 5), pupils not assessed, severe weakness R arm, flexion L arm, severe weakness R leg, flexion L leg. EWS not recorded (actual score was 11).
- [Day 11] 0430; subcutaneous morphine 10 mg & midazolam 10 mg infusion check is documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart, running at 0.74 mls/hr.
- [Day 11] 0430 administration of morphine 5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 11]; Nursing notes entry written retrospectively for the time period 1900–0730. The time at which the notes entry was made was not documented. Notes show deterioration throughout the night with requirement for morphine & midazolam administration via subcutaneous infusion and injection 'with little effect'. Reference made to 'IDC' drainage (indwelling catheter), provision of IV fluids and completion of observations. [Mrs A's] son was noted to stay overnight.
- [Day 11] 0845 vital sign and neurological observations recorded — GCS 7 (deficits in eye opening — score 1, verbal response — score 1, and motor response — score 5), pupils equal, 3mm, + reaction, severe weakness R arm, flexion L arm, severe weakness R leg, flexion L leg. EWS not recorded.
- [Day 11] 0910; subcutaneous morphine 10 mg & midazolam 10 mg infusion check is documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult inpatients)* chart, running at 0.74 mls/hr.
- [Day 11] 0700 or 0900 (documentation is unclear) medical notes entry; extensive documentation of ward round discussion with [Mrs A's] son regarding the potential of [Mrs A's] fall to have caused neurological deterioration given conflicting medical opinions (CNS lymphoma and intracerebral haemorrhage). Clear reference is made to [Mrs A's] poor prognosis and the intention to involve a palliative care team in [Mrs A's] care. Documented plan includes palliative care referral for [Day 12], increase in morphine dose and PRN administration of morphine and midazolam for comfort.
- [Day 11] 1035; new syringe of subcutaneous morphine 15 mg & midazolam 10 mg infusion documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart, running at 0.69 mls/hr. Evidence of drug administration is documented x 2 as '10 mg' at 1035 with 2 initials for one medication & 1 initial for the other entry.

- [Day 11] no time documented; subcutaneous morphine 15 mg & midazolam 10 mg infusion check (11.9 mls remaining) is documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart, running at 0.69 mls/hr.
- [Day 11] 1230 administration of morphine 5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 11] 1510 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 11] 1700 vital sign observations recorded — GCS not documented. EWS not recorded.
- [Day 11] 1730; Nursing notes entry written retrospectively for the time period 0700–1930. [Mrs A] was noted to be unrousable to pain but restless requiring PRN morphine & midazolam medication 'with some effect'. It is noted that IV fluids were in progress and [Mrs A's] urinary catheter was draining. Reference made to 'full' care provision and the presence of [Mrs A's] family.
- Reference was made to a decision to undertake observation recording once per shift to minimise distress to [Mrs A].
- [Day 11] (time not documented — initials consistent with morning shift nurse) Patient Care Plan updated to note reduction on frequency of observations to once per shift, NBM status with IV fluid and 'full cares' provision. There is no reference to the urinary catheter.
- [Day 11] 1750 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 11] 1905 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 11] 2030; subcutaneous morphine 15 mg & midazolam 10 mg infusion check (9.6 mls remaining) is documented on the *CPP MED-15 Continuous subcutaneous infusion of medication via syringe driver (adult in-patients)* chart, running at 0.69 mls/hr.
- [Day 11] 2100 vital sign & neurological observations recorded — GCS 7, pupillary reaction and motor response not documented. EWS not recorded.
- [Day 11] 2100 administration of morphine 5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 11] 2350 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 12] 0035 administration of morphine 5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.

- [Day 12] 0050 administration of midazolam 2.5mg SC (subcutaneous) is documented on [Mrs A's] national medication chart.
- [Day 12] 0221 medical notes entry (night float doctor); 'ATSP (asked to see patient) re: Discomfort & haemoptysis' (coughing up of blood). Deteriorating observations noted with sats 82% (oxygen saturations low), increased WOB (work of breathing), respiratory gurgling, anaemia (low haemoglobin count), thrombocytopaenia (low platelet count). 'New haemoptysis discussed with 'reg' ? cause'. Plan documented to administer 10 mg morphine + 5 mg midazolam STAT, increase PRN doses.

  Additional note to above included 'discussion with daughter. Reported that cause of haemoptysis unclear — could be due to infection'. It is noted that [Mrs A] may 'pass away imminently' and that [Mrs A's] daughter was 'happy to continue with symptom based treatment'.
- There are no nursing notes entries for the above episode of care.
- [Day 12] — a once only prescription for morphine 10 mg SC and midazolam 5 mg SC is located on [Mrs A's] national medication chart. There is no date and time of dose on the prescription. There are 2 initials documented against administration for morphine at 0130, 1 initial for midazolam at 0130.
- [Day 12] — a PRN (as required) prescription for morphine 5–10 mg SC Q1H, and midazolam 2.5–5 mg SC Q1H is located on [Mrs A's] national medication chart. There is no prescriber signature for midazolam.
- [Day 12] 0345 medical notes entry (night float registrar); 'Patient passed away 0240. Unclear cause of death from notes'.
- [Day 12]; Nursing notes entry written retrospectively for the time period 1900–0700. The time of documentation is not provided. 'sig event' Died @ 0240 hrs daughter present'. Retrospective summary included reference to agitation and airway secretions, OCHS (on call house surgeon) review, the use of suctioning 4–5 times and administration of morphine and midazolam. Oxygen was removed at 0100 'as coughing/spitting up blood'. [Mrs A's] daughter was noted to be present when [Mrs A] died. It is documented that 'awaiting coroners case [writing is unclear for this word and the 2 that follow] 0600 hrs'. It is noted that IV fluids and infusion pump were removed.

Following [Mrs A's] death — factual summary of events

- [Day 12] 0345 medical notes indicate that the medical registrar advised the night float doctor to handover the requirement to discuss [Mrs A's] case with the coroner to the 'day team'.
- [Day 12] 0645 medical notes entry (night float doctor); notes a discussion with the coroner who will 'take jurisdiction in case'. It is noted that the coroner agreed to

removal of lines, the police were contacted to 'escort body' and that handover to the haematology team would occur 'mane' (morning).

- [Day 12] 0930 nursing notes entry for the period 0700–1500; documentation includes 'Pt deceased @ handover — body prepped by night RN'. Reference is made to preparations required to transfer [Mrs A's] body to the mortuary and 'paperwork completed'.
- This is the last entry in [Mrs A's] patient examination and progress notes in the clinical file.
- [Day 12] — 'Hospital Record of Death' form is included in [Mrs A's] clinical file, time of death noted to be 0240.
- Dated [after death] 1413; general discharge summary letter to [Mrs A's] GP is located in the clinical file outlining the events occurring from [Mrs A's] admission to [Hospital 1] and her death on [Day 12].
- The DHB *Serious and Sentinel Event Investigation Report* indicates that a SAC1 review was completed on 16 December 2016.
- The *response letter from Capital & Coast District Health Board to the Health & Disability Commissioner* dated 19 April 2017 indicates that the *Serious and Sentinel Event Investigation Report* was submitted to the HDC (date not provided). Reference to this is not included in the event report document provided to me.
- The *response letter from Capital & Coast District Health Board to the Health & Disability Commissioner* dated 19 April 2017 indicates that a copy of the report was provided to [the family] in February 2017.
- Evidence that the DHB *Serious and Sentinel Event Investigation Report* was submitted to the national HQSC (Health Quality and Safety Commission) central repository was not provided to me.
- The reportable event document of [Day 9] relating to [Mrs A's] fall was not provided to me.
- A subsequent reportable event document for [Mrs A's] death (if completed) was not provided to me.

Response(s) to the Commissioner's questions:

…

2. *The management of [Mrs A's] falls including assessment of risk, interventions to manage her falls and care following the event.*

[Mrs A] experienced an unwitnessed fall on [Day 9] that the Capital & Coast (CCDHB) serious and sentinel event review team concluded 'is likely to have hastened her deterioration' in the context of concurrent, rapidly progressing newly diagnosed lymphoma. The CCDHB *Serious and Sentinel Review Report* (16 December 2016)

undertaken after [Mrs A's] death on [Day 12] identified that initial nursing assessments at the time of [Mrs A's] transfer to [Hospital 1] were not completed until two days after her admission. They also noted that there were lengthy periods between review and reassessment of the Patient Care Plan, falls and delirium risk that 'potentially led to a lack of recognition of the rapid progression of the patient's condition and the risk associated with this'. The *Serious and Sentinel Review Report* chronology (timeline) identifies clinical record references to [Mrs A's] mobility, unsteadiness, falls risk, delirium risk and the omissions to completion and documentation of expected assessments. The review team identified two root causes for [Mrs A's] fall:

- Lack of recognition for deterioration of general condition
- Insufficient risk assessment

- The report details that the patient admission to discharge plan (PADP) requires that each patient is assessed for falls, pressure injury and infection control risk within one hour of admission to the ward (according to *CCDHB Policy 1.1415 patient admission to discharge plan (PADP)*). In [Mrs A's] situation this was documented two days later ([Day 3] — approx 46 hrs post admission). Additional to the report, the following components of the PADP were noted to be incomplete in the clinical record provided to me:
  - Resuscitation status, health passport, advance care plan, family violence screening, estimated date of discharge & EDD discussion with family

- The remainder of the PADP document (delirium risk assessment and plan of care) are required to be completed within eight hours of admission, reviewed daily and all assessments reviewed if the patient's condition changes (according to *CCDHB Policy 1.1415 patient admission to discharge plan (PADP)*). In [Mrs A's] situation there were no risk assessments carried out or a care plan completed until two days later ([Day 3]). At this point the falls and delirium risk assessments were both recorded as no risk. Additional to the report, the following was documented in the Patient Care Plan by the morning shift RN:
  - 'assist x 1' to meet ADLs (activities of daily living), 'assist PRN (as required)/ supervise' for mobility. The falls risk Yes/No section was not completed.

The review team acknowledge (in the *Serious and Sentinel Review Report)* that there was a lack of recognition of [Mrs A's] baseline condition on admission and lack of staff recognition of the progression of [Mrs A's] lymphoma prior to transfer from [Hospital 2] to [Hospital 1]. They (CCDHB review team) cite that the absence of formal handover document may have contributed to this, yet also acknowledge that [Mrs A's] discharge summary and progress notes from [Hospital 2] were supplied at the time of transfer and could have been referred to in order to ascertain [Mrs A's] state of ill-health.

The *Serious and Sentinel Review Report* identified a 'concern that there were no further reviews and updates of the patient's admission to discharge plan for five days'.

This is noted to have 'enabled a general lack of recognition of the patient's worsening condition across all the nursing team'. The report elaborates on factors that contributed to this lack of recognition, particularly in relation to inadequate falls risk assessments and initiation of appropriate additional measures to reduce the risk of [Mrs A] falling. A copy of the report, and recommendations was provided to [the family] in February 2017.

It appears that several assumptions have been made regarding [Mrs A's] health status, and communication of such, between health professionals involved in the care of [Mrs A] at the time of her transfer from [Hospital 2] to [Hospital 1]. In my opinion these have negatively impacted upon appropriate health assessment, data analysis and clinical decision making. This has been acknowledged by Capital & Coast DHB as a departure from hospital policy and expected standards of nursing practice.

According to the New Zealand Nursing Council Registered Nurse Scope of Practice (NCNZ 2007):

> *They [registered nurses] provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making ... Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards. (p. 3)*

It would, therefore, also be expected that the nurses caring for [Mrs A]:

- Undertake preliminary assessment of [Mrs A] at, or as close as clinically feasible to, the time of admission to the ward at [Hospital 1] including:
    - History of present concern and recent events
    - Physical examination (relating to above findings)
    - Documentation of all assessment findings to ensure that evidence was present in the clinical record for staff reference
    - It is also standard practice within healthcare settings to undertake risk assessment to mitigate or exclude risk of health care related harm such as falls, pressure injury, malnutrition, delirium and polypharmacy

      Devise and document a plan of care, based on assessment findings and treatment plans, to ensure that all health professionals involved in the patient's care are aware of care requirements and the patient's expectations.
      Bickley (2012), Zator Estes et al. (2013).

  The clinical records provided by [Hospital 2] at the time of [Mrs A's] transfer to [Hospital 1] provide documented evidence of [Mrs A's] increased risk of falling.

- Admission clerking notes ([Hospital 2]) documented that [Mrs A] was 'lightheaded', 'bowels loose' and 'fatigue++'.
- The [Hospital 2] 'Patient Transfer/Discharge' summary from ICU to the ward included documentation of 'High Falls Risk' within the neurological section of the summary record.
- [Mrs A] noted to be 'assisted with mobility; using frame very unsteady on feet. HIGH FALLS RISK' (nursing notes, clinical records [Hospital 2]).
- Daily documentation of 'assisted', 'mobilised with frame & supervision' and similar comments from RNs caring for [Mrs A] at [Hospital 2].
- Physiotherapy mobility assessment undertaken (nursing referral); 'Pt's fatigue restricting her mobilisation. Finding the frame helpful'.
- Administration of opioid (Sevredol) for pain relief.

Opinion: I concur with the CCDHB *Serious and Sentinel Review Report* findings that the absence of preliminary assessment on [Mrs A's] admission to [Hospital 1] was detrimental to her care and overall outcome. In my opinion the failure of nursing staff to ensure that [Mrs A's] health status was assessed and documented at the time of her admission to [Hospital 1] is a severe departure from expected standards of practice.

According to the information provided to me, at the time of [Mrs A's] admission to [Hospital 1] the following were significant indicators of [Mrs A's] ill-health that would, in my opinion, contribute to her risk of falling:

- Hypoxaemia (low oxygen saturations) necessitating supplemental oxygen administration, accompanied by shortness of breath on exertion
- Raised EWS as a result of intermittent tachypnoea (elevated respiratory rate), tachycardia (elevated heart rate), oxygen requirement
- Drain presence
- Requirement for supervision when mobilising
    - Use of mobility aid in [Hospital 2] — walking frame and supervision required
    - Previous documentation of high falls risk by nursing and physiotherapy staff at [Hospital 2]
- Administration of multiple medications (polypharmacy)
- Requirement for opioid analgesia (pain relief)
- Weakness, fatigue, lethargy
- Delirium risks associated with age 65+ and severe illness

The CCDHB acknowledge that [Mrs A] should have (according to hospital policy) been assessed within an hour of admission, a care plan devised within eight hours and a daily review undertaken to identify and manage risk, and care requirements. In addition to this, the information provided to me suggests that the RNs undertaking clinical assessment and ongoing care provision for [Mrs A] failed to appreciate the significance of relevant clinical indicators within their interactions with [Mrs A], or review of prior documentation relating to her care. Examples are outlined within the timeline in this report and include:

- [Day 3] falls risk assessment (1135) identified 6 risk factors. The associated care planning statements are blank (there is no indication as to the care required). Medication effects was not identified as a risk factor. [Mrs A] was receiving 6 medications, including morphine at this time.
- [Day 3] Patient Care Plan completed by the morning shift RN identified that [Mrs A] required 'assist x 1' to meet ADLs (activities of daily living), 'assist PRN (as required)/supervise' for mobility. The falls risk Yes/No section of the care plan was not completed.
- [Day 4] 1140 nursing notes referring to [Mrs A's] condition from 0700; '++ fatigued', difficulty with independent washing, increasing breathlessness, 'dizzy when changing positions'. The falls risk Yes/No section of the Patient Care Plan was not completed.
- [Day 4] 1355 nursing notes refer to audible wheeze & crackles on chest auscultation, pitting oedema & 'confusion?' The falls risk Yes/No section of the Patient Care Plan was completed with a tick and a line thorough it (meaning is unclear). The CAM risk was identified as –ve (negative) in the Patient Care Plan despite documentation of the comment 'disorientated'.
- [Day 5] 0420 nursing notes entry; 'Incontinent of urine x 1, woke up distressed which caused incontinence'. Falls risk assessment for incontinence (as an underlying issue) was not updated at this time. Patient Care Plan elimination/ output section was not updated at this time.
- CCDHB *serious adverse event report* 'progress notes for the period that the PADP was not completed indicate a continued decline in the patient's condition' … 'the fact that the care plan was not reviewed and updated enabled a general lack of recognition of the patient's worsening condition across all the nursing team'.

According to the New Zealand Nursing Council Registered Nurse Scope of Practice (NCNZ 2007):

> *They [registered nurses] provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making … Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed*

competence, meet legislative requirements and are supported by appropriate standards. (p. 3)

In addition to missing assessment information there appears to be a lack of correlation between assessments that were undertaken and the plan of care that was subsequently devised through the process of data analysis and clinical decision making in this case. This raises questions concerning the level of understanding and practice amongst the RNs involved in [Mrs A's] care. It would be prudent of the ward and CCDHB senior nursing staff to undertake a learning needs analysis to establish whether there is/the extent of knowledge deficit amongst the RNs practising in this ward. Whilst it may be that other factors such as staffing levels and nursing workloads or the utility of the documentation available have negatively implemented on the RNs' ability to document findings and risk assessment, it cannot be assumed that limitations in understanding have not contributed to [Mrs A's] care and overall outcome.

Opinion: Clinical assessment and subsequent care planning by the nursing staff involved in [Mrs A's] care failed to identify indicators of the severity of [Mrs A's] deteriorating condition and her risk of falling. In my opinion, whilst each individual omission in assessment, planning and written communication represents a mild departure from expected standards when considered in isolation, the cumulative effects of missed, incomplete, or incorrect nursing assessment in this case were detrimental to [Mrs A's] care. I consider this to be a moderate departure from expected standards.

The CCDHB *serious adverse event report* recommendations include that the review findings are presented to the ward senior nursing team in order that the team devise a plan as to how adherence to the requirements of the falls management policy will be achieved. It is my opinion that the actions taken by the CCDHB as a consequence of this case should be extended to include:

- Documentation audit to establish the frequency and severity of 'absent' assessment and documentation of:
    - Admission PADP components within the first hour of admission
    - Patient Care Plan and additional assessments within eight hours of admission
    - Daily review and update (as a minimum)
- Review of staffing levels and nursing workloads on the shifts where documentation of [Mrs A's] assessment and care was incomplete to evaluate the potential impact of nursing workload on documentation compliance
- Learning needs assessment +/- education plan to facilitate improved RN abilities in assessment and clinical decision making

[Mrs A's] daughter's letter of complaint to the HDC (dated […]) expresses concern regarding a seven hour delay in communication of [Mrs A's] fall to the family. The *CCDHB response letter to the Commissioner* (dated 19 April 2017) outlines the sequence of events following [Mrs A's] fall and acknowledge that the CCDHB policy, to notify the nominated next of kin if a patient falls, was not upheld in [Mrs A's] case. A written apology from [CCDHB] was provided to the family within the letter to the Commissioner. The letter also acknowledges that although the documentation by the RN at the time of [Mrs A's] fall indicated that the next of kin had not been informed this was 'not recognised by the morning staff'. The documentation of [Mrs A's] fall is clearly indicated in the clinical record by way of a sticker for 'fall or near miss requiring a reportable event' placement. There is no evidence in the *serious adverse event report* to explain why this was overlooked by the medical and nursing staff on duty on the morning of [Day 9]. This raises questions concerning the standard practices and expectations for staff to review clinical records at the commencement of their care for a patient. The nursing notes entry pertaining to the fall indicate that [Mrs A] was 'still to be reviewed by medical staff' however there is no mention of the communication undertaken between RNs at the handover of care. The 'Falls reassessment completed by' section is signed by the attending RN and the 'yes' box is ticked for 'falls prevention strategies reviewed & amended', however the fall risk reassessment was not completed until 1620 hrs that day ([Day 9]) by another RN.

Review of the documents provided to me raises further questions concerning [Mrs A's] care, and the communication of such amongst clinical staff, following her fall. Whilst the nursing notes at the time [Mrs A] was discovered following her fall identify that she was alert and orientated to place, date and person a full set of neurological observations was not completed until 0735. It would be expected that, if a patient had an unwitnessed fall resulting in injury to the head (and the potential for loss of consciousness) the RN would initiate neurological observations and seek medical review as a matter of urgency.

- The on call house officer completed a partial assessment at 0740 (incomplete due to a medical emergency call). The ward round registrar completed a full assessment at 0940 identifying limb strength deficit and head injury, requesting a CT head and to 'continue neuro obs'.
- A physiotherapist assessment was undertaken at 1200 noting a smile droop on the L) side and decreased level of consciousness. There is documented evidence of the physiotherapist's plan to 'liaise with the medical staff', resulting in an urgent CT scan at approximately 1230 hrs.
- There is a nursing notes entry at 1305 hrs by the transit RN who is presumed to have accompanied [Mrs A] to CT scan.
- There is no evidence of a baseline assessment of [Mrs A's] condition by the oncoming morning shift RN until 1620 hrs that day (notes written in retrospect).

- GCS and neurological observations were however, undertaken at 0735 (GCS 15), 0920 (GCS 15 — pupillary response not documented, limb strength not documented), 0950 (GCS 15) and 1205 hrs (GCS 15), and 1315 (GCS 12 — pupillary response not documented, limb strength not documented).

  During the morning [Mrs A's] neurological status deteriorated to the point that she was noted to be 'virtually unresponsive' at 1400 (retrospective nursing notes) and the medical impression is documented as 'dying from aggressive lymphoma' (medical notes 1330 hrs). There is no GCS neurological assessment documented for this time.

- Subsequent nursing notes are documented retrospectively at 1605 for the time period 0700–1530.

  This represents a significant period of time in which a nursing assessment of [Mrs A] and the deterioration that ensued were not documented.

- The next neurological assessment was documented at 1915 hrs (GCS 12), representing a period of some six hours between observations.

- Thereafter a set of observations were documented 5 hours later at 0030 hrs. [Mrs A's] GCS was recorded as 9, the correct score was 8.

Opinion: The clinical records for [Day 9] contain multiple references to an acute deterioration in [Mrs A's] condition and several medical review statements concerning alterations to the plan of care and communication with [the family]. It is acknowledged that in situations of acute deterioration clinical notes may have to be documented retrospectively. However, best practice recommends that nursing documentation should:

> *Be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient or client including standard care and out of the ordinary care.*
>
> *Be accurately dated, timed and signed, with the signature printed alongside the first entry.*
>
> *Be consecutive …*
>
> *Identify problems that have arisen and the action taken to rectify them.*
>
> *Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared, with rationale for the nursing action and/or inaction.*
>
> New Zealand Nurses Organisation (NZNO) 2017 p. 4

It is my opinion that the nursing documentation relating to [Mrs A's] care following her fall is inconsistent with the standards above. In particular, there is a lack of documented evidence that nursing assessment was linked to clinical decisions,

interdisciplinary communication, care planning and actions taken in [Mrs A's] care. In situations where acute deterioration leads to change in the plan of care or treatment the need for accurate assessment and documentation are paramount. Whilst it is unlikely that a change in documentation practice would have influenced [Mrs A's] outcome in this situation I consider the lack of apparent framework and consistency of clinical assessments, observations and nursing documentation to be a moderate departure from expected standards.

3. Additional advice requested — Serious Adverse Event review, report and recommendations set by the DHB

The *Serious Adverse Event Review Report* […] is consistent with the *Health Quality and Safety Commission New Zealand (2012) National Reportable Events Policy* (current at the time of the event investigation) as the following principles were reflected in the investigation report. I have provided opinion and recommendations in relation to areas that I believe could be improved in order to implement meaningful changes to prevent the recurrence of root cause and contributory factors in this event:

3.1 Open disclosure/open communication.

Opinion: The CCDHB have acknowledged, and apologised for, the seven hour delay between the time of [Mrs A's] fall and the family ([Mrs A's] son) being informed of her fall. This time delay was acknowledged (by the CCDHB) to have occurred contrary to the CCDHB policy of notifying the next of kin if a patient falls (no specific time period for this was identifiable in the information provided to me). The haematology consultant and Executive Director, Clinical Medicine, Cancer and Community Directorate for the CCDHB have each apologised for this delay (verbally and in writing, respectively). Whilst this delay in communication is extremely unfortunate in the context of [Mrs A's] rapid decline [the family] appear to have received truthful and open communication following this event, and the subsequent information provided by CCDHB to the Commissioner's office.

3.2 System changes. Reporting is … accompanied by meaningful analysis which leads to system changes designed to prevent recurrence of events.

The review team have completed an analysis of written documentation pertaining to [Mrs A's] fall, and subsequent death. They consequently identified several areas where DHB policies were not upheld and the potential impact that this may have had upon [Mrs A's] care, and ultimate outcome. The review report recommended that the review findings be presented to [the] senior nursing team (no date provided) and a plan be developed to improve adherence to the hospital falls management policy. The recommendation specifies that a timeline is required and feedback be provided to the directorate's Associate Director of Nursing and Quality teams (no date provided). The review report thus indicates that lessons learnt will be disseminated locally (the directorate). Evidence that the port was submitted Nationally to the central repository (via the Health Quality and Safety Commission — HQSC) was not provided to me.

Opinion: The SAC 1 Event Review report identified two root causes of [Mrs A's] fall that relate to the following factor categories*:

- patient — complexity and seriousness of condition
- task and technology — use of protocols and decision making aids
- individual (staff) — lack of recognition for deterioration of general condition
- team — written communication
- organisational and management — policy, safety culture and priorities

*Taylor-Adams & Vincent (2001)

The recommendations made are linked to the report findings with respect to the management of falls and policy compliance. However I believe that the event analysis and recommendations are limited.

In my opinion the evidence provided to me also identified contributory factors that relate to the following categories:

- individual (staff) — knowledge and skills
- team — supervision and seeking help

The CCDHB review team identified that there was a lack of recognition, amongst the nursing staff caring for [Mrs A], for the deterioration of [Mrs A's] general condition. The report identifies that this is linked to a lack of risk assessment and documentation of care planning. In my opinion the documentation of nursing notes provided to me demonstrates limited evidence of correlation between risk assessments, the Patient Care Plan and evidence of the care provided. This suggests a lack of knowledge and skills amongst the nursing staff with respect to health assessment and critical thinking. The fact that a baseline health assessment of [Mrs A's] condition on admission to [Hospital 1] was not completed by nursing staff warrants further investigation. Inconsistency and inaccuracies in the frequency, recording and interpretation of neurological assessments following [Mrs A's] fall also warrant further investigation. It is important that the event review investigation considers all potential factors that may have contributed to non completion of required assessments, observation and care planning documentation.

- task and technology — use of protocols and decision making aids
- organisational and management — policy, safety culture and priorities

There is limited evidence of investigation as to why existing policies, assessment and care planning documents were not utilised in the provision and evaluation of nursing care. It is important for future practice, the family's reassurance, and mitigation of further risk that the following are explored further:

- documentation compliance audit to evaluate consistency of completion/non completion for nursing health and risk assessment records in various wards in the directorate. This would identify the frequency and severity of policy breach beyond [Mrs A's] isolated case.
- review of document utility — are documents fit for purpose?/how are documents used in practice? This could be achieved via staff interview and/or survey. It is important to establish whether documents serve their purpose to guide and direct patient care and evaluation before employing strategies to enforce compliance.

In my opinion the Patient Care Plan provides an extremely limited framework in which to apply and evidence the nursing process. Links between assessment (including risk), planning and evaluation are not explicit in this case, nor is there an evident link between the care plan and documentation of nursing notes.

- team — written communication

There is limited evidence of a framework for written communication in the documentation of nursing notes within the clinical record. As previously stated the nursing documentation relating to [Mrs A's] care following her fall is inconsistent with the Zealand Nurses Organisation (NZNO) standards (2017). There are multiple entries that do not state the time of documentation and it appears to be accepted practice to document retrospectively, contributing to non-chronological recording of sequential events. Several medication administration signatures were also noted to be absent from the national medication chart (see timeline in this report). It would be prudent for the review team to explore practice and opinion with regards to the DHB documentation policy and expected standards of practice.

It would also be good practice to use a communication tool such as the ISBAR sticker format within the clinical notes as a 'red flag' to nursing and medical staff that key information is detailed (HQSC 2016, CDHB 2013). In [Mrs A's] case this would have clearly documented changes in the plan of care that occurred as a consequence of her deterioration and investigative results.

- work environmental factors — staffing levels and skill mix, workload and shift patterns

The review team have considered continuity in nurses caring for [Mrs A] to determine whether this may have impacted on her care. They identified that a total of 14 nurses provided care for [Mrs A] over a ten day period. There is no further analysis of this statement in the report provided to me. There is no evidence in the review report that factors such as staffing levels, skill mix, or nursing workload were investigated, nor were any staff interviewed to provide clarity and/or explanation as to why assessments were not completed or reviewed as expected. It would be beneficial to this investigation to undertake the actions below:

- Review of nursing workload and staffing levels at the time of [Mrs A's] admission and ongoing care to establish the presence/absence of causal factors
- Review of document utility — as above through a process of staff interview/survey and audit

3.3 Accountability is provided by assuring the community that when adverse events and near misses occur, action is taken both at the local and national level. Action at the local level focuses on learning, improving safety and reducing the possibility of recurrence. At the national level action focuses on analysing aggregated data, reporting publicly on reportable events and sharing information about actions taken to reduce the possibility of recurrence or ensuring prevention.*

Opinion: The investigation and reporting process has demonstrated to the family, DHB staff and the Commissioner that appropriate systems are in place to identify, investigate and report adverse events. The report recommendations have a significant focus on senior staff awareness and the employment of strategies to ensure that hospital policies are upheld. The identification that clinical assessments and documentation expectations were not upheld is a significant finding that warrants some additional investigation (see 3.2 opinion).

Evaluation of the findings and impact of subsequent strategies will be an important component of 'closing the feedback loop' for [the family].

*The responsibility for National data analysis lies with the Health Quality & Safety Commission. It is not clear in the information provided to me that a report of this investigation has been submitted to the central repository of the HQSC in order that the learning may contribute to National understanding and patient safety.

3.4 Reporting must be safe. Consumers and staff must be empowered to report events without fear of retribution. Events that are reported must be investigated with a focus on determining the underlying system failures and not blaming or punishing individuals. Providers must ensure a just culture prevails so individuals are not held accountable for system failures.

Opinion: The report reflects an open communication style in which members of the review team, medical staff and executive director (clinical medicine, cancer and community directorate — CCDHB) have contributed to the review, reporting process, verbal, and written communication with [the family] and the Commissioner's office. The CCDHB have analysed the findings using the HQSC principles to identify root causes in organisational and systems factors that have impacted on the care provided to [Mrs A] and her family.

The report does not detail how information and lessons learned from this event will be shared with the staff directly involved in [Mrs A's] care. Nor is it evident that the staff have participated in debriefing sessions or been offered employee assistance

programme (EAP) support to enable their concerns to be voiced. The rapid decline in [Mrs A's] general condition following her fall, and the conflicting information provided by various medical specialists concerning the CT scan results and plan of care are likely to have caused distress to those staff involved in this incident and subsequent investigation. It is recommended that the CCDHB consider this to be an integral part of any serious adverse event investigation and include reference to measures taken within the event review report.

During the process of completing the investigation, report compilation and analysis of information gleaned the CCDHB have:

5.5 Undertaken an incident review for serious and sentinel events

Opinion: The methodology is consistent with recommended methods of clinical incident investigation and analysis (Taylor-Adams & Vincent 2001, Vincent et al. 2000, HQSC 2012, 2016, 2017). Limitations, in my opinion, of the DHB's review process and analysis of findings have been detailed in the preceding text.

5.6 Developed recommendations to eliminate, control, or accept the root causes or causal factors identified for the adverse event

Opinion: As discussed above, the recommendation to develop strategies to improve staff compliance with the DHB falls management policy may well contribute to patient safety in the future. However, it is my opinion that further exploration of the potential factors influencing staff engagement with existing assessment and documentation practices is warranted in order for risk reduction to make a meaningful contribution to patient safety.

Timelines for implementation of the documented recommendations (within the review report) have not been provided to me. It will be important to 'close the feedback loop' on all recommendations to ensure that the actions indeed translate into action and shared learning. The actual, and intended, actions should be monitored and shared with clinical nursing staff, the Commissioner's office and [the family] (should they wish to receive further updates). The findings of further investigation and all recommendations need to be tracked to ensure that the intended changes to systems and practice are i) implemented and ii) effective (HQSC 2016, p.22).

4. Additional considerations important to this complaint.

I believe that all considerations important to this complaint and my instructions from the Commissioner's office have been addressed in the preceding text. I would urge the CCDHB to evaluate the culture and understanding amongst the clinical nursing staff with respect to the role of health assessment as a foundation for nursing practice and clinical decision making. Whilst the care provided within an acute environment is influenced by the ability of the whole organisation's ability to respond appropriately, it

is vital that systems and processes are in place to enable staff to provide appropriate care.

Dr Jane Hardcastle

14 July 2017

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