Aged Care Facility
Registered Nurse, RN A
Registered Nurse, RN B
Registered Nurse, RN C

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01025)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly man by an aged-care facility and three registered nurses in 2018. The man resided in an independent living cottage at a retirement village and sought assistance from nurses at the rest home/hospital after a fall. There was a lack of clarity about the roles and responsibilities for staff responding to village residents who had a head injury, which resulted in a delay in the escalation of the man's care.

2. The report highlights the importance of aged-care providers having clear expectations of the care provided for village residents who live independently by staff in the rest home.

Findings

3. The Deputy Commissioner was critical of shortcomings in the system at the facility that left staff unclear about their roles and responsibilities to village residents. As a result, the facility missed opportunities to fully inform the man's family, accurately record the man's assessment, offer extended monitoring/observation following a head injury, and support staff on subsequent shifts with information about the fall and that the man was taking warfarin.

4. The Deputy Commissioner was critical of a nurse for not checking the documentation of his assessment of the man, and not fully informing the family. The Deputy Commissioner was also critical of another nurse for not checking the accuracy of the documentation she completed on behalf of the first nurse. Lastly, the Deputy Commissioner was critical of a third nurse for a lack of adequate assessment of the man, and for leaving the man alone while awaiting the ambulance.

Recommendations

5. The Deputy Commissioner recommended that the facility consider improving the information village residents receive about an emergency, a medical incident, and requests for assistance; undertake a review of relevant policies and procedures; implement a training programme to include orientation, documentation, post-falls assessment and warfarin, and monitoring following a fall; use an anonymised version of this report as a case study; update HDC on the actions recommended in an external review; and provide a formal written apology to the man's family.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms D about the services provided to her father, Mr E, by the facility, Registered Nurse (RN) A, RN B, and RN C. The following issues were identified for investigation:

- *Whether the facility provided Mr E with an appropriate standard of care on 5 and 6 Month3[1] 2018.*
- *Whether RN A provided Mr E with an appropriate standard of care on 5 Month3 2018.*
- *Whether RN C provided Mr E with an appropriate standard of care on 5 Month3 2018.*
- *Whether RN B provided Mr E with an appropriate standard of care on 6 Month3 2018.*

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

8. The parties directly involved in the investigation were:

The aged care facility	Provider
RN A	Provider
RN B	Provider
RN C	Provider
Ms D	Complainant/consumer's daughter

9. Also mentioned in this report:

RN H	Registered nurse

10. Further information was received from:

Ambulance service	
Home support worker	
RN F	Registered nurse
Ms G	Village manager
District Health Board (the DHB)	
HealthCERT	

11. Independent clinical advice was obtained from RN Julia Russell (Appendix A).

[1] Relevant months are referred to as Months 1–3 to protect privacy.

Information gathered during investigation

Introduction

Mr E

12. At the time of events, Mr E was independent and in his eighties. He resided at the village in an independent living cottage[2] from 27 Month2 until his admission to hospital on 6 Month3 following a fall. Mr E took a blood-thinning medication, warfarin.[3]

Aged-care facility

13. The aged-care facility (the facility) operates both a rest home and hospital and a retirement village. At the start of 2018, the rest home/hospital provided rest-home and hospital-level care for up to 45 residents, contracted by the DHB. The rest home/hospital is managed by a nurse manager, and a village manager had primary responsibility for the daily operation of the village at the time of these events.

14. Mr E's Occupation Right Agreement with the facility stated under the heading "Medical and pharmaceutical":

> "The Operator will ensure that a person is available at all times to respond to calls by the Resident and ensure that a medical practitioner is available on call to respond to an emergency at any time."

15. There was an option for village residents to have an additional agreement with the facility for care services, but Mr E did not have such an agreement.

5 Month3 — fall

16. On 5 Month3, Mr E fell backwards and hit his head while walking his dog at a park. Mr E returned home to the village and telephoned his daughter, Ms D. Ms D told HDC that she advised him to contact the nurse immediately and state that he was on warfarin.

17. Mr E arrived at the rest home/hospital seeking assistance at about 9am. RN C and RN A were on duty. RN C was the senior nurse on duty and was responsible for the direction and delegation of care, and RN A was a bureau nurse employed by an agency. RN A had worked at the rest home/hospital previously.

18. RN C asked what happened and "quickly checked the back of [Mr E's] head for injuries and saw a superficial laceration that was not bleeding or oozing". She asked about medications, and Mr E said that he was on warfarin. Ms D told HDC that in her view, this warranted "at the very least, a call to the [doctor] on call for further advice".

[2] Mr E had an Occupation Right Agreement and did not have an additional agreement for care services.
[3] For atrial fibrillation following an acute ruptured abdominal aortic aneurysm repair procedure.

Assessment by RN A

19. RN C asked RN A to assess Mr E. RN C put out the blood pressure machine and asked RN A to take Mr E's blood pressure and vital signs, clean the wound, and then advise her of the results. RN C then left to complete the documentation in the nurses' station.

20. RN A stated: "[RN C] said that [Mr E] was my responsibility as he lived in the village." RN A said that he raised concerns about undertaking Mr E's dressing because he did not know Mr E, and he was doing the medication round.

21. RN A cleaned the wound, which was "superficial and not bleeding", and Mr E told RN A that he was on warfarin. RN A stated that he explained "the risk of internal bleeding, [and] that if internal bleeding occurred brain tissue might die", and told Mr E that "he would have to stay with [him] for a while because of the increase[d] risk of bleeding". RN A took time to clean the scalp injury so that he could observe Mr E for over 30 minutes. RN A did not make any recommendation to Mr E to seek medical advice in relation to the warfarin medication, and did not check Mr E's last INR[4] result. RN A noted that he did not have access to Mr E's medical notes.

22. RN A stated that he enquired a couple of times if Mr E felt dizzy or nauseous, and Mr E said he felt fine. RN A said that he asked Mr E whether he could check his eyes[5] and blood pressure as part of observations, owing to the risk of internal bleeding. RN A recalled that Mr E refused to have his blood pressure taken and eyes checked, and commented that if he had pain he had Panadol at home. RN A stated:

> "I offered to walk him back to his cottage to which he refused. I offered to organize [for] him to go to hospital to which he refused. I reassured him and reminded him again to let us know if he became nauseated, vomited, dizzy or [had] any bleeding."

23. The facility stated that Mr E was reported to be lucid and oriented, and there was no indication that he was not able to make an informed decision when he refused[6] the nursing assessment offered or medical review recommended, and returned home.

24. RN A stated: "At the time I was not familiar with what was required for residents in the apartments but followed [RN C's] direction." He said that he has since been shown where progress notes for the residents who live independently are located.

25. The facility stated:

> "[W]hen a RN becomes involved in an emergency they have a professional responsibility to provide the person with the agreed care for the context of the situation. As [Mr E] was a [village] resident, the nurses administered first aid."

[4] INR is the international normalised ratio to check for the coagulation or clotting rate of blood. A low INR result means a risk of a blood clot, and a high INR means a risk of bleeding.
[5] For pupil dilation.
[6] The facility stated that the nurses acted in accordance with Right 7(2) and (7) of the Code of Health and Disability Services Consumers' Rights.

Documentation of assessment

26. RN C told RN A that she would complete the incident form and progress notes and record RN A's assessment of Mr E. RN A told RN C that he "assessed where [Mr E's] head was knocked, that [Mr E] declined to go to hospital and that [Mr E] had gone home".

27. RN C asked a home support worker (HSW) to retrieve Mr E's records from the village, as "[i]nformation in relation to independent residents is securely held in the village Office. No information is held in the nurses' stations on independent resident[s] and the nurses do not have automatic access to these records." The aged-care facility said that there was no requirement to keep up-to-date medical history or notes for residents living independently, like Mr E, and it is the resident's choice whether they update information on their health status and medications with village staff.

Incident form

28. The incident form completed by RN C recorded the actions taken as: "Cleansed [superficial laceration on the scalp] & [RN A] explained any bleeding noted as [Mr E] is on warfarin."

29. The incident form lists both RN A and RN C as involved parties, and notes that relatives were informed and that a doctor was "not required at this moment — orientated/alert to time, place/person". The section on "Neurological obs required? (did they hit head or un-witnessed fall & does not/cannot recall if hit head)" is left blank. There is an action note to "watch for bleeding".

30. RN C stated: "I completed the incident form as [RN A] and other bureau nurses insist that we do so as we are the Senior [staff] at the village." RN A said that he was aware of the electronic system, but did not have access to complete the incident form. The facility stated that incident forms were completed on paper and later uploaded into the electronic system, so registered nurses, including bureau nurses, could complete their own documentation on paper without requiring access to an electronic system.

31. The facility acknowledged that "it is best practice for the RN providing the care to document that care provided, including incident forms". The facility stated:

> "[T]he incident form completed for [Mr E] by [RN C] could have contained further information e.g. it was not recorded on the incident form that [Mr E] had declined having his vital signs observations taken."

32. RN C stated:

> "Normally, an incident occurring outside the village would not be recorded. However, as [Mr E] had sought and received assistance from care home staff, an incident form was completed."

Progress notes

33. The progress notes were completed by RN C on behalf of RN A, who stated that he was not aware of where the progress notes were kept at the time. RN A did not review or approve the notes.

34. RN C told HDC that "[a]lthough it is accepted that the nurse who provides the care should be the one to make the record in the patient notes, in practice that is not always the case". There was no documentation of Mr E refusing to have his observations taken.

35. The facility stated that it "has never been a [facility] policy or common practice whereby permanent staff complete documentation on behalf of agency nurses".

Information given to Ms D

36. The Falls Policy required staff to notify family of a fall, and at 10am, RN A telephoned[7] Ms D to say that he had seen Mr E and cleaned the wound, there was no external bleeding, and Mr E had returned to his cottage. Ms D told RN A that she had already spoken to her father. RN A does not recall mentioning to Ms D:

- that Mr E had refused to have his observations taken;
- that medical advice should be sought in relation to the warfarin medication; or
- the risk of internal bleeding.

37. Ms D recalled a male nurse telephoning her, saying that her father had fallen and that he had cleaned the wound. Ms D said that the nurse confirmed that he knew that Mr E was on warfarin, and she recalled the nurse saying that he was not concerned because there was no bleeding. Ms D stated that she asked whether her father needed to see a doctor, and she recalled the nurse saying only if the wound started bleeding.

38. Ms D said that the conversation with RN A had reassured her, and she told HDC that "if [RN A] had said, 'your Dad refused to see a doctor, and I am concerned about this' I would have taken him myself to see the emergency Doctor".

39. The facility stated that Mr E was not deemed to lack competence, and an Enduring Power of Attorney had not been activated, and therefore there was no legal obligation for RN A to disclose this information to Ms D. The facility said that Mr E was alert and lucid and able to share information directly with his daughter.

40. The facility acknowledges that it would have been preferable for Ms D to be made aware that her father had declined having his observations taken and going to hospital for a medical assessment.

Follow-up

41. RN A discussed follow-up for Mr E with RN C, and recalled RN C saying that Mr E was living independently, so it was different to residents in the care home. The facility stated that normally no further monitoring would take place unless requested by the resident. RN C told HDC that residents in independent living have a bell in their room to call for attendance, or they can come to the care home to request healthcare assistance if they need it.

[7] RN C stated that she also telephoned Ms D, but Ms D recalled receiving a telephone call only from a male nurse, and the telephone records show only one call to Ms D that day (which is therefore likely to be from RN A).

42. RN C said that she asked an HSW to check on Mr E, and at 10am the HSW reported that Mr E was feeling fine.

43. At about 3pm, RN C handed over to RN H (on the next shift) that Mr E had sustained a fall and had returned to his cottage. RN C documented Mr E's fall and laceration on the duty report for shift handover, and noted to "watch for bleeding as he is on warfarin".

44. At 7.16pm, RN H telephoned Mr E to check on his condition, and recorded in the progress notes that he reported feeling fine. The facility told HDC that Mr E's fall was not recorded on the duty report to the next shift, as Mr E's condition had not changed, and he reported being "fine".

45. Mr E took his warfarin medication on the evening of 5 Month3.

6 Month3

46. At about 10.45am, Mr E called for assistance, and the nurse on duty in the rest home/hospital, RN B, telephoned him. RN B said that Mr E reported having pain on the right-hand side of his forehead, and a lump at the back of his head, and said that he had had a fall the previous day. RN B commented that when she telephoned Mr E at 10.45am she did not have any information about his situation "on hand".

47. RN B recorded in the progress notes that Mr E "had been complaining of pain since yesterday not relieved with pain relief". She advised him to go to hospital for further investigation, and to call back if his condition changed, and said that she would call for an ambulance and send an HSW to stay with him until the ambulance arrived.

First 111 telephone call

48. RN B called for an ambulance at 10.49am. In the transcript of the conversation, RN B was asked whether the problem was immediately life-threatening, and she replied, "[I]t's not life threatening." She said that Mr E had had a fall the previous day, had a "lump on his back" and "right forehead area pain", and that since the previous day he had been "complaining with this kind of pain". When asked whether this was a possible head injury, she replied "Yes."

49. The ambulance call handler stated, "We'll send an ambulance as soon as we can. If we do not have one immediately available, is it safe for the patient to wait?" and RN B replied "yes" and said: "I'll just ask him that he can ring us, any time, if … there's any changes." The call handler asked, "Is it medically safe for him to wait, according to your assessment?" and RN B replied: "Yes, so far, because he can still, uh, verbalise." The call handler stated: "If the patient's condition gets worse, in any way, call us back immediately."

50. The facility stated that RN B did not have sufficient information to make an accurate diagnosis/prognosis, but did correctly identify that Mr E required further investigation in hospital. RN B was not aware that Mr E was on warfarin. She told HDC: "I would have expected him to mention any other medication he was taking at this time as he is living independently."

51. RN B stated that when asked if the condition was immediately life-threatening, she replied "no" because Mr E was still alert and responsive, did not appear in any distress, and was not short of breath. She told HDC:

> "My understanding regarding what an immediately life threatening situation is includes people who are experiencing shortness of breath, are in cardiac arrest, shock, are unconscious, and myocardial infarction."

Follow-up after first 111 call

52. RN B asked an HSW to stay with Mr E until the ambulance arrived, and to update staff if his condition changed.

53. RN B had several follow-up telephone calls with Mr E while he was waiting for the ambulance. Telephone records for 6 Month3 show calls to Mr E's cellphone number at 10.33am, 10.42am, 10.53am, 11.19am, 11.28am, 12.19pm, and 12.34pm. The facility stated that if Mr E had not responded, staff could go directly to check on him.

54. At 11.13am, RN B telephoned Ms D to inform her of Mr E's condition. Ms D told HDC that her father had telephoned her "to say he was feeling terrible, had seen the nurse and an ambulance was on its way".

55. At 11.24am, the ambulance dispatcher telephoned the facility, apologised that the ambulance had not yet arrived, and performed a welfare check asking whether Mr E's condition had changed. Staff replied that there had been no change.

56. By about 11.30am, the ambulance had still not arrived, and the HSW left Mr E and returned to the facility to prepare for lunch, and informed the nursing staff. RN B said: "[T]he ambulance took much longer than we ever anticipated." She then contacted Mr E to check whether his condition had changed, and he reported no change.

57. At 11.45am, RN B noted that the call bell for Mr E's cottage had been activated, and she telephoned him. RN B visited Mr E and recalled that he was alert and responsive, the pain was tolerable, he had no shortness of breath, and he was not in distress. She recalled staying with Mr E for about ten minutes, and reassured him that the ambulance would arrive soon.

58. RN B told HDC: "I had to return to the care home where my main responsibility is in the hospital." She reminded Mr E to contact the care home if there was any change in his condition.

59. RN B stated that she did not take Mr E's observations as she did not take her "kit" with her, and she was not aware that Mr E was on warfarin. She told HDC:

> "We are not set up to take Neuro[logical] observations in the village setting, only in the care home. In most instances where there is a call out from an independent apartment or cottage/unit, a home support worker answers the bell. They do not carry out observations — they will call an ambulance, where required, and administer first aid."

60. The ambulance was dispatched at 11.56am.

Second 111 telephone call

61. Ms D recalled that at around 12.15pm, her father rang her saying that he was feeling worse, he had vomited, and the ambulance had not arrived. Ms D told HDC that she telephoned the nurses' station and asked them to ring 111. RN F took the telephone call and informed RN B. RN B telephoned Mr E, and he reported having vomited twice.

62. At 12.18pm, RN B telephoned 111 again and updated the ambulance dispatcher of the deterioration in Mr E's condition. When asked whether the problem was now immediately life-threatening, RN B replied, "Yes." The ambulance, which had already been dispatched, arrived at 12.19pm.

63. Mr E was transported to the Emergency Department at 12.40pm, but that afternoon he fell into a coma, and he died on 9 Month3 from a brain bleed.[8]

Further information

RN A

64. RN A commented that he "was very sad to hear of the family's loss". On reflection, he stated that the facility did not provide him with any orientation regarding independently living village residents, and said that he could have been "more insistent that [Mr E] go to hospital".

65. RN A told HDC that every facility has its own policies and protocols, "so wherever we go as a bureau nurse we just listen and follow their permanent staff". He also stated that he now asks a care provider to give him orientation and brief knowledge of policies and protocols.

66. RN A stated:

> "I now ask to do the documentation for the care I provide including the incident forms — I have reflected on this event and now try to do my own documentation. This can be difficult as I have had other experiences at other places where the permanent staff have completed the documentation because they have access to the systems they use."

RN C

67. RN C said that she "was shocked and very sorry to hear that [Mr E] had been taken to hospital and had subsequently passed away". She wished to extend her deepest sympathies to Mr E's family.

68. RN C has reflected on the need to ensure that staff have clear policies around documentation of patient care when bureau staff are rostered on, and what information can be discussed with the family when notifying them about the health of a resident. She is also more conscious of the risk of bleeding in patients on warfarin.

[8] "Subdural Haemorrhage 3 Days Fall Trauma on Warfarin 3 Days."

RN B

69. RN B reflected that the things that she missed on the day were that she did not take any observations of Mr E, as she did not take her kit with her when she attended him, and the knowledge that he was on warfarin. RN B stated: "I did my best on that day to check on [Mr E]. But it's still quite frustrating and sad to know even if you did your best it leads to this situation."

70. RN B said that she reflected on the differences between managing hospital residents and residents (like Mr E) who live independently. She identified that for residents who live independently, she needed to be more comprehensive in gathering information and asking follow-up questions, as staff are less familiar with their medical conditions.

Mr J's review[9] of the facility's investigation — June 2018

71. The review found that the facility conducted a timely investigation and has proactively prepared an improvement plan based on its learnings from the incident. The review included the following:

- On 5 Month3:
    a) Staff provided assistance to Mr E in a timely way and checked on him later that day. It is understandable that no further action was taken in light of Mr E's repeated comments that he was fine. Mr E was properly advised that if his condition changed, he should let staff know (which subsequently he did).
    b) It may have been helpful for Mr E to have received advice from a medical practitioner, given the combination of a fall while on warfarin. It was noted that RN A had offered to arrange a hospital admission but that Mr E had declined "as he was entitled to do".
    c) The family may have appreciated the opportunity to know that Mr E declined to have observations taken and/or that Mr E declined the offer to go to hospital.
    d) An HSW checked Mr E at 10am, the incident was notified in the handover to nurses on the afternoon shift, and RN H checked Mr E at 7.16pm. He reported feeling fine. This appears to be an appropriate response in respect of an independent living resident at the village.
    e) The explanation on the incident form for not consulting a doctor appears inconsistent with RN A's advice to Mr E about seeking further medical attention at the hospital.
- On 6 Month3:
    a) On 6 Month3, a staff member was not with Mr E at all times when he was waiting for the ambulance. This is inconsistent with the facility's policy,[10] but arises in the

[9] A legal opinion obtained by the facility on its investigation.
[10] "The Guide to Managing Emergency Call outs" states that "[where an ambulance has been called] [the facility] staff member stays with the resident until the ambulance staff arrive".

context of what seems to be a very long delay in the ambulance response time (an hour and a half).

b) Neither the HSW nor RN B followed up with the ambulance to check on arrival time until Mr E's daughter called the village to advise that Mr E was vomiting.

The facility

72. The facility said that it was "deeply saddened by [Mr E's] death" and has acted upon the recommendations from the facility's investigation[11] and Mr J's review.

73. The facility stated that it is "satisfied that it and the staff involved in [Mr E's] care provided him with an appropriate standard of care on 5 and 6 [Month3], acting in accordance with [Mr E's] own wishes".

74. The facility said that Mr E was living independently in a cottage and, under the terms of his agreement, had not engaged the facility to provide any care services other than emergency call first aid response. The facility stated that as a consequence:

- It did not have access to current medical information for Mr E.
- The registered nurses support an emergency call response that provides first aid (not comprehensive nursing assessment and monitoring).
- Mr E needed to go to a medical centre or hospital for a comprehensive assessment for a head injury.
- There is no requirement for handover between shift changes of registered nurses, or for registered nurses to provide for ongoing monitoring of village residents.

75. The facility acknowledged that a staff member should have stayed with Mr E until the ambulance arrived, and expressed regret that on this occasion a person was not with Mr E for the entire time that he waited. The facility added that the ambulance took an hour and a half to arrive, and that staff did continue to provide support to Mr E by checking in by phone and visiting him.

Responses to provisional opinion

Ms D

76. Ms D was given an opportunity to respond to the "Information gathered" section of the provisional opinion. Ms D told HDC:

> "When Dad was looking at the facility we were told there would be 24 hour MEDICAL CARE available, not first aid. This was the point of Dad going there, after his aortic aneurysm. Surely a head injury with someone on warfarin requires more than first aid and deserves a holistic approach to the injury."

[11] The facility's investigation report 2018.

77. Ms D expressed her view that "had [her father] seen a [doctor] or the nurse had rung a [doctor] for advice, he would not have taken his warfarin that night, and the outcome may have been different".

The facility

78. The facility was given an opportunity to respond to the provisional opinion, and asked HDC to reconsider the findings. The facility considers that all of the nurses involved went above and beyond the scope of their duties.

79. The facility accepted that there are opportunities for improvement, such as seeking permission from an independent resident to share medical information with family members. It added that this change has been implemented.

80. The facility told HDC:

> "[The facility] actively discourage[s] independent living residents from relying on the Care Home or the Care Home employees for medical or emergency care. Our Care Home employees have a primary duty of care to the paying (high-needs) residents of the Care Home."

81. The facility added that the rest home/hospital clearly made an exception for Mr E "and elected to observe his injury, perform basic first aid and provide him with the advice that, given he was on [w]arfarin medication, he should seek independent medical advice".

82. The facility told HDC that care homes are staffed to meet the needs of the care home residents, and stated that it is not reasonable to expect staff to be available to independent residents whenever an incident occurs, in this case outside the village. The facility said that if care home employees were required to be engaged in providing care (other than first aid) to independent residents[12] who have had falls, medical incidents, or other emergencies, they would be failing in their primary duty of care.

83. The facility stated that the Occupation Right Agreement (ORA) does not set up the expectation that village residents can use the on-site care home as a drop-in medical facility and/or that it will be a registered nurse who responds in person to calls for assistance.

84. The facility disagreed that it failed to discharge its duty of care to Mr E. It reiterated:

> "First responders in the Village to emergency calls from independent residents provide a first-aid response — and request an Ambulance where required or requested by the resident. We acknowledge that Nurses are trained to record vital signs and can perform neurological observations — however, they are only required to do this in the Care Home for residents of the Care Home. A first-aid response will be provided to an emergency call out to an independent resident."

[12] Who are not signed up to an agreement for the provision of care services with the facility.

85. The facility told HDC that the Falls Policy (see Appendix B) — which requires its registered nurses to assess the resident and take observations, including neurological observations if they have hit their head — applies to care home residents only, and not to residents living independently. The facility stated: "The duty of care from the [registered nurses] in respect of independent residents is vastly different to the duty of care owed to Care Home residents." The facility commented that RN B was required to provide a first aid response. It said that there was no obligation to provide extended monitoring or observation of Mr E in his own home.

86. The facility told HDC that it takes its obligations to residents seriously, and "will perform a further full review of [its] ORAs, policies and procedures and make any further necessary amendments where required to ensure there is no dispute as to the scope of the services which are provided to independent residents".

87. The facility commented that in order to perform a first aid response, the first responders in the village do not require access to an independent resident's personal notes. This information about independent residents is obtained when a resident moves into the village for the first time, for the purpose of assessing whether the individual is able to live independently. This information is not kept up to date, and is not relevant for performing first aid.

88. The facility said that it is unfortunate that RN A was under the impression that he needed access to the electronic system to complete an incident form, when this could have been done on a paper form. The facility told HDC that in response to this, it implemented new procedures and training for bureau staff to ensure that such confusion is not repeated.

89. The facility told HDC that it acknowledges HDC's comments regarding integrated documentation, training in relation to emergency calls from independent residents, and completing documentation, and has implemented improvements where required.

90. The facility provided further context around the occasions when a registered nurse may be able to attend to a village resident and provide more advanced clinical support, including when there are more nurses on site at the village, such as weekdays when a nurse may be holding clinic hours for village residents, and the occasions on which care by the nurses on site at the village is beyond the care home requirements.

RN A

91. RN A was given an opportunity to respond to the relevant parts of the provisional opinion, and advised that he acknowledged what could have been done differently, and has learnt from this. He reiterated that he gave clear verbal handover to RN C. He told HDC that the facility did not provide him with orientation as a bureau nurse, and he always relied on facility nurses and followed their orders. RN A added: "[W]e were told that we are still not responsible for [village] residents [as they are] living independently and they haven't paid any 24/7 nursing care and haven't signed any contract with [the facility]."

RN C

92. RN C was given an opportunity to respond to the relevant parts of the provisional opinion, and advised that she had nothing further to add.

RN B

93. RN B was given an opportunity to respond to the relevant parts of the provisional opinion, and she commiserated with Mr E's family on their loss. She commented that it was Mr E's choice whether to update her on his health status and medication, as he was living independently.

Opinion: Introduction

94. Mr E resided in an independent living cottage at the village. On 5 Month3, he fell and hit the back of his head and, on returning home, sought assistance from the nurses at the rest home/hospital.

95. This investigation considers the assessment of Mr E by RN A on 5 Month3, the documentation completed by RN C, and the care provided by RN B the following day, when Mr E's condition deteriorated and an ambulance was called. It also considers whether, in the context of Mr E residing at the village as an independent resident under an Occupation Right Agreement without additional care services, systems at the facility supported clear expectations of care for village residents by staff at the rest home/hospital.

Opinion: Aged care facility — adverse comment

The facility's responsibility to village residents

96. Mr E was living independently in the village and, under the terms of his Occupation Right Agreement with the facility, the facility was to ensure that a person was available at all times to respond to calls by the resident and ensure that a medical practitioner was available on call to respond to an emergency at any time. Mr E had not engaged the facility to provide any care services other than emergency call first aid response. The facility told HDC that its registered nurses support a first aid response, but do not provide comprehensive nursing assessment and monitoring in situations such as Mr E's.

97. My independent clinical advisor, RN Julia Russell, advised:

> "When a RN becomes involved in a situation such as an emergency, they have a professional responsibility to ensure they provide the person with the best standard of care."

98. RN Russell advised that while a comprehensive nursing assessment need not occur, it would be accepted practice for a registered nurse to undertake an initial assessment relevant to the situation.

99. I acknowledge that an "on-site" rest home and hospital that is part of a retirement village complex is not an emergency department or an accident and medical centre. It will more than likely not have a doctor immediately available, and is neither equipped nor best placed to provide advanced care in the event of an emergency situation.

100. However, under the terms of the Occupation Right Agreement, the facility has undertaken to ensure that calls for assistance from a resident will be responded to. In my view, it is therefore foreseeable that residents of a retirement village may present to the on-site home or hospital requesting attention following a medical incident or accident, and for nursing staff to undertake an appropriate triage, initial assessment, and treatment as warranted, in accordance with their professional responsibilities.

101. Operators of retirement villages with on-site rest homes and hospitals should recognise the professional responsibilities of their employed nurses to respond appropriately in such circumstances. The entities must clearly communicate the scope of their responsibility to village residents. They must also ensure that there are policies and procedures in place for their staff to follow in the event of an incident, and for all staff, including bureau staff, to be orientated to this information, and appropriately equipped to intervene as warranted.

102. The facility had policies and processes for managing incidents and emergency call-outs for village residents (see Appendix B). As part of those processes, the facility provides a 24-hour response to urgent or emergency calls by residents, and ensures that appropriately trained staff are available.

103. Two registered nurses were available to Mr E when he presented following his fall, and he was assessed by a nurse and his wound was attended to. The following day, RN B called an ambulance for Mr E and attended him.

104. The nurses' actions demonstrate to me that the facility's staff were largely aware of their professional obligations to village residents and the facility's processes. I accept that the facility and its staff recognised the duty of care they owed to Mr E when he presented to the care home after his fall on 5 Month3, and when he called them needing an ambulance on 6 Month3. However, in my view, there was a lack of clarity regarding the extent of staff responsibility for incidents involving village residents. This is discussed below.

Assessment on 5 Month3

105. I am concerned that RN A, as a bureau nurse, said that he was not aware of the processes for managing incidents with village residents, did not know where village residents' notes were stored, and understood that he needed to have access to the electronic system to complete an incident form, when the facility said that he could have completed a hard copy form. RN A told HDC that the facility did not provide him with any orientation regarding village residents who were living independently.

106. I appreciate that there can be difficulties integrating temporary staff into a shift, and that RN A deferred to, and was guided by, RN C, as the senior nurse on duty, who ultimately followed the correct process. However, as my expert, RN Russell, commented, the facility should have equipped RN A to complete the nursing role in which he was working.

107. RN A's unfamiliarity with the process inhibited his ability to complete the documentation himself, which in turn contributed to important information being omitted from that documentation, and as a result this information was not readily accessible to staff on subsequent shifts. Although there is individual responsibility for those failures, I am concerned that the facility's system did not easily facilitate RN A to fulfil his responsibilities himself.

108. As RN Russell commented, it would be beneficial if the facility record-keeping systems were integrated. I also consider that the facility should ensure that all staff, including bureau staff, receive adequate orientation on their responsibilities to village residents, including how to complete relevant documentation.

Information given to Ms D on 5 Month3

109. The facility's policies required RN A to notify Mr E's family following his incident. After assessing Mr E, RN A contacted Ms D and discussed what had happened, but omitted to mention that Mr E had declined having his observations taken or seeking further medical treatment.

110. Despite being Mr E's daughter, Ms D was not automatically legally entitled to Mr E's personal or health information. However, as RN Russell notes, it would have been prudent for RN A to have asked for Mr E's permission to share with his daughter that he had declined observations being taken or further medical treatment.

111. I note that the facility's policy has since been updated to require staff to request permission from the village resident to advise family/next of kin when a resident declines to follow medical advice. I accept RN Russell's advice that "[w]ith appropriate staff education this action will ensure that resident choices are sought, and actions appropriately recorded", and I have added a recommendation to support this action.

Ongoing monitoring and handover

112. RN A stayed with Mr E for more than 30 minutes, observing him, before Mr E returned home.

113. The Falls Policy stated that if a resident had an unwitnessed fall and hit their head, they would require monitoring, including neurological observations and checking their level of consciousness 2–4 hourly. In response to my provisional opinion, the facility stated that its Falls Policy does not apply to residents who live independently. The facility told HDC that as Mr E lived independently in the village with no additional agreement for care services, normally no further monitoring would take place unless requested by the resident. RN A similarly said that he discussed follow-up for Mr E with RN C, and recalled RN C saying that "[Mr E] was independent living so it was different to residents in the care home".

114. While I acknowledge the facility's submission, I note that the Falls Policy refers to "all residents" and as such could reasonably be assumed to apply to residents living independently. Staff in this case appeared to understand that some level of further monitoring was required: RN C identified that Mr E required further follow-up, and a home support worker was sent to check on Mr E at 10am, and she reported that Mr E was feeling fine. A further check took place at 7.16pm, when RN H made a follow-up telephone call to Mr E, who again reported being "fine".

115. While I am reassured that individual nurses followed up on Mr E, the facility's submissions that further monitoring was not required demonstrates a lack of clarity for care home staff about their responsibilities to village residents. It is not clear what monitoring or observations were, or should have been, offered to Mr E during those checks. Neither is it clear that a home support worker had sufficient skill and expertise to assess the status of Mr E's condition adequately or recognise signs of a head injury. In my view, the facility could provide more specific and practical guidance around monitoring for village residents, including the degree of monitoring required, who should undertake such monitoring, and the length of time that monitoring is required after a village resident has had a fall. I note that in response to my provisional opinion, the facility has considered my feedback on this lack of clarity and has reviewed policies and provided further training.

116. I also note that information about Mr E's fall was not handed over between RN H's shift and the following shift. The facility noted that there is no requirement for handover between shift changes of registered nurses, or for nurses to provide for ongoing monitoring of village residents. RN Russell noted that an opportunity for improvement was better communication between shifts. I agree. In circumstances such as a head injury, there is potential for a person's condition to decline progressively over time. In my view, it would be appropriate for the facility to ensure that its policy includes an explicit requirement for care home staff who have been involved in an incident with a village resident to hand over important information relating to that incident between shifts in the duty report. More robust safety-netting measures should be put in place to prompt follow-up by staff. This should aid in clarifying the facility's expectations for care home staff's ongoing monitoring of village residents.

Attending village residents in an emergency

117. I am concerned about a lack of clarity in the facility's expectations for its staff regarding the care to be provided to village residents in an emergency.

118. RN B asked a home support worker to stay with Mr E until the ambulance arrived, and to update the nurses if his condition changed. Typically, home support workers have received first aid training. However, there is no evidence that the support worker who attended Mr E had a first aid certificate, as required by the facility's policy, and therefore the support worker was not suitably qualified to attend in this emergency situation.[13]

[13] A "suitably qualified person" is defined in the policy as a person who holds a current first aid certificate.

119. I am also concerned about the lack of clarity in the policy regarding when it is more appropriate for a registered nurse to attend. The policy[14] states that a suitably qualified person should attend, and that a registered nurse is available via the telephone for consultation. The policy also says that on some occasions, a nurse may be able to attend to the resident and, if appropriate, provide more advanced clinical support. In response to my provisional opinion, the facility provided further context to when this would apply, such as on weekdays when a registered nurse may be holding clinic hours for village residents, and when care by the nurses on site at the village is beyond the care home requirements. However, I am still of the opinion that the policy was unclear on when it was appropriate for a registered nurse to attend.

120. The policies were also unclear about the level of assessment required. When Mr E contacted the care home on 6 Month3, the facility's policy required an available nurse to attend to and assess Mr E, including taking his vital signs. However, the facility told HDC that a comprehensive nursing assessment is not part of the emergency response it provides to village residents, and that residents would need to attend a medical centre or hospital in such circumstances.

121. When RN B attended to Mr E, she did not take his vital signs in accordance with the facility policy, saying that she did not take her kit, and that staff were not set up to take neurological observations in the village setting, only in the care home. In response to my provisional opinion, the facility stated that RN B was required to provide a "first aid response", and not neurological examinations.

122. It is evident that both the facility and its staff are unclear about what constituted a "first aid response", and what staff needed to do for Mr E as a village resident in the midst of an emergency. In my view, this contributed to the lack of assessment Mr E received, and to inadequate information about the urgency of Mr E's situation being conveyed to the ambulance staff. As noted above, nurses have a professional responsibility to undertake an accurate assessment. The facility should support its staff in ensuring that they can fulfil that responsibility, particularly in emergency situations.

Conclusion

123. I support RN Russell's advice that there are opportunities for the facility to improve its understanding of how staff support village residents. As RN Russell comments, improvements in policy and education may help to ensure that staff understand their roles and responsibilities in line with the facility policy, and contribute to improved care of residents.

124. There were shortcomings in the system that left staff unclear about their roles and responsibilities to village residents. As a result, the facility missed opportunities to fully inform family, accurately record Mr E's assessment, offer extended monitoring/observation following a head injury, and support staff on subsequent shifts with information about the fall and that Mr E was taking warfarin. However, I accept that the facility's duty of care to

[14] Guide to Managing Emergency Callouts.

Mr E in this case was initially an emergency first aid response and, for the most part, it discharged that duty of care.

Opinion: RN A — adverse comment

125. On 5 Month3, when Mr E presented to the rest home/hospital following his fall, RN C delegated bureau nurse RN A to assess Mr E. RN C put out the blood pressure machine and asked RN A to take Mr E's blood pressure and vital signs, clean the wound, and then advise her of the results so that she could complete the documentation.

Assessment and documentation on 5 Month3

126. The facility had a policy for Managing Incidents for Residents of the village (as distinct from residents of the rest home/hospital). The policy required a registered nurse to undertake an assessment and record the person's vital signs. The facility's care home also had a Falls Policy, which, in response to my provisional opinion, the facility said applied only to care home residents. This policy required monitoring, including neurological observations, if a person had hit their head.

127. RN A cleaned Mr E's superficial wound and asked him if he felt dizzy or nauseous, which he did not, and Mr E told RN A that he was taking warfarin. RN A then stayed with Mr E for over 30 minutes to observe him, which RN A said he did because of the increased risk of bleeding on warfarin. RN A advised Mr E to inform the nurses if his condition worsened, and Mr E said that he had Panadol at the cottage and returned home.

128. RN Russell advised that the expected standard of care in this instance was for RN A to take Mr E's vital signs,[15] do the dressing, and encourage him to attend the emergency department. RN Russell advised that checking the warfarin medication and INR was not the responsibility of RN A. RN A told HDC that he asked Mr E if he could take his blood pressure and check his eyes (neurological observations) and organise for him to go to hospital, but Mr E declined. There is no documentation about Mr E declining observations or further treatment.

129. If, as RN A says, Mr E declined observations, I accept that RN A had to respect Mr E's decision. My primary concern is that RN A did not record his assessment of Mr E or complete an incident form. Instead, the documentation was completed by RN C, and was missing important information such as Mr E declining further treatment.

130. The Nursing Council of New Zealand Competencies for Registered Nurses requires nurses to keep clear and accurate records of discussions, assessments, and care. My expert nursing advisor, RN Julia Russell, advised that a critical element of the role of a registered nurse is for nurses to make their own recordings of information such as dressings and conversations

[15] Under the Managing Incidents for Residents Policy and Procedure, vital signs includes neurological observations.

with residents and their families, and it is mandatory for registered nurses to fulfil their competencies.

131. RN A acknowledged that he should have documented his assessment of Mr E, but stated: "[A]t the time I was not familiar with what was required for residents in the apartments but followed [RN C's] direction." RN C told HDC that bureau nurses do not complete incident forms or progress notes, so she completed the documentation herself.

132. RN A also stated that he did not have access to the electronic system to fill out the form electronically. The facility told HDC that RN A could have filled out a paper version of the incident inform, which was how RN C eventually completed the form.

133. Ideally, RN A would have completed the necessary documentation himself, and had the means to do so by using a paper form. However, I accept that given his position as a bureau nurse, it was reasonable for him to be guided by RN C's direction, and for RN C to have assisted him with sourcing and completing the necessary documentation.

134. In my view, RN A was not adequately orientated to the systems and processes in place at the facility, and more importantly the interface between the rest home/hospital and the village. Nonetheless, notwithstanding the shortcomings in his orientation, I am critical that RN A did not check the incident form completed by RN C to see whether the information about the assessment and discussions had been recorded correctly. As eventuated, the incident form lacked important details, particularly around Mr E's refusal of observations and further care.

Communication with Ms D

135. The facility's policy required RN A to contact Mr E's family to advise them of the incident. RN A telephoned Mr E's daughter to inform her of the incident, but did not mention that Mr E had declined having his observations taken and seeking further medical assessment. Ms D told HDC that if she had known this, she would have contacted her father to encourage him to do so.

136. RN Russell advised:

> "[RN A] was responsible for his conversation with [Ms D] and should have clarified that he had not taken any observations to her and ensured that [RN C] also knew this, as she had delegated the task to him."

137. I acknowledge RN Russell's advice, but note that Mr E was competent to make his own decisions, and that RN A would have needed Mr E's permission to talk to his family about his care. However, ideally, RN A would have sought Mr E's views on informing Ms D that he had declined treatment.

Conclusion

138. In summary, I accept that it was reasonable for RN A, being a bureau nurse and unfamiliar with responding to incidents involving village residents, to rely on RN C to assist him by completing the necessary documentation of his assessment of Mr E. I also accept that it

would have been reasonable for RN A not to have taken observations if Mr E had declined having them taken. However, I am concerned that, having delegated completion of documentation to RN C, he did not check its accuracy to ensure that important details, such as Mr E's declining of recommended treatment, were included. I also consider that there were missed opportunities to alert Mr E's family to the discussions that occurred.

Opinion: RN C — adverse comment

139. On 5 Month3, when Mr E presented to the rest home/hospital following his fall, he saw RN C, who delegated bureau nurse RN A to assess Mr E. RN C put out the blood pressure machine and asked RN A to take Mr E's blood pressure and vital signs, clean the wound, and then advise her of the results, so that she could complete the documentation. RN C was not present during RN A's assessment of Mr E.

140. Following RN A's assessment, RN C completed the necessary documentation, including an incident form. RN C told HDC that bureau nurses do not complete incident forms or progress notes, so she completed the documentation herself. RN A stated that because he was not familiar with what was required for village residents, he followed RN C's direction.

141. After completing the documentation, RN C did not check with RN A whether all relevant information had been recorded. As it was, significant information, including Mr E's having declined to have his observations taken or seek medical treatment, was not included. The documentation also did not record that no dressing had been applied.

142. My expert nursing advisor, RN Julia Russell, advised that "[a]s RNs it is the responsibility of both [RN C] and [RN A] to ensure information is correctly recorded". I agree. Completing another nurse's documentation can lead to confusion, and increases the risk that information is not recorded or is recorded inaccurately. While I acknowledge that RN C was assisting RN A, as a bureau nurse, in completing the required documentation, she should have checked with RN A whether all relevant information had been recorded accurately.

Opinion: RN B — adverse comment

143. At about 10.45am on 6 Month3, Mr E called for assistance, and the nurse on duty in the rest home/hospital, RN B, called for an ambulance at 10.49am. My expert nursing advisor, RN Russell, considered that RN B's decision to call the ambulance was acceptable. However, two aspects of RN B's care are concerning.

Leaving Mr E alone while awaiting the ambulance

144. The facility's policies require a staff member to stay with the resident until the ambulance staff arrive. The policy also required that a staff member monitor the resident's condition

by recording physical changes and vital signs, and, in the event of deterioration, ensure that the Emergency Services are notified and understand that their attendance is now time critical.

145. RN B sent a home support worker to stay with Mr E until the ambulance arrived. However, when the ambulance had not arrived by 11.30am, the support worker left Mr E.

146. Mr E was left alone for 15 minutes until 11.45am, when RN B attended Mr E in response to the call bell. She stayed with him for ten minutes, then left, advising Mr E that she had to return to the care home because of her responsibilities there, and to contact the care home if there was any change in his condition. Although RN B kept in phone contact with Mr E throughout the morning, she did not return to him or arrange for any other staff member to stay with him.

147. The facility's guide for managing emergency call-outs noted that in no circumstances should a nurse who is the sole registered nurse in a hospital setting be leaving the building where the hospital residents are located. I note that on 6 Month3, RN B was not the sole registered nurse, as RN F was also on duty. I accept that RN B had responsibilities in the care home and that she did not expect the ambulance to take so long to arrive. However, I share my expert advisor's concern that RN B did not stay with Mr E or alternatively arrange for someone else to wait with Mr E. This is a valuable safety-netting precaution for cases such as Mr E's, where a resident's condition deteriorates.

Lack of adequate assessment

148. The facility's policy required RN B to undertake an assessment and record Mr E's vital signs if applicable. However, although RN B noted that Mr E was alert and responsive, his pain was tolerable, he had no shortness of breath, and he was not in distress, she did not take any vital signs including neurological observations. She told HDC that she did not take her "kit" with her, and that staff were not set up to take neurological observations in the village setting, only in the care home. On reflection, RN B said that she missed taking Mr E's observations.

149. The facility told HDC that a comprehensive nursing assessment is not part of the emergency response it provides to village residents, and that RN B was required to provide only a "first aid response", not to take any neurological observations. My expert, RN Russell, advised that while a comprehensive assessment may not be necessary, it would be accepted practice for a nurse to undertake an initial assessment relevant to the situation, including asking questions such as, "what happened? — when/how/why did you fall? — what medications are you on?".

150. RN B told HDC that she was not aware that Mr E was on warfarin. She stated: "I would have expected him to mention any other medication he was taking at this time as he is living independently." RN Russell advised that RN B's actions did not meet the expectations of a registered nurse in the event of an emergency situation, as she did not undertake the basic assessments of the situation, instead relying solely on the information provided by Mr E.

151. On reflection, RN B said that on the day she missed the knowledge that Mr E was on warfarin. RN Russell advised that given the information RN B had, her actions met the expectations of care. While I acknowledge that advice, I agree with RN Russell's other comment, and consider that it was not acceptable for RN B to rely on Mr E, who was clearly unwell and awaiting emergency care, to volunteer important information in this situation. In my view, RN B should have undertaken a basic assessment, and specifically asked Mr E if he was taking any medication, so that she could pass on this information to the paramedics. In accordance with the facility's policy, she should also have taken Mr E's vital signs.

152. RN B told the ambulance service that Mr E's situation was not life-threatening. My expert nursing advisor, RN Julia Russell, commented that if RN B had been aware that Mr E was taking warfarin, "she may have considered that the call to the ambulance should have been urgent". In my view, RN B's failure to undertake a basic assessment and elicit key information was a missed opportunity to recognise the potential seriousness of Mr E's situation. However, as discussed in relation to the facility, I accept that there was a lack of clarity in its expectations for the extent of assessment by care home staff of village residents involved in incidents or emergencies.

Changes made

153. The facility has made the following changes:[16]

a) Reminded staff that progress notes and incident reports should be completed by the staff member who attends to the resident in all circumstances.

b) Provided training on:

   i. Requesting permission from residents to contact next of kin to tell them of an incident and the recommendation that a medical assessment be done (if the resident declines assessment), and on recording in the progress notes the key details discussed.

   ii. The guidance that a staff member should stay with a resident at all times while waiting for an ambulance, and prioritise care-related services over other service offerings in the village.

   iii. A protocol for following up on ambulance arrival times if there is a delay of over 30 minutes after calling 111.

   iv. First responders advising independent living residents to obtain a medical assessment from a doctor.

   v. Post-falls assessment and increased risks with warfarin, and documentation and reporting.

[16] Recommendations from the facility's investigation report (2018), and provider responses.

c) Written information is provided to residents after a head injury.

d) Staff advise residents who have had a knock to the head to seek medical assessment.

e) Nurses are advised and encouraged to seek additional support from the nurse on call when unexpected events occur that may require additional resources.

f) Orientation training is provided on how to access village resident information.

Recommendations

154. In light of the changes already made (as noted above), I recommend that the facility do the following:

a) Provide a formal written apology to Mr E's family for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Consider improving the information village residents receive about the responsibility of the facility in the event of an emergency, a medical incident, and requests for assistance.

c) Undertake a review of the facility's relevant policies and procedures and report back to HDC on any changes. This should include staff requesting permission from the village resident to advise family/next of kin where they decline medical advice, improving communication between shifts, and making medical history (including medications being taken) and current health status information about village residents available for staff at the rest home/hospital. Consideration should be given to reviewing policies relating to documentation following an emergency, a medical incident, and requests for assistance.

d) Implement a training programme for all nurses who may interact with village residents, including:

   i. ensuring that staff, and in particular bureau staff, receive orientation;

   ii. enabling staff to complete their own documentation and have the skills and knowledge to do this;

   iii. providing staff education on post-falls assessment and increased risks with warfarin, and on documentation and reporting; and

   iv. clarifying the degree of monitoring required following a fall, who should undertake the monitoring, and the length of time that monitoring is required for village residents.

e) Use an anonymised version of this report as a case study, to encourage reflection and discussion during the above training programme.

f) Provide an update on the actions recommended in the review.

155. The information requested in points (b) to (f) above is to be provided to HDC within three months of the date of this report.

Follow-up actions

156. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN A, RN B, and RN C.

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

158. I will be writing to the Retirement Villages Association of New Zealand and the New Zealand Aged Care Association to request an update on the work that has been undertaken on the information village residents receive about the responsibility of the facility to provide health and disability services.

159. The Retirement Villages Association of New Zealand will be asked to provide an update on the work it has undertaken to develop an action plan in response to the findings in the 2019 Commission for Financial Capability (CFFC) report on the interface between retirement villages and aged care in retirement villages.

160. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will also be sent to the Ministry of Housing and Urban Development, and it will be asked to provide an update on the Retirement Villages Act 2003 (RVA) and its associated regulations. The Ministry will be asked to update HDC on any planned or current review of the legislation that is underway as it relates to the transition and interface between retirement villages and rest-home care, including disclosure requirements for residents.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from RN Julia Russell:

"5 October 2020

Amended 6 January 2019 report, re: [Mr E] (Dec) C18HDC01025

The purpose of this report is to review the complaint made to the Health and Disability Commissioner by the family of [Mr E]. The specific questions this report has been asked to address include:

1. The specific nursing assessment undertaken on the 5 [Month3] — following [Mr E's] fall;
2. Adequacy of the nursing care provided on the 6 [Month3] when his condition began to deteriorate;
3. Adequacy of the information nursing staff relayed to [the ambulance service] and should they have followed up sooner when there was a delay in the ambulance arriving;
4. Appropriateness of the level of supervision provided to [Mr E] prior to the ambulance arriving;
5. Adequacy and appropriateness of the improvement actions identified by the facility; and
6. Any other matters that you consider amount to a departure from accepted standards.

For each question the following elements need to be considered:

a) What is the standard of care/accepted practice?

b) If there has been a departure from the standard of care or accepted practice — how significant do you consider this departure to be?

c) How would it be viewed by your peers?

d) Recommendations for improvement.

Documents reviewed for this report include: the initial complaint; formal complaint … 26 [Month3]; copy of the death certificate; incident form 5 [Month3]; progress notes; handover 5 [Month3] by [RN C]; Village call outs with other resident information taken out for confidentiality; initial investigation notes from conversation with [RN C] and …; [RN B] written statement [Month3]; meeting notes [home support worker]; [RN F] statement; letters to [Ms D] email 14 and 21 [Month3]; [RN A] — meeting with … and … 23 [Month3]; [RN A] [meeting], phone records 5–6 [Month3]; meeting with [RN C] 8 [Month3]; [ambulance service] call log [Month3]; audio transcript first 111 call; transcript for welfare check; audio transcript for second 111 call; policies; and [facility]

document review. Also provided were the ambulance records from the call and the call log from [the facility].

Background

[Mr E] moved into an independent living unit at [the facility] in [Month1]. At the time of this incident — 5 [Month3] he was independently mobile, living alone, and taking his dog for walks. On the morning of the 5 [Month3] while walking his dog, an incident occurred resulting in [Mr E] falling and hitting his head sustaining a minor wound to the back of his head.

When [Mr E] returned to [the facility], he was seen by two registered nurses (RNs). The first, [RN C] spoke with [Mr E] and ascertained that he had fallen. [RN C] asked a second registered nurse — [RN A] — to undertake an assessment of [Mr E] and dress what is described as a superficial wound on the back of his head. [RN A] was a bureau nurse on that shift, not a permanent employee of [the facility]. However, he had worked there on a number of shifts over the previous month. [Mr E] told both registered nurses he was taking warfarin. In the minutes of [the] meeting with [RN A] he says he requested [Mr E] numerous times to have his observations, including checking his eyes (neurology observations). However, according to minutes of meetings with both [RN C] and [RN A], [Mr E] declined and returned to his unit. [RN C] in her undated statement: completed the incident form, updated the notes, says the family was advised (this is also recorded on the incident form) and advised the afternoon shift. However, it is clear from [RN A's] meeting minutes and from [Mr E's] daughter, [Ms D], that it was [RN A] that contacted [Mr E's] daughter [Ms D] regarding what had occurred.

The next day, 6 [Month3], [Mr E] used the care call in his village unit at 1045, [RN B] responded by calling him on his phone and was advised he was feeling unwell. [RN B] called [Ms D] and called an ambulance. Two calls were made to [the ambulance service] — the initial one at 1049 hours did not identify [Mr E's] situation to [the ambulance service] as potentially life threatening. [RN F] made the second call at 1217 hours because [RN B] considered that [Mr E's] situation had then become life threatening as he started vomiting. In an email from [RN B] to [RN I] on … she noted she was not aware until she spoke to him that he had had a fall and was never aware he took warfarin.

As [Mr E] was alone, and as per [the facility's] policy Guide to Managing Emergency Call Outs, a home support worker (HSW) was sent to be with [Mr E] until the ambulance arrived. The HSW stayed for a short period of time but left [Mr E] after approximately 10 minutes — knowing he was alert and returned to her lunch time tasks at 1130 hours — leaving him alone. [RN B] and [RN F] were both aware the HSW had left [Mr E] and [RN B] returned to see [Mr E] at 1145 hours and stayed with him for approximately 10 minutes and then left. [Mr E's] daughter [Ms D] had been called by her father to say he had vomited, and she called [the facility] to advise them of this. [RN B] asked [RN F] to call the ambulance again and advise [Mr E's] condition had changed. [RN B] was not with [Mr E] when the ambulance arrived so rang to confirm with him that he was on his way to the hospital.

Issues raised and responses:

1. The specific nursing assessment undertaken on the 5 [Month3] — following [Mr E's] fall.

When [Mr E] went to the care facility, he spoke with [RN C]. [RN C] asked [RN A] to undertake a dressing to [Mr E's] scalp. [RN A] meets [Mr E] and assesses the scalp wound as not requiring a dressing. [RN A] spoke with him and took time encouraging [Mr E] to have some observations taken. The information that [RN A] provided at the … meeting demonstrates he understood [Mr E] was taking warfarin and because of that and as part of the observations, neurological observations should have been taken. In notes and that he did not tell [Ms D] that [Mr E] had declined having his observations taken. Unfortunately, this information was not written at the time of the event on the incident form; it was recorded in meetings after the event. If [Ms D] had known that [Mr E] was recommended to see the Doctor/Hospital and had declined having observations taken this may have prompted her to encourage her father to have observations done or for her to take her father to the emergency doctor/department.

[RN C] records in her statement that Bureau Nurses do not complete incident forms and progress notes, so she completed the documentation. However, the incident form that [RN C] completed does not record all the information that was taken from [Mr E]. The incident form does not record that there was no dressing done, no observations taken, and neither RN suggested or made a recommendation to take observations when [Mr E] returned to his unit. [RN C] did have two staff follow up with [Mr E] to check he was feeling all right following his fall. This may be because she did not know as she may not have discussed the matter further with [RN A].

[RN A] states in the minutes of his … meeting that he should have done his own recordings of information such as dressings and conversations with residents and their families. These are critical elements of a RN role, and for a RN to fulfil their competencies, they must be able to do this. The description of the assessment/ treatment recorded of the situation that was recorded in the various meetings with staff was adequate. However, [RN A] was responsible for his conversation with [Ms D] and should have clarified that he had not taken any observations to her and ensured that [RN C] also knew this, as she had delegated the task to him.

It appears from these reports, meetings, and minutes, that there are a number of system errors that prevented [RN A] being able to complete the tasks of his role. [RN A] and other bureau staff would require access to electronic systems to record incident forms and progress notes especially when they had been working for a number of shifts at [the facility]. [RN A] should have been able to complete the RN role he was working in and the responsibilities of the role includes residents who live independently at [the facility] which he had not been aware of until that day when he was working in that area they were his responsibility (as advised by [RN C]).

A follow up call was made to [Mr E] at 1725 by [RN H] as she followed up on [RN C's] request. Information about [RN H's] call to [Mr E] was recorded in the village notes. As

per [the facility's] policy neither when [RN C] and [RN A] called [Ms D] they did not provide her with the information that her father had declined to have any observations taken.

There is one area that is a mild departure from the standards of care expected. This is where [RN C] did not record on the incident form that [Mr E] declined to have any observations done. This information was not provided to [Ms D] by either [RN C] or [RN A] as she was the next of kin not [Mr E's] enduring power of attorney and as such did not have any right to this information. An area for improvement would have been to have asked [Mr E] if he wanted them to call [Ms D] and tell her that information and this has been an area of improvement undertaken by [the facility].

The reports written by both [RN I] and [Mr J] provided several key actions to improve this situation for the future. They need to specifically improve communication and the ability for bureau staff to be able to communicate across the shifts. It would be of benefit for these two documents to be integrated with a focus on policy awareness for all staff, documentation and communication for RNs.

2. a) Adequacy of the nursing care provided on the 6 [Month3] when his condition began to deteriorate.

[Mr E] used the call bell at 1045. [RN B] called [Mr E] — he advised the Nurse that he had had a fall and had a pain on the R side of his forehead and a lump on the back of his head. [RN B] called [Ms D] to advise her that [Mr E] should go to the hospital which she concurred with and an ambulance was called.

Two calls were made to [the ambulance service] — the initial call at 1049 hours did not identify to [the ambulance service] that [Mr E's] situation was life threatening as he appeared alert and orientated. Had she been aware that [Mr E] was taking warfarin — had taken it the previous night after a fall in the morning — she may have considered that the call to the ambulance should have been urgent. [Mr E's] daughter [Ms D] had called [the facility] to tell them. The RNs at [the facility] considered that it had then become urgent as [Mr E's] condition had deteriorated. The second call probably did not hasten the ambulance arriving as it was already dispatched — [the ambulance service's] call log records the ambulance was dispatched at 1155.

Information had been handed over from [RN C] to [RN H]. However as [Mr E] had been fine at 1925 hours when [RN H] called him on the telephone it may have not been handed over to the next shift(s) as not needed to be handed over. This situation is an opportunity for improvement in the communication processes amongst the staff at [the facility].

Given the information [RN B] had the actions taken meet the expectations of care provided. However, there are opportunities for improvement here with better communication amongst shifts and with issues that affect the Village residents who have been seen by [facility] staff.

b) Adequacy of information nursing staff relayed to [the ambulance service] and should the nursing staff have followed up sooner when there was a delay in the ambulance arriving?

The first ambulance call that was made did not identify [Mr E] as having a life-threatening injury. Given the information [RN B] had this was the correct call. However, when the situation had changed — [Mr E] had started vomiting — a further call was made and the dispatcher was advised there was a change in condition. However, as noted in point 2, the ambulance had already been dispatched.

[RN B] records in the email of … that she did not tell the [the ambulance service] dispatcher that [Mr E] had a fall and that he was on warfarin and she had not taken any equipment to take observations. However, she did return to [Mr E] when [RN F] told her he had vomited, but again did not take any observations at that time either even though she did know he had had a fall. The ambulance arrived just a few minutes after [RN B] had left for the second time.

The actions of [RN B] met the expected standards of care for an RN working with a resident who resides in an independent living unit. [Facility] policies provided as part of this review are very comprehensive however ensuring staff at all levels understand and are able to action policies is essential for the safe and appropriate management for all residents. There are no records to review when education is provided for the RNs about their responsibilities to people who live in the Village as well as what information is available in the person's unit regarding their health status and medication as well as reviewing her assessment skills. There are a number of improvement opportunities here for [the facility]: implement a training programme for all RNs who may interact with Village Residents; and, the possibility of having current health status information available in the unit from staff who are not familiar with Residents. Also, [RN I's] report notes the education opportunities for individual nurses.

3. Appropriateness of the level of supervision provided to [Mr E] prior to the ambulance arriving.

[RN B] delegated a HSW to be with [Mr E] until the ambulance arrived. [The facility's] Guide to Managing Emergency Call Out Policy states that a staff member should stay with a resident when an ambulance is called. Whilst the HSW did stay with [Mr E] for 10 minutes, the HSW was confident that he was stable after this time. However, he did in fact deteriorate after the HSW had left. It is difficult to determine whether the HSW left because of the expectations of her other tasks or that she was unware that the policy says that it is a requirement for the staff member to stay with the Village person when an ambulance was called. It appears that [RN B] was also unaware of the policy as she also left [Mr E] — even though she knew he had vomited.

Initially a HSW stayed with [Mr E] and [RN B] also went to see him — neither were able to stay and this does not meet [the facility's] own standards or the standards that are expected of care providers and is a mild departure from the standards. This has been addressed by [the facility].

4. Adequacy and appropriateness of the improvement actions identified by [the facility].

In response to this complaint, [the facility] undertook a comprehensive internal review which led to several actions raised by [RN I] that included:

- Advice following an incident and injury, that all first responders suggest to Village residents that they seek a medical assessment;
- Standardise protocols for first response — which includes reviewing the policy, procedure and practice;
- Develop a hand out for residents in the event of a head injury;
- Review home care shift reports to identify risks and escalate issues to the RN on call; and
- Review on call policy.

A further review of the incident was done by [Mr J] who recommended a number of improvements; these included: improvements to documentation practices — that the staff member involved completes the documentation, that the key elements that are discussed with families and residents are included in any and all documentation, education to all staff regarding the policy requirement for a staff member and that in the event of an ambulance being called, record ambulance waiting times. A further key point is for staff to know the policy and stay with the Resident when an ambulance has been called. Both [Mr J's] and [the facility's] reports identify a series of valid improvement actions. The actions that [RN I] suggested should have been completed by [month] 2018, however, there are no time frames for [Mr J's] report as to when those actions will occur. The two reports would be best integrated to have a comprehensive set of actions.

In conclusion following his fall [Mr E] spoke with his daughter, [Ms D], who suggested he see the Nurse at the Care Facility, which he agreed to do. [Mr E] lived independently and was able to make decisions for himself. [Ms D's] complaint indicates he had made some previous poor choices in relation to his health and it is impossible to know exactly why he chose to leave without having any observations taken. [Ms D's] concerns about her father's treatment were: there was no formal assessment carried out; information has been provided that was not recorded at the time of the injury; and, there were no neurological observations taken, this would have included an assessment of pupil reaction and blood pressure and it would have been recorded regularly, at prescribed intervals. If [Ms D] had known [Mr E] had declined observations being done and there was no further attempt to take these, she could have undertaken to follow this up herself.

There are two departures from the expected standards of care.

There were a further number of opportunities to remedy the inactions, including:

- better communication with [RN A] by [RN C]; if there had been better communication with [RN A] the documentation by [RN C] would have been better, as she would have known there were no dressings/observations taken;
- staff requesting Village residents' permission to contact family in the event of an incident, where there is not an activated enduring power of attorney;
- all staff completing their own documentation and having the skills and knowledge to do this and if they do not complete their own documentation it is recorded as such;
- improved handover by staff across the 24-hour shift would have meant the staff on the 6 [Month3] knew about the fall and the warfarin; and
- clearer information from the phone calls made by [RN C] or [RN A] to [Ms D] may have led [Ms D] to take [Mr E] to the emergency doctor or the hospital.

This report identifies opportunities for [the facility] to improve their understanding of how staff support Village residents and to assist in improving communication and education amongst their staff to assist in supporting Village residents. They provide departures from the expected standards and the actions from [RN I's] and [Mr J's] reports. If integrated, these reports will identify the range of options that should address the issues that have arisen.

Julia Russell, RN, MPhil (Nursing)"

Further clinical advice

The following further advice was received from RN Russell:

"This 5 August 2019 report has been amended on the 19 September 2020. The purpose of this report is to consider:

A. the 31 May 2019 response by [the facility]; and
B. points 2 and 2a of the 6 January 2019 report regarding [Mr E] (dec).

Information for this report includes the 6 January 2019 report and the 31 May 2019 overview provided by [the facility].

<u>Section A</u> Response to summary of key points 1–9

Points 1, 3, 6, 7, 8, 9, 13, 14,15a, b and c are acknowledged with comments relevant to other points are as below.

Points —

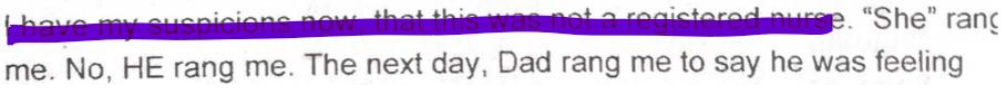
2 & 3 It is clearly understood that [Mr E] was living in [the village] as an independent resident with capacity to make decisions and take the advice of the RNs regarding treatment by [facility]-based RNs.

4 The level of assessment provided by [RN B] on the morning of the [6] [Month3] is an area of improvement for her and the service. If a RN attends an incident and has access to equipment to undertake measurements then it would be considered as good practice for her to use the equipment.

[The facility] provides a personal service in the event of emergencies and this role is often undertaken by RNs. As these are RNs it is expected that they will work as such and be accountable for their practice which includes documentation. If someone else completes your documentation, it would be expected that you would check that the information is correct. [RN C] completed [RN A's] documentation but did not record that the requests she had made for observations to be taken had not been completed by him.

[RN B] went to see [Mr E] in his apartment. [RN I] states that a comprehensive assessment was not required by [RN B]. However, an appropriate assessment with relevant questions should have occurred, in which case the appropriate urgency would have been communicated to [the ambulance service]. [RN B] knew [Mr E] had sustained a fall, but it is not clear whether she understood that was the day before or the previous week — clearly understanding when the fall had occurred would have assisted in determining the potential urgency of the situation.

5 [Ms D] does not recall speaking to more than one RN on 5 [Month3]. In her complaint letter she records speaking to an RN, a man. Below is an excerpt from [Ms D's] complaint letter.


I have my suspicions now that this was not a registered nurse. "She" rang me. No, HE rang me. The next day, Dad rang me to say he was feeling

It is therefore very unlikely that [RN C's] recollection of her conversation with [Ms D] is correct.[1]

Comments made in the 31 May 2019 letter by [RN I]

Points 1, 4, 6, 8 are acknowledged; further comments regarding the other points are as follows.

Points —

2 As per points 2 and 3 above.

3 As demonstrated in the excerpts in point 8 below the staff — [RN A] and [RN C] both understood they had responsibility to support Village residents. It

[1] RN C stated that she also telephoned Ms D, but Ms D only recalled receiving a telephone call from a male nurse and the telephone records show just one call to Ms D that day (which is therefore likely to be from RN A).

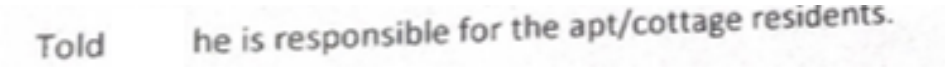
appears that this is not the case in this situation but as the two RNs believed they did their actions should have been consistent with that belief.

5 Registered Nurses are responsible for completing their own documentation. [RN A] was a bureau nurse which is why [RN C] completed the documentation. Whilst this is understood as regular practice at the rest home/hospital, having RNs complete another RN's documentation can lead to confusion about who provided the care to [Mr E], spoke to [Ms D]. Whilst it is acknowledged that [Mr E] had the right to refuse treatment, see point 8, an improvement to practice would have been to tell [Ms D] that the observations had not been taken. With that information she would have been able to have made an informed decision which may have meant she took [Mr E] to the doctor/hospital.

7 See point 10 below regarding the family of a Village resident being entitled to the resident's information.

8 [RN I's] comments regarding the potential for [Mr E's] recordings being within the normal range are correct and this is why head injuries are observed for an extended period of time. This does not justify [Ms D] not being provided the information she was entitled to, that [Mr E] had no observations taken.

9 The phone call/statement between Village Manager Ms G and [RN C] on the 7 [Month3] records [RN C] saying '[RN A] was responsible for the Village residents'.



10 & 11 [The facility] suggests that in the future they will ask Village residents if they can share information with their families. This is an excellent improvement point.

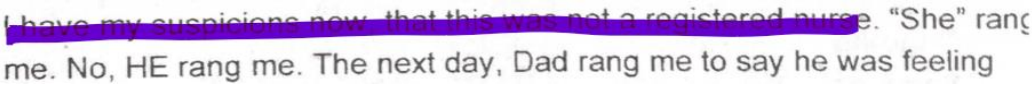
10 & 11 When a RN becomes involved in a situation such as an emergency, they have a professional responsibility to ensure they provide the person with the best standard of care which includes hand over. [RN C] directed [RN A] to undertake an assessment, which he was only able to partially complete. This partial completion of the task should have been recorded on the incident form and the information provided to [Ms D] when she was called. As [RN I] suggests if the observations were taken, they could have been normal. However, the observations were not taken, [Ms D] was not informed, and she did not get the chance to make an informed decision which she was entitled to have.

12 An HSW was sent to check on [Mr E]. There is no report regarding what was found at this check and this check was not a replacement for the observations that were not taken.

13 [RN C] identified [Mr E] as requiring further follow up, this was only for an approx. 10-hour period. An improvement opportunity would be to clarify the length of time following a fall that monitoring is required.

15 The basis for the report is the information/statements from the staff. See [RN C's] comments. As the senior nurse she considered [RN A] as the RN on that day was responsible for the Village — whilst this may not be the [facility] view it was the view of the nurse in charge on the day. [RN C] 'told [RN A] he is responsible for "the apt/cottage residents"' which is noted in the initial phone call/statement.

The two excerpts from phone conversations between [RN C], [Ms G] Village Manager and [RN A] indicate that the RNs at work believed they had a responsibility for the apt/cottage people. [RN C] states she called [Ms D] when [Ms D] says she was called by a male nurse and on the incident form [RN C] did not record that the observations were not taken.


I have my suspicions now, that this was not a registered nurse. "She" rang me. No, HE rang me. The next day, Dad rang me to say he was feeling

Note the highlighted blue areas from the initial phone call/statement from [RN C] to [Ms G] on 7 [Month3]. [RN C] notes that [RN A] did not take [Mr E's] observations. There is a difference in the information provided by [Ms D] and [RN C] with [Ms D] not recalling being called twice or by a female caller.

16 & 17 [The Village] policy states that a staff member will stay with the resident. [RN I] reports that other providers have this service provided by a phone service. If this event occurred and a person was waiting for the ambulance, phone contact would not have been broken as occurred when the staff left [Mr E] alone. The policy was set by [the facility] and was not followed and whilst the reason for the staff involved leaving [Mr E] is acknowledged, the reason that policy would be in place would be the potential for an event such as this to occur. As such, not following their own policy is considered a mild departure from the expected standard.

*Code of Disability Standards HDC, 1993

Expert advice comments

The expected standards of care were not met by:

i. [RN C] undertook to record the information and actions [RN A] took as part of [Mr E's] care. The incident form completed by [RN C] states that [Mr E's]

daughter was called, which she was by [RN A]. [RN C's] statement records that she called [Ms D], which she clearly did not.

[Facility] comment

In a meeting with [RN C] 8 [Month3], which was just after the event, [RN C] states that '[RN A] called the daughter of the resident, she said the same thing happened, although it was near the driveway and it was a cat' (13). She did advise in her statement that she had contacted the daughter to advi[s]e of the fall and been told by [Ms D] that [Mr E] had already advised her of the fall. [The facility] understand this to be a separate conversation to the call made by [RN A] after he had attended to [Mr E].

Follow up comments to i. [RN C] claims to have spoken with [Ms D] which as is evident in [Ms D's] statement she spoke with a male RN, see point 9 and 15 above.

Expert advice

ii.a [RN A] should have provided adequate information to [Ms D] and to [RN C] and failure to do so is a serious departure from the expected standard of care.

[Facility] comment

[RN C's] and [RN A's] statements indicate that information from the assessment had been requested by [RN C] and provided by [RN A]. [RN A] states that he advised [RN C] of the outcome of the assessment including where [Mr E's] head was knocked, that [Mr E] declined to go to hospital and that [Mr E] had elected to return home.

Follow up comments to ii.a. [RN A] spoke to [Ms D] and told her that he had seen her father. However, he did not say he had not taken any observations as he had been asked to by [RN C]. [RN C] knew he had not taken the recordings, but it appears he did not tell her he had not told [Ms D] that no observations had been taken. As a result of this, [RN C] did not record on the incident form that there had not been any observations nor was [Ms D] advised of this. No doubt the verbal information was handed over to [RN C] but [RN A] did not check the incident form to see if the information he had provided had been recorded. If this check had occurred, then the information that was not recorded could have been added. As RNs it is the responsibility of both [RN C] and [RN A] to ensure information is correctly recorded.

Expert advice

iii. [The facility] has made considerable improvements with the reports and recommendations from [RN I] and [Mr J]. It would be of benefit for these two documents to be integrated with a focus on policy awareness for all staff, documentation and communication for RNs.

[Facility] comment

Management, including [RN I], reviewed the findings of [Mr J's] report and recommendations were implemented. Relevant policy reading records, First Aid

certificates, training records and content are provided including training completed on emergency calls in the Village.

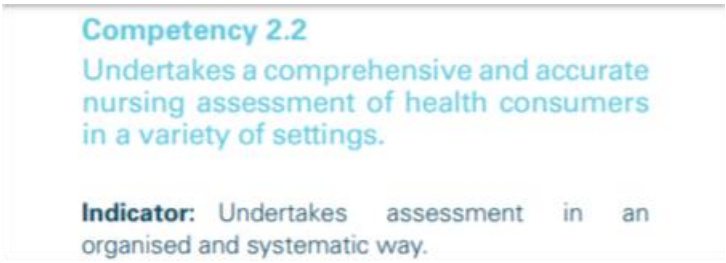
Follow up comments iii. It is acknowledged that all the recommendations from [Mr J's] and [RN I's] reports have been implemented. The information [RN B] and [RN F] had regarding [Mr E] was gathered from his phone call to them. [RN B] records in her initial information that she was unaware of the fall the previous day and that [Mr E] took warfarin.

Section B

2. Did the actions of the registered nurses who attended to [Mr E] on the 6 [Month3] meet the expectations of care?

[Mr E] was called by the afternoon RN as requested by [RN C]. [Mr E] had advised he was fine and as such no information was passed on to the next shift(s) (information from [RN I] letter 31 May 2019).

[RN I] states on page 1 point 4 of the 31 May 2019 letter: an emergency response is provided to Village residents, as such a comprehensive nursing assessment is not part of this function. Competency 2.2 of the Competencies for Registered Nurses http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse describes assessment as comprehensive but also accurate — taking place in a variety of settings.



Competency 2.2

Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.

Indicator: Undertakes assessment in an organised and systematic way.

This role is undertaken by registered nurses and whilst it is not the suggestion of the writer that a comprehensive assessment take place it would be accepted practice for a RN to undertake an initial assessment relevant to the situation, in this case a resident's home. An assessment such as this would include questions such as — what happened? — when/how/why did you fall? — what medications are you on?

[RN I] notes that [the facility] chooses to provide a personal response to their Village Residents unlike some other villages. Given [the facility's] decision that the emergency response is performed by RNs then the RNs should be trained and equipped to undertake tasks that would be expected of a RN such as basic recordings. [RN I] notes improvement would be to have the RN that went the next time to take the equipment to complete the observations. The actions of [RN B] do not meet the expectations of a RN in the event of an emergency situation as she did not undertake the basic assessments of the situation, she relied solely on the information provided by [Mr E].

Areas for improvement will depend on how [the facility] decide they want to respond to emergency situations and if they use RNs in these roles ensure they understand their responsibilities as RNs. There are also policy improvement opportunities such as the time for monitoring a head injury. [RN B] did not have all the information/training required for the situation, given this these actions are a minor departure from the standards expected.

a. Adequacy of the information nursing staff relayed to [the ambulance service] — should the nursing staff have followed up sooner when there was a delay in the ambulance arriving?

When [RN B] made the initial call to [the ambulance service] for an ambulance she had not identified the situation as life-threatening as she did not consider it as such. This decision was based on the information she had. Once she was aware [Mr E] had vomited [RN B] asked [RN F] to call the ambulance again who indicated that the situation had changed. This was the correct action. Given the information both RNs had there would have been no other reasons for her to change the urgency of the call until [Mr E] had vomited. Had [RN B] and [RN F] been aware of the timing of the fall and that [Mr E] was taking warfarin, their actions would not have met the expected standards of care. However, they did not have all of the information in part due to the lack of assessment of [Mr E], but in a larger part because of the lack of information that was available to them.

End of report

Julia Russell, RN, M Phil (Nursing)"

Further clinical advice

The following further advice was received from RN Russell:

"4 October 2020
This is the third report following the [Month3] incident when [Mr E] fell and hit his head when he was out in the community. Following the fall [Mr E] spoke to his daughter [Ms D] who suggested he ask [facility] staff to provide nursing assistance to the minor wound on his head and get checked. When he arrived at [the facility] [Mr E] advised staff while he was there that he took warfarin. [Facility] staff encouraged [Mr E] to have his blood pressure etc checked. [Ms D] was called by [facility] staff to say her father had been into [the facility]. The following morning, [Mr E's] condition began to deteriorate, and further assistance was sought from [facility] staff. Nursing staff called [the ambulance service] and arranged for the ambulance to see [Mr E] and transfer him to hospital. [Mr E] died on 9 [Month3] from a subarachnoid haemorrhage. Following this incident [the facility] undertook a comprehensive internal review completed by [RN I] [the facility] Clinical Director and an external review by [Mr J], these reports saw a number of changes in practice and policy occur.

Further information has been provided for review:

1. [Facility] response dated 5 Dec 2019.
2. [RN A] email response 24 October 2019 and 22 January 2020.
3. [RN B] response 4 Dec 2019.
4. [RN C] response dated 17 July 2020.

Responses to questions a–d in the expert advice request 21 July 2020:

a. Comment on whether the material provided changes your previous advice from January 2019 and August 2019, in particular any level of departure from expected standards regarding [the facility], [RN C], [RN A], and [RN B].

In the January 2019 and August 2019 report there were four departures from accepted care noted. These are as follows:

i. [RN C] undertook to record the information and actions [RN A] took as part of [Mr E's] care. The incident form was completed by [RN C] and key information including [Mr E] declining observations was not recorded.

Whilst it is acknowledged there are occasions when notes are written by colleagues and that [the facility] had a practice of casual staff having incident forms written by permanent staff, this does not mean this is acceptable or correct and as such remains a departure from the expected standards by [the facility]. This remains a mild departure from the standards expected of registered nurses. It is also an area of improvement that [the facility] has already implemented.

ii. The differences between [RN C] who recorded on the incident form that she had called [Ms D] — [Mr E's] daughter and [Ms D's] statement that only one call was made assertion. Given the information provided in the recent material further consideration has been given and this paragraph has been amended to:

[RN C] undertook to complete the incident form for [RN A], as permanent staff complete casual staff documentation at [the facility]. [RN C] and her post incident statement states she called [Mr E's] daughter. [RN A] also stated in a post incident meeting he had called [Mr E's] daughter. There is a difference in the information provided by [Ms D] and [RN C] regarding the calls made by [the facility] staff following [Mr E's] visit to [the facility] to get checked. [Ms D] recalls receiving one call, made from a male staff member.

iii. Neither [RN C] nor [RN A] advised [Ms D] that [Mr E] did not have the observations taken.

There is a difference in the view of [the facility] and the writer that the actions of these staff is in keeping with appropriate communication. There has been a legal review by the HDC to clarify this.

[The facility] has now added to their procedures that they will request permission from the resident to advise family/next of kin when a resident declines to follow medical advice. With appropriate staff education this action will ensure that resident choices are sought, and actions appropriately recorded.

iv. The actions taken by [RN B] on the morning of the 6 [Month3] would have been better completed had she as the registered nurse ensured that [Mr E] was not left and that she had taken equipment to be able to complete a set of observations

[The facility's] policy states that a staff member will stay with the resident. Given the length of time the ambulance took this meant the Support Worker and the RN needed to be with [facility] residents. Clinical Director [RN I] reports that other providers have this service provided by a phone service. If this event occurred and a person was waiting for the ambulance, phone contact would not have been broken as occurred when the staff left [Mr E] alone. The policy was set by [the facility] and was not followed and whilst the reason for the staff involved leaving [Mr E] is acknowledged, the reason that policy would be in place would be the potential for an event such as this to occur. As such, not following their own policy is considered a mild departure from the expected standard.

This policy has since been reviewed in accordance with the Guide to Managing Emergency Call Outs. [The facility] has reviewed relevant policies and notes that the requirement that somebody (either a staff member, if practical given the needs and requirements of the wider village and residents, or a family member/friend or other appropriate person) stay with the resident while waiting for an ambulance remains.

v. [RN B] had sufficient information following her initial phone conversation with [Mr E] to establish that he required a hospital assessment for a potential head injury. She elected to contact the ambulance service straight away to transfer him to hospital, which [the facility] considers was reasonable in the circumstances.

The actions taken by [RN B] in calling the ambulance are acceptable.

2. Consider section C 'error to correct' comment, and paragraph 16, paragraph 17, paragraph 18.2 and 18.5, in [the facility's] response dated 5 Dec 2019 and amend your previous report if necessary.

Correction in the 31 [Month3] report to acknowledge the material from [the facility] Clinical Director, [RN I] was used in preparing the report.

- Paragraph 16 — Definition of 'Representative' — Legislative Position. There is a legal response to this point from the Health and Disability Commissioner's office
- Paragraphs 17.1 the date is the 5 [Month3]
- Paragraph 18

- There is a difference in the information provided by [RN C] and [Ms D] — [Mr E's] daughter, who recalled one phone call and that one phone call was from a man and the information provided at meetings following the incident on the 7 and 8 [Month3]. It needs to be emphasized the report says it is unlikely that [RN C] made the phone call to [Ms D]. [RN C] recalled making the phone call following the event — this information was not recorded on the incident form that she completed nor did she record what she told [Ms D] in this phone conversation.

- Paragraph 18.2 — the correct date is 6 [Month3]
- Paragraph 18.5 — the documentation referred to was the incident form.

3. Consider paragraphs 13 to 21 in [RN C's] response dated 17 July 2020 and please re-frame your response to consider both scenarios (see the paragraph below on different versions of events).

Changes to the paragraph — attached is the amended report.

[RN C] recorded on the incident form that [RN A] saw [Mr E] following his fall and they had called [Ms D]. There is a difference in the information provided by [Ms D] and [RN C] who states in meetings on the 7 and 8 [Month3] that she called [Ms D]. [Ms D] recalls one call made from a male staff member. An opportunity for improvement would be to ensure that the actions or the change from planned care are recorded. On this occasion this means that it would be recorded there had been no observations taken by [RN A].

4. Review and comment on the adequacy of policies/documents provided — are there any recommendations for improvement.

As indicated in the review documents provided by [the facility] and [Mr J] there have been a number of actions and policy reviews taken and completed following this incident. These include the Falls Policy and the First Responder Guide. The [facility's] and [Mr J's] reviews completed after the incident suggested a number of recommended improvements which were made. These improvements in policy and education will assist in ensuring that staff understand their roles and responsibilities in line with facility policy and procedure as well as contribute to improved care of residents.

Following this further review there are two mild areas of departure from the standards of care which [the facility] has addressed:

1. Where [RN C] did not record on the incident form that [Mr E] declined to have any observations done. This information was not provided to [Ms D] by either [RN C] or [RN A] as she was the next of kin not [Mr E's] enduring power of attorney and as such did not have any right to this information.
2. Initially a HSW stayed with [Mr E] and [RN B] also went to see him — neither were able to stay and this does not meet [the facility's] own standards or the standards that are expected of care providers and is a mild departure from the standards.

End of report

Julia Russell, RN, M Phil (Nursing)"

Further clinical advice

The following further advice was received from RN Russell:

> "I don't think the warfarin medication and INR checking was the responsibility of [RN A]. The [date] [Month3] was a Saturday. The warfarin prescription is based on a blood test — the INR. The amount of warfarin that is taken is relevant to the INR. [The facility] would have no information about these details, how much warfarin he was taking, how often he had an INR done — or the capacity to check an INR. The frequency of doing these tests is variable with some people being tested a number of times per week while others are done much less often. These requests are made by a GP or Nurse Practitioner (NP) and could only be done at an Emergency Dep[artment] or a Lab[oratory] with the appropriate request form (completed by a GP/NP). The RN's responsibility was to check his vital signs and do the dressing and given it was a Saturday encourage him to attend an Emergency Dep[artment]."

Appendix B: Relevant standards

Policies

Managing Incidents for Residents Policy and Procedure — March 2017

This applies to both care home and village residents, and includes:

> "An event that occurs to … Residents in their dwelling in the Village don't need to be recorded in [Software] Events. For example if a resident has a fall and fractures their arm and no staff were involved isn't an incident. Their situation is considered to be the same as a person living in their own home outside the village.
>
> It would only be considered an incident if this incident occurred while a staff member was attending to the resident e.g. was showering the resident.
>
> 1. **Procedure for Incidents:**
>
> … Attend to and assess the person(s) involved in the incident. If possible find out what has happened.
>
> Apply first aid as required to save life and attend to any injury. …
>
> An RN (if available) should undertake an assessment and record the person's vital signs if applicable.
>
> If there is concern about the person's condition contact the medical practitioner, and follow orders.
>
> …
>
> If the person has hit their head with no obvious head injury or had an unwitnessed fall they will require monitoring ie. Neurological observations. …
>
> A member of staff should stay with the resident until the ambulance arrives. Monitor the Resident's condition, if there is deterioration ensure that the Emergency Services are notified and know that their attendance is now time critical. Keep a record of physical changes and vital signs.
>
> Notify EPOA/family as soon as is practically possible …"

Residents Rights & Responsibilities Policy and Procedure — January 2018

This states: "Residents are responsible for their own actions if treatment or care is refused."

Guide to Managing Emergency Call outs — February 2018

The policy, which applies to village residents, states:

Health Service Response

> "The Operator will arrange for a 24 hour a day response to any urgent or emergency calls by a Resident and will ensure that appropriately trained staff are available, and will facilitate access to emergency and/or paramedic support as required.
>
> …
>
> **Practical Application**
>
> If there is no response, or if it is clear there is an emergency, a suitably qualified person attends the resident's villa/apartment immediately. A 'suitably qualified person' may be a Home Support Worker, a Caregiver, the Village Coordinator, a Night Porter or any other designated staff member (whom holds a current first Aid Certificate) that attends village emergencies.
>
> …
>
> There is always a registered Nurse available for consultation via phone for staff.
>
> The [facility] staff member stays with the resident until the ambulance staff arrive.
>
> We recognise that on some occasions, a Registered Nurse may be able to attend to the resident and, if appropriate, provide more advanced clinical support. However, in no circumstances, should an RN who is the sole RN in a Hospital setting be leaving the building where the Hospital residents are located."

[Facility] Falls Policy — April 2016

The Falls Policy, which applies to care home residents, states:

> "To ensure all residents who have falls are attended to in a safe manner and that a full assessment and evaluation follows.
>
> …
>
> Appropriate First Aid is given. All falls are evaluated and action plans written.
>
> …
>
> Roles and responsibilities:
>
> Responsibility [of] Registered Nurse/Senior Staff Member:
>
> Assess condition of resident …
>
> take basic recordings: BP, TPR and monitor for next four hours
>
> head injuries neurological checks
>
> Monitor level of consciousness 2–4 hourly. Any changes to be reported to Medical Officer. …

Dress wound as appropriate."

The updated Falls Policy (March 2019) states:

"Contact family unless prohibited by the resident. If resident has declined recommended treatment advise family unless explicitly prohibited by the resident."

Standards

The Nursing Council of New Zealand (NCNZ) publication (amended 2016) Competencies for Registered Nurses, Competency 2.2 states:

"Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.

Undertakes assessment in an organised and systematic way."

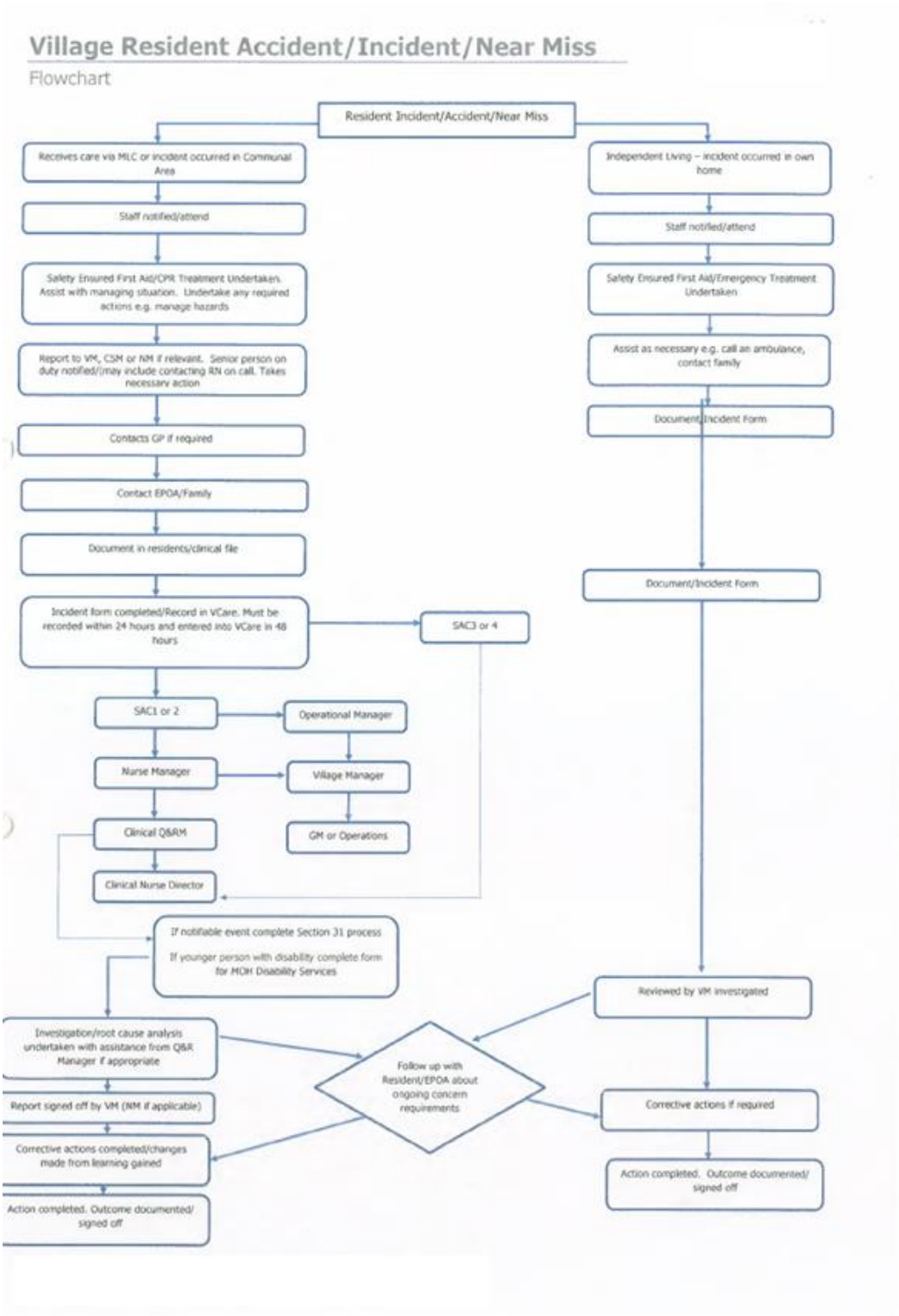
Competency 2.3 states: "Ensures documentation is accurate and maintains confidentiality of information."

The NCNZ publication *Code of Conduct for Nurses* (June 2012) Standard 4.8 states:

"Keep clear and accurate records (see Guidance: documentation).

Guidance: documentation

Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been."



Medical Emergency Flowchart

Procedure

MEDICAL EMERGENCY OCCURS

↓

Initiate First Aid as appropriate

FIRST AID KIT IS LOCATED: _____

Our First Aiders are:

↓

Call for nursing/medical assistance if available at the site,
Phone 1-111 for ambulance if required

↓

Notify Next of Kin for the person with medical event

↓

Village Manager or Nurse/Care Services Manager to be advised and communication procedures followed

Contact Numbers

Village Manager	
Nurse/Care Services Manager	
Operations Manager	

↓

Complete report in the correct reporting system as per Incident Management Procedures