Killarney Rest Home (2009) Ltd

Registered Nurse, Ms E

Registered Nurse, Ms D

Enrolled Nurse, Ms C

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00940)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A was 81 years of age when she entered Killarney Rest Home on 7 July 2011 for respite care. She had been diagnosed as having advanced dementia.

2. At about 6.30am on 10 July, Mrs A had an unwitnessed fall and sustained bruising to the right of her forehead. The night duty care assistant (CA), Ms F, and the on-call back-up staff member, CA Ms G, completed an Accident/Incident Report form. At 10.35am, Mrs A was noted to be unresponsive. She was reviewed by the rest home manager, enrolled nurse (EN) Ms C, who arranged for an ambulance to transfer Mrs A to Emergency Department. Mrs A was assessed by Emergency Department staff as having no neurological abnormality, but was admitted for observation. She returned to the rest home on 14 July, was assessed as requiring full-time care, and was admitted to the rest home for long-term care.

3. The Clinical Manager, registered nurse (RN) Ms D, signed that she checked the Accident/Incident Report form completed by Ms G on 10 July, recording Mrs A's fall. RN D did not record any follow-up action.

4. At 10.00am on 24 July, Mrs A fell off a chair, sustaining bruising to her left eye and hand. This fall was recorded on an Accident/Incident Report form completed by CA Ms I. RN D recorded that she assessed Mrs A, gave her Paracare[1] for pain relief, and advised care staff to monitor her for 24 hours.

5. On 2 August, Ms F completed an Accident/Incident Report form, recording that at 5.15am, Mrs A received a blow to her head from a door swinging back onto her. RN D signed that she checked the form but did not record any follow-up action.

6. At 11.05pm on 3 August, Mrs A fell again. Ms G completed an Accident/Incident Report form and recorded that Mrs A reported a painful upper thigh. On 4 August, RN D recorded in the Daily Progress Notes that she assessed Mrs A's left hip area. She found no injury, but gave Mrs A Paracare and instructed staff to mobilise her as able.

7. On 5 August, RN E was advised of Mrs A's 3 August fall. RN E stated that she assessed Mrs A, but there is no record of the assessment, or that care staff were given any direction for managing Mrs A's mobility, pain, or falls risk.

8. On 6 August, care staff observed that Mrs A was unable to stand. EN C reviewed Mrs A, but did not make any changes to the management of her care.

9. On 9 August, RN D reviewed Mrs A and found that she was in severe pain and unable to walk. RN D ordered X-rays, which showed that Mrs A's left hip was fractured.

10. Mrs A was transferred to hospital, where she had surgery to repair her fractured hip. She did not return to Killarney Rest Home.

[1] Paracetamol syrup.

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Decision

11. RN D failed to obtain a detailed history, fully complete the admission documentation, or prepare a care plan. She also failed to complete a falls risk assessment, and did not ensure that Mrs A's ability to make decisions was assessed and her enduring power of attorney (EPOA) sighted and retained on file. Additionally, RN D failed to inform Mrs A's family or attorney of her falls. On 4 August 2011, when RN D was aware of Mrs A's pain and inability to walk, she failed to arrange a general practitioner (GP) assessment. RN D did not provide services to Mrs A with reasonable care and skill and breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

12. The rest home manager, EN C, failed to ensure that care planning and falls risk assessments were completed and documented. She also failed to obtain a GP or registered nurse assessment of Mrs A between 5–8 August 2011, and failed to ensure that Mrs A's family or attorney were informed of her falls. EN C did not provide services to Mrs A with reasonable care and skill and, accordingly, also breached Right 4(1) of the Code.

13. By failing to provide safe care and ensure its staff were complying with its policies and procedures, Killarney Rest Home (2009) Ltd (the owner and operator of Killarney Rest Home) failed to comply with the Health and Disability Sector Standards and breached Right 4(2)[3] of the Code.

14. Killarney Rest Home (2009) Ltd also failed to ensure that a detailed history was recorded, a care plan and falls risk assessment were completed, and a plan was implemented to address the issue of falls. In addition, Killarney Rest Home (2009) Ltd failed to ascertain Mrs A's legal status or respond appropriately following Mrs A's falls. Accordingly, Killarney Rest Home (2009) Ltd did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

15. Adverse comment was made about RN E.

16. Killarney Rest Home (2009) Ltd, RN D, and EN C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

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[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[3] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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Complaint and investigation

17. The Health and Disability Commissioner received a complaint from Mrs B about the services Killarney Rest Home (2009) Ltd provided to her mother, Mrs A, in July and August 2011. The following issues were identified for investigation:

- *Whether Nurse Manager EN C provided an appropriate standard of care to Mrs A from 7 July 2011 to 9 August 2011.*
- *Whether registered nurse RN D provided an appropriate standard of care to Mrs A from 7 July 2011 to 9 August 2011.*
- *Whether registered nurse RN E provided an appropriate standard of care to Mrs A from 7 July 2011 to 9 August 2011.*
- *Whether Killarney Rest Home (2009) Limited provided an appropriate standard of care to Mrs A from 7 July 2011 to 9 August 2011.*

18. An investigation was commenced on 4 March 2013. This report is the opinion of Ms Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

19. The parties directly involved in the investigation were:

Mrs B	Complainant
EN C	Enrolled nurse/Manager
RN D	Registered nurse/Clinical Manager
RN E	Registered nurse
Killarney Rest Home (2009) Ltd[4]	Provider

20. Information was reviewed from:

Mrs B
EN C
RN D
RN E
Directors, Killarney Rest Home (2009) Ltd
The DHB
St John Ambulance

Also mentioned in this report:

Mr A	Mrs A's husband
Ms F	Night duty care assistant
Ms G	Care assistant
Dr H	General practitioner
Ms I	Care assistant

[4] On 10 June 2013 NNNM Enterprises Limited took over the lease, management, and operation of Killarney Rest Home (2009) Limited.

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21. Independent expert advice was obtained from Ms Kaye Milligan, a registered nurse with expertise in aged care. Ms Milligan's advice is attached as **Appendix A.**

Information gathered during investigation

Background

22. In 2011, Mrs A was 81 years of age and living at home with her husband, who was her primary carer.

23. On 3 June 2011, the Mental Health Service for Older People specialist visited Mrs A at home to assess her for short-term respite care. He found that Mrs A had advanced dementia and was at risk of harm because of her wandering. He recommended that she receive respite care in a secure dementia unit.

Respite care admission

24. On 7 July 2011, Mrs A was admitted to the secure dementia unit at Killarney Rest Home (Killarney)[5] for short-term respite care.[6]

25. RN D was the Clinical Manager at Killarney. She admitted Mrs A and completed a Short Stay Client Medication Record and a Resident Admission Form, and started an Admission Assessment. RN D recorded Mrs A's diagnoses as Alzheimer's disease, hypothyroidism, and "NOF" (previous fractured neck of femur hip), but no detail is recorded. RN D recorded on the Resident Admission Form that Mrs A was prone to wander, and recorded in the Daily Progress Notes that Mrs A was able to walk independently but required continence support and assistance with her daily cares.

26. RN D advised HDC that she completed a care plan and a Waterlow assessment,[7] as well as the admission assessment, with the assistance of Mr A and Mrs B, Mr and Mrs A's daughter. There is no evidence in Mrs A's records of either a care plan or a Waterlow assessment. The admission assessment is blank apart from the medical diagnoses. RN D said that she also completed a "daily care plan" for Mrs A, which was placed in her wardrobe for staff to follow, and a copy of the plan was placed in Mrs A's file. However, Killarney was unable to provide HDC with a copy of the daily care plan.

27. In response to the provisional opinion, Killarney Manager EN C stated that RN D's above statement is incorrect as the file contained the forms but they were incomplete. In response to the provisional opinion, RN D stated that she is positive that she

[5] At the time of the events complained about, Killarney was owned and operated by the registered company Killarney Rest Home (2009) Ltd. Reference to Killarney in this report includes Killarney Rest Home (2009) Ltd.

[6] The Ministry of Health advised HDC that Killarney provided care for up to 11 residents requiring rest home level care, and 11 residents requiring secure dementia care.

[7] The Waterlow assessment/score gives an estimated risk for the development of a pressure sore in a given patient. No falls risk assessment was included in Mrs A's records.

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completed the daily care plan, falls risk assessment, pressure risk assessment and the admission care plan. She stated that she remembers filling out the forms which were then placed in Mrs A's file.

28. Mrs A's son-in-law is recorded as her enduring power of attorney (EPOA). However, no copy of the EPOA or evidence of its activation is in Mrs A's records. In response to the provisional opinion RN D submitted that the Manager always kept copies of EPOAs in her files and there was usually a copy in the patient's notes. She said she cannot remember if Killarney had a copy of Mrs A's EPOA or not, as sometimes they had to wait for families to get this legalised and documented.

First fall

29. At 6.35am on 10 July, a night-duty CA, Ms F, found Mrs A lying on the floor between her dresser and bed. Mrs A had a large bruise on the left side of her forehead. Ms F applied Arnica cream[8] to the bruise and notified the on-call back-up staff member, CA Ms G. At 6.45am, Mrs A was observed to be "drifting in and out of sleep". Ms G completed an Accident/Incident Report form.

30. At 10.35am on 10 July, EN C recorded in the Daily Progress Notes that Mrs A was unresponsive, that her blood pressure was 115/60mmHg,[9] her pulse 52 beats per minute (bpm),[10] and her temperature 36.8°C.[11] EN C arranged for an ambulance to transfer Mrs A to hospital for further assessment.

31. RN D said that she checked the Accident/Incident Report form that Ms F had completed. RN D recorded in the Recommendations section on the back of the form, "Situation was dealt with well". RN D did not date her notation.

Admission to hospital

32. On admission to hospital, Mrs A was observed to be confused, and to have a Glasgow Coma Scale score of 14.[12] A CT scan of her head showed no haemorrhage or acute changes. However, Mrs A was found to have a urinary tract infection, and was commenced on a five-day course of Augmentin (an antibiotic). She was also found to have allergic conjunctivitis in both eyes, which was treated with chloramphenicol eye drops.

Return to Killarney

33. Mrs A was discharged back to Killarney on 14 July, with instructions to staff to complete the prescribed course of Augmentin, and for her GP, Dr H, to check her eye infection in one week. A copy of the hospital discharge summary was sent to Killarney and to Dr H.

[8] A homeopathic remedy aimed at assisting the body's response to injury, trauma, and muscle recovery.
[9] Normal blood pressure is considered to be around 120/80mmHg.
[10] A normal adult pulse rate is 60–100 beats per minute.
[11] The normal core body temperature of a healthy, resting adult is around 37.0°C.
[12] A reliable, objective way of recording the conscious state of a person by assessing verbal, motor, and eye opening responses. The sum of the assessment ranges from 3 to 15. A score of 3 signifies coma.

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34. At 1.30pm on 14 July, RN D recorded that Mrs A had returned to Killarney Rest Home at 11.30am, "as a permanent resident". RN D recorded that Mrs A was to be given the antibiotics and eye drops as prescribed by the hospital medical staff.

35. Mrs A continued to be able to walk independently, and was reported to have a good food and fluid intake. The night staff reported that she was very confused and wandered most of the night.

Second fall

36. On 22 July, Dr H saw Mrs A for her routine three-monthly review, but did not make any changes to her medication regimen.

37. At 10am on 24 July, Mrs A fell out of a chair in the rest home lounge. She was assisted back into the chair, and observed to have a bruised and swollen left hand and bruising to the outside of her left eye. An Accident/Incident Report form was completed by CA Ms I, who recorded that Mrs A was given the analgesic Paracare, and Arnica cream was applied to her bruises. The plan was "to keep an eye on her" for the rest of the shift.

38. At 10.10pm, RN D assessed Mrs A for any injuries, recording that she had good range of movement in her left hand and, although her fingers were swollen, she was able to move them. An entry in the Daily Progress Notes by Ms G indicates that Mrs A was able to walk without difficulty and was responding well.

39. On 25 July, RN D completed the Interventions and Recommendations sections of the Accident/Incident Report form, recording that she had suggested to EN C that Mrs A's left hand be X-rayed. EN C decided that the hand would be bandaged and Mrs A be observed for 24 hours. There was no documented change in Mrs A's normal patterns of behaviour over the next 24 hours.

40. At 5.15am on 2 August, Ms G accidentally collided with Mrs A when she opened the lounge room door. Mrs A did not fall over, but sustained a "nasty bump on [her] forehead". Ms G reported the incident, and Ms F recorded the incident on an Accident/Incident Report form. The follow-up action documented was, "[a]ll falls etc should be notified to on call". In response to the provisional opinion, EN C said this incident should have been reported to RN D immediately, but neither RN D nor EN C was contacted. EN C said RN D had told staff not to contact her (RN D) between 10.00pm and 6.00am so as to not disturb her flatmates. In response to the provisional opinion, RN D said that statement was incorrect and that EN C was aware that at that time she lived by herself in a one bedroom flat.

Third fall

41. At 11.05pm on 3 August, Ms G heard Mrs A calling from her bedroom, and found her sitting on the floor between her dresser and bed. Ms G reported the accident to a care assistant, and completed an Accident/Incident Report form, recording that Mrs A was complaining of a "sore upper thigh area", and that she was helped back to bed. There is no other information recorded on the form.

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42. RN D said that she was notified about Mrs A's fall at 9am on 4 August, and she had difficulty obtaining a clear account from Mrs A about her pain, because of her dementia.

43. At 9.20am on 4 August, RN D recorded in the Daily Progress Notes that Mrs A had had a fall in the night because her stockings had been left on when she was settled for the night, and she had slipped over.

44. RN D recorded that Mrs A was reporting pain in her left hip and that, when an attempt was made to evaluate the range of movement, Mrs A was reluctant to move or straighten the leg. RN D noted that Mrs A was given Paracare. At 10.50am on 4 August, RN D recorded in the Daily Progress Notes:

> "[Mrs A] can rotate & lengthen X 2 legs, sore on R knee, arnica rubbed in, wheelchaired into lounge, will observe, to mobilise if able."

45. Mrs A's daughter, Mrs B, stated that she was not advised about her mother's fall on the night of 3 August, until a friend visiting Mrs A on 4 August saw the bruising.

46. At 2.15pm on 4 August, a care assistant recorded in the Daily Progress Notes that Mrs A was unable to walk, and was left in bed to rest. At 3.15pm, RN D recorded:

> "Please reassess [Mrs A] tomorrow for mobility for possible X-ray. Give 20mls regular paracare."

47. EN C stated that "the entry on 04/08/2011 at 1515hrs by [RN D] appears to have been added at a later date as no other entries in any file at Killarney Rest Home has half a page blank?"

48. RN D said that she made it clear to EN C that Mrs A needed to be assessed again on 5 August, or earlier if she showed any signs of pain or distress. In response to the provisional opinion, EN C said RN D did not tell her this. EN C said that she was told that Mrs A could rotate and straighten both legs so would not require hospitalisation, but that Mrs A's pain relief needed to be kept up as her right knee was sore. EN C said RN D performed all the assessments of Mrs A and said she had contacted the family. RN D told HDC that she did not work for the following four days.

49. Although Killarney provided staff with Short Term Assessment/Care Plan forms and a Falls Risk Assessment Tool used to identify and manage care and risk issues, no care plan or falls risk assessment had been started for Mrs A, and there was no indication in her records that her falls were reported to Dr H.

RN E

50. RN E advised HDC that 5 August 2011 was her first day of work at Killarney. RN E was, at the time, a new graduate and she received two days of orientation from RN D

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prior to commencing work at Killarney.[13] RN E does not recall receiving any formalised handover from RN D, and said she was informed about Mrs A's fall by the care staff. In response to the provisional opinion, RN D submitted that the handover to RN E was not possible because of an issue with the telephone and, as RN D was going out of town, EN C agreed to give RN E a handover.[14] RN D stated that she left written handover information for RN E.

51. RN E said that she read Mrs A's clinical notes, and noted RN D's record of her assessment of Mrs A, which stated that Mrs A could rotate both legs and there was no shortening of her legs. RN E told HDC that she does not recall seeing the note made by RN D requesting that Mrs A be reassessed, and believes that it was not in the records on 5 August 2011 as, if it had been, she would have reassessed Mrs A. In response to the provisional opinion RN D stated that she completed the documentation on the date and time stated in the records. She said if she documents anything later she always states that at the time of writing.

52. EN C stated that RN E did assess Mrs A but she did not record the assessment.

53. RN E stated that during the breakfast-time medication round, she asked Mrs A if she had any pain, and Mrs A said she did not. RN E said that she did not document this, but asked the care staff to observe Mrs A and monitor her for any signs of pain. RN E said that she was unfamiliar with the residents and was not in a position at that time to notice whether a resident's condition had changed. She said that she had to rely on the care staff for this information.

Family concerns

54. Mr A and another family member visited Mrs A on 5 August. Mr A was alarmed at his wife's injuries and reported his concerns to Mrs B. Mrs B telephoned EN C that day to request that her mother be seen by a doctor. Mrs B stated that EN C assured her that Mrs A was "fine on painkillers". Mrs B understood EN C to say that, if needed, EN C would call an ambulance for Mrs A. In response to the provisional opinion EN C said she did not speak to Mrs A's family on 5 August, and that the conversation with them was on 6 August.

55. On 6 August, EN C recorded in the Daily Progress Notes that she had reviewed Mrs A, whose family was concerned about her condition. EN C wrote:

> "Please make sure that [Mrs A] has 20mls paracare 4–6hrly for pain over next 48hrs for reassessment on Monday 8/8/11."

[13] In response to the provisional opinion, RN D stated that RN E was put into a position outside her scope of practice and ability. RN D thought two days of orientation was totally insufficient and when she queried that with the Manager, the Manager would not allow any more orientation due to finances. RN D stated that RN E should have been working under the guidance of a RN but EN C would not allow them both to be on duty together. RN D said that when questioned about this, "the owners" said they could not afford it and she was "told to pull [her] head in".

[14] In response to the provisional opinion, EN C stated that RN E was given a verbal handover regarding Mrs A.

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56. In response to the provisional opinion EN C said that she was called before 12.00pm on 6 August to see Mrs A because Mrs A was sleepy and delirious. EN C said she found that Mrs A was able to talk to her. EN C said that she "assessed" Mrs A, and stated, "I thought I had rung the family stating that she was coherent when I saw her and that we would reassess on Monday".

57. Mrs B said that she and her father visited her mother on 6 August. Mrs B recalls that her mother was incoherent, and her whole leg down to the ankle was very bruised, swollen, and cold. Mrs B said that she asked one of the carers to call a doctor, and stated:

> "[The carer] rang RN but she was away so rang [EN C] (I believed she was an RN too) from the office and handed me the phone. [EN C] said to leave it to her she would call and check her out and let me know. She did not call back. Dad was very distressed but said he could not cope at home with Mum."

58. In response to the provisional opinion EN C said she never claimed to be a RN. She said she received no other calls from Killarney staff over that weekend. EN C stated that she regrets that she was not more proactive and did not send Mrs A to hospital on 6 August, but stated that Mrs A was coherent and pain free when she saw her, so she followed what the RNs had put in place. EN C stated that as an EN, she was guided by the RNs, which was in accordance with her scope of practice.

6–8 August

59. At 2pm on 6 August, a care assistant recorded in the Daily Progress Notes that Mrs A was "very sleepy & delirious today" and that her family were very concerned. In response to the provisional opinion EN C said that this entry was written after she had attended and assessed Mrs A.

60. At 9.25pm on 6 August, the afternoon shift care assistant (signature unable to be read) recorded in the Daily Progress Notes that Mrs A needed to be taken to the toilet in a wheelchair, and was unable to feed herself.

61. On 7 August, Mrs A's condition remained unchanged. She was unable to walk, and required two staff to assist her from her bed to a chair and to the toilet. She was given regular pain relief as instructed.

62. At 10pm on 8 August, a care assistant recorded in the Daily Progress Notes:

> "[Mrs A] complaining of a lot of pain in her Lt hip and leg. When talking to [Mrs A] she says the pain is constantly there. Very painful on all movement even with regular Panadol."

Admission to hospital

63. At 11am on 9 August, RN D recorded in the Daily Progress Notes that she had reviewed Mrs A, who, five days post-fall, was in a lot of pain and unable to take weight on her left leg or to walk.

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64. RN D advised HDC:

> "On my return [following four days' leave] I was horrified to find that [Mrs A] was very distressed and in pain and she had not been seen to. I then sent her to [Hospital], under much protest from the manager [EN C] and the owner moaning about the cost of the ambulance and that she was alright and didn't need to go.
>
> I then rang [Mrs B] and told her what had happened."

65. In response to the provisional opinion EN C denied that she had made such comments to RN D.

66. At 2.12pm on 9 August, Mrs A was taken from Killarney by ambulance to hospital, where an X-ray showed a fracture to Mrs A's neck of femur with 50% displacement.

67. Mrs A had surgery on 10 August to repair the fracture. Her family was unwilling for her to return to Killarney. She had an extended stay in hospital because of the unavailability of Stage 3 Dementia Unit beds.[15] Mrs A was discharged on 21 September 2011 to another rest home for ongoing care.

Additional information

RN D

68. RN D stated that when she took the position of Clinical Manager/RN at Killarney on 3 May 2010, she made it clear to the manager and owners that she had no previous experience in the role. The previous clinical manager had left before RN D started, so she received no orientation to the job, and EN C, who was the Manager, provided her training.

69. RN D stated that there was no registered nurse on the premises at night. She said that there was an on-call system, but the care staff did not always call the registered nurse on duty if there was a problem.[16] RN D stated that she tried to change some of the systems at Killarney, such as ensuring that the on-call registered nurse was advised of all unwitnessed falls, and that the registered nurse assessed the resident at the time of the accident, but was told that the cost to implement this was too high. In response to the provisional opinion RN D added that her request that any unwitnessed falls were to be reported to the RN on call, who would then attend to assess the patient, was not implemented due to the cost of paying the RN a call out fee.

70. RN D stated that she resigned her position at Killarney after this incident. She said she felt that she was not provided with the tools to do her job.

71. RN D stated that she has spoken to Mrs B about these events, and apologised to her.

[15] Dementia is categorised as having five stages. Stage 3 is when there is a reduced capacity for independence.
[16] As stated EN C said that RN D told staff not to call her between 10.00pm and 6.00am.

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EN C

72. EN C advised HDC that RN D's claim that she was discouraged from ordering an ambulance for Mrs A is "completely false". EN C stated:

> "As a small rest home costing is a factor but not at the expense of our Residents. Any witnessed/unwitnessed fall must be reported to on call R/Ns unfortunately [RN D] at the time was unhappy to receive calls after 10pm or before 6am as it disturbed her flatmates."

73. EN C advised HDC that she understood that RN D had completed all the necessary documentation for Mrs A but found, after she was advised about this complaint, that only the first page of the Admission Assessment Form had been filled in, and no other assessment documentation had been started. There was no evidence that RN D had started a falls risk assessment or a short-term care plan to minimise future falls.

74. EN C stated:

> "We placed trust in a Clinical Manager/R/N who appeared to be doing well at her job unfortunately we never found out until she had left the number of care plans etc not completed as in [Mrs A's] file."

75. In response to the provisional opinion EN C stated that she "accept[s] full responsibility for this incident" which she said occurred because RN D "deemed it unnecessary to complete all relevant documentation".

76. EN C stated that she no longer provides hands-on care to the residents, but works running the business with the owners. She advised that three registered nurses are now in charge of the clinical areas.

RN E

77. RN E said that she was a new graduate when she took her position at Killarney. She stated:

> "I now realise that I ought to have undertaken a comprehensive nursing assessment on [Mrs A] when I heard that she had had a fall. I ensure that I now do this as a matter of course. I also ensure that I complete accurate and current assessments on all the residents and that I document all information in the clinical notes. I also ensure that resident's care plans are kept up to date. …
>
> I believe my orientation of 2 days was inadequate and that I was not fully prepared to work as sole registered nurse after such a short period. In future I will endeavour to ensure I have a thorough and more comprehensive orientation when commencing a new job as a Registered Nurse.
>
> Since this incident Killarney has employed a Clinical Leader who is able to provide support and education and this definitely made a difference to the care provided to residents."

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Killarney policies/procedures

78. Killarney provided HDC with copies of its policies and procedures relating to the care of the elderly that applied at the time of this incident. These included: Admission, Documentation and Accident/Incident policies, a Waterlow Risk Assessment Tool, a Falls Risk Assessment Tool, Initial Pain Assessment, and a Short Term Assessment/Care Plan. In response to the provisional opinion Killarney stated that all staff were required to read the policies and procedures when they were appointed and this was checked at their staff appraisals, which were conducted two weeks after appointment, then three months after appointment, then annually. Staff were required to sign that they had read the policies and procedures.

79. The Admission Policy stated that the registered nurse admitting a resident will use all relevant information, such as the GP and/or hospital referral and the resident and family interviews, to complete care assessments and falls and pressure area risk assessments. This information is used to complete goals and a nursing care plan for the resident. The person admitting the resident is to complete all the relevant admission forms. The policy also stated that the resident is to be reviewed by the rest home's medical practitioner within 48 hours of admission, if it was more than two days since the resident was last seen by his or her own GP.

80. The Documentation policy provided a list of the legislation and standards that determined the documentation to be completed on each resident, and the purpose of documenting that information. The policy stated that the frequency of documentation is dependent on legislative requirements, best practice, and the "degree of risk associated with the service", and the requirements outlined in applicable policies and procedures.

81. The Accident/Incident policy stated that all accidents/incidents must have the appropriate form completed and filed before the end of the shift, so that management can ensure that solutions are found and the situation does not arise again. The policy stated that the forms are to include an indication of corrective action if the resident suffers three or more falls or incidents of the same kind in one month, and the forms are to be followed up by the registered nurse to determine whether immediate corrective action or staff training is required.

Job descriptions

82. The Killarney registered nurse job description stated that the registered nurse's "prime concern" is the health and well-being of the residents. The tasks listed in the job description included staff orientation, performance appraisals and in-service training, and liaising with the owner and manager regarding appropriate training for new staff. The registered nurse was responsible for clinical good practice and safety, medication administration, special dietary requirements, and liaising with residents/families about resident care needs. The registered nurse was also responsible for ensuring that all documentation was kept "professional, objective, precise, legible, dated and signed by the relevant staff member". The registered nurse was to be on call 24 hours, seven days a week.

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83. RN D's Employment Agreement, dated 3 May 2010, was provided to HDC. The agreement showed that RN D was employed at Killarney as a registered nurse. She agreed to "carry out and comply" with her manager's directions and her general responsibilities as a registered nurse.

84. EN C was employed as an enrolled nurse at Killarney in October 2001. She was the Clinical Manager from 2007 until 2009, when she was appointed to the role of Manager. The Killarney Manager's job description stated that the Manager's "prime concern" is the health and well-being of the residents. As well as commercial obligations, the Manager was responsible for ensuring that appropriate training was provided to new employees, that staff orientation was of a high standard, and that staff practice was regularly reviewed by performance appraisals. The Manager was also required to arrange and facilitate monthly in-service training.

85. Killarney advised that there was no job description for the position of Clinical Manager.

Change in management of Killarney Rest Home

86. Killarney Rest Home (2009) Ltd advised HDC that on 10 June 2013, NNNM Enterprise Ltd took over the lease, management, and operation of Killarney Rest Home.

Responses to the provisional opinion

87. The following responses were received in response to the provisional opinion, in addition to the responses incorporated into the facts gathered section above.

Killarney Rest Home

88. Killarney stated that it thought the staff were all capable in their jobs and "relied on staff in place at the time to carry out their positions". It stated that RN D failed to complete the required admission documentation, care plans and assessments, which was not discovered until she had left Killarney. Killarney and EN C stated that RN D told them that the documentation had been completed.

89. Killarney Rest Home (2009) Ltd stated that it operated Killarney until it was sold in 2013 with no further incidents. EN C referred to several changes that had been made at Killarney since these events, to ensure this situation never occurs again, as follows:

a. Killarney has employed three RNs, of which one is on call 24/7, meaning that EN C is never on call for any clinical assessments. The new RNs are fully aware of the standards of care required by Killarney's policies.

b. All new admissions have a complete daily care plan done on admission, as well as a short term care plan, falls risk, and Waterlow assessment, which allows for a more in depth long term care plan to be completed within three weeks in accordance with Killarney's policy.

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c. All admission documentation completed by RNs is now discussed with the Manager. This means that any issues or concerns are discussed fully and appropriate measures are taken to ensure best practice at all times.

d. Education in Accident/Incident documentation has been held and is scheduled for every two years.

e. Dementia training has been completed by existing staff, and new employees must complete this training within one year.

RN D

90. RN D stated that she had "no previous experience" as a clinical manager when she started at Killarney and was given no training while she was employed there. She stated that she was never told that she was not completing the admission documentation and care plans correctly. She stated she was "open and honest" when she was employed, stating that she had been working night shift for many years and she would need help with the paperwork.

91. She was employed to work four days per week. According to her job description she was on call "24/7", but she was never called and notified of events on her days off, and so she was not called about Mrs A's health.

92. RN D submitted that incident and accident forms were not always given to her to complete immediately after the incident concerned and, at times, they remained on the Manager's desk for some time before they were forwarded to her. She said she asked numerous times for guidance and acknowledgement that she was completing them correctly as she had not completed the forms previously. She only found out how to complete them correctly when an audit was conducted shortly before she left.

93. She cannot recall who phoned the family and notified them of the falls. She recalls that she spoke to Mrs B on a few occasions but cannot recall what about. She stated that notification of family should be marked on the incident form and documented in the notes.

RN E

94. RN E said the comment with regard to her is fair.

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Relevant standards

95. The New Zealand Health and Disability Sector Standards (NZS 8134.1.2.:2008) published by the Ministry of Health state:

"**Informed consent**

Standard 1.10 Consumers and where appropriate their family/whanau of choice are provided with the information they need to make informed choices and give informed consent.

…

Standard 1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment and support as well as for decision-making.

Standard 1.10.3 Information is made available to consumers in an appropriate format and a timely manner.

Service Management

Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

…

Quality and Risk Management Systems …

Standard 2.3 The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

Criteria The criteria required to achieve this outcome include the organisation ensuring:

2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

…

2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

…

3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner"

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Opinion: Breach, RN D

96. RN D was the Clinical Manager at Killarney, although her employment agreement was as a registered nurse. There was no job description for the Clinical Manager role, but the Killarney registered nurse job description stated that the registered nurse's "prime concern" is the health and well-being of the residents. The tasks listed in the job description included staff orientation, performance appraisals and in-service training, and liaising with the owner and manager regarding appropriate training for new staff.

97. The registered nurse was also responsible for clinical good practice and safety, medication administration, special dietary requirements, and liaising with residents/families in relation to resident care needs.

98. The registered nurse was also required to ensure that all documentation was kept "professional, objective, precise, legible, dated and signed by the relevant staff member". The registered nurse was to be on call 24 hours, seven days a week.

99. A standard expected of a registered nurse is to demonstrate accountability for directing, monitoring, and evaluating nursing care that is provided by enrolled nurses and others.[17] A registered nurse must also be competent to undertake comprehensive and accurate nursing assessments of health consumers in a variety of settings.[18]

100. RN D provided suboptimal care to Mrs A with regard to care planning, falls risk assessment and planning to prevent or minimise further falls, communication with Mrs A's family, and assessment of Mrs A following her fall on 3 August 2011.

Care planning

101. Killarney's Admission Policy required the registered nurse admitting a new resident to use all relevant information to complete care, falls, and pressure risk assessments, and to complete all relevant admission forms.

102. RN D admitted Mrs A to Killarney. RN D completed a short stay medication record and resident admission form, and began an admission assessment. However, the admission assessment was not completed.

103. On 14 July 2011, when Mrs A returned to Killarney from hospital, RN D recorded that Mrs A had returned "as a permanent resident" and was to be given antibiotics and eye drops as prescribed by the hospital medical staff.

104. RN D obtained no detailed history on 7 July or 14 July and, although there is a brief assessment on the resident admission form stating Mrs A's diagnoses, my expert advisor, RN Kaye Milligan, advised that this assessment was inadequate and a severe departure from expected standards.

[17] Nursing Council of New Zealand, "Competencies for registered nurse scope of practice" (December 2007), Competency 1.3.
[18] Nursing Council of New Zealand, "Competencies for registered nurse scope of practice" (December 2007), Competency 2.2.

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105. Furthermore, there is no care plan in Mrs A's clinical records. RN D told HDC that she completed a "daily care plan" for Mrs A, which was placed in Mrs A's wardrobe for staff to follow, and a copy of the plan was placed in Mrs A's records. However, no "daily care plan" was found in the records and, in response to my provisional opinion, EN C said RN D did not prepare a daily care plan. As advised by Ms Milligan, "daily notes are written, [but] they do not constitute a plan of care. Completing an assessment and writing an individualised care plan is a requirement in this environment and is the responsibility of the RN." Ms Milligan stated that failure to complete an individualised care plan during Mrs A's time at Killarney Rest Home was a severe departure from expected standards.

Falls risk assessment and planning

106. Mrs A's clinical record contains no falls risk assessment, either at the time of admission or after she had fallen on 10 July and 24 July 2011. No plan was implemented to address the issue of falls. As advised by Ms Milligan, "the RN and manager would have responsibilities to put a plan in place that would help to minimise or prevent future falls". Ms Milligan's advice was that failure to complete a falls risk assessment after the falls of 10 July and 24 July 2011 was a severe departure from expected standards.

Communication with family

107. RN D recorded that Mrs A's son-in-law was her EPOA. However, there is no copy of the EPOA document on Mrs A's clinical records, nor is there a copy of the required medical certification activating the EPOA. In my view, both RN D and EN C had a responsibility to ensure that this documentation was in place and was sighted or, if Mrs A was considered competent, to ensure that she consented to her health information being shared with her family.

108. The family was not informed of the fall on 24 July or the fall on 3 August 2011. As noted by my expert, the Health and Disability Services Standards require communication with consumers and their family/whānau where appropriate. It was the responsibility of RN D to ensure that Mrs A's family was notified.

Assessment following fall on 3 August

109. On Thursday, 4 August 2011, RN D recorded that Mrs A had "pain in L hip area" and was "very reluctant to move and straighten her leg". At 10.50am she recorded that Mrs A could "rotate and lengthen X 2 legs". At 2.15pm the care assistant documented that Mrs A was unable to walk and, at 3.15pm, a record made by RN D requested an assessment the following day "for mobility for possible X-ray".

110. I note that RN E believes that the entry allegedly made at 3.15pm was not present in the record when she came on duty on Friday, 5 August. However, in response to the provisional opinion, RN D strongly asserted that she did not make the note retrospectively. It is not possible for me to determine whether this allegation is true. However, it would be of concern if RN D changed the clinical record retrospectively with no notation to indicate this.

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111. Ms Milligan noted that as Mrs A had been able to walk independently prior to the fall, and was unable to walk afterwards, "this major alteration should have initiated a GP or other medical assessment. The pain assessment is brief and refers to the area of pain only with no pain scale being used as would be expected."

112. On 9 August, after having returned from four days' leave, RN D found that Mrs A was in pain, and unable to take weight on her left leg or to walk. RN D then arranged for Mrs A to be admitted to hospital. This action was appropriate.

Conclusion

113. RN D has submitted that she lacked experience and training for her role. She also submitted that she completed the required documentation and does not know why it is not present in Mrs A's records. However it is evident from the documentation present that she failed to obtain a detailed history, did not fully complete the admission documentation, and did not prepare a care plan. She also failed to complete a falls risk assessment, and did not ensure that Mrs A's ability to make decisions was assessed, and her EPOA and the medical certificate (if any) activating it were sighted and retained. Additionally, she failed to inform Mrs A's family or her attorney (if the EPOA had been activated) of her falls. On 4 August 2011, when RN D was aware of Mrs A's pain and inability to walk, she should have immediately arranged for a GP assessment. I remain of the view that RN D did not provide services to Mrs A with reasonable care and skill and, accordingly, I find that she breached Right 4(1) of the Code.

Opinion: Breach, EN C

114. At the time of these events, EN C was Killarney's Manager, and she had prime responsibility for the health and well-being of Killarney's residents. An enrolled nurse practises under the direction and delegation of a registered nurse as required by the Nursing Council of New Zealand. The Nursing Council of New Zealand states in the competencies for the enrolled nurse scope of practice that enrolled nurses are required to seek guidance from a registered nurse when encountering situations beyond their own knowledge, competence or scope of practice.

115. On 4 August, RN D documented that Mrs A should be reassessed on 5 August. RN D said she made that clear to EN C. In response to the provisional opinion EN C denied that this was communicated to her and said the entry in the notes at 3.15 pm on 4 August was made at a later date, rather than on 4 August. As stated above, I am unable to reach a conclusion as to whether this assertion is correct.

116. There is no record that Mrs A was assessed by a registered nurse on Friday, 5 August following her fall during the night of 3 August. EN C advised HDC that an assessment was carried out by the registered nurse, but there is no documentation of this having been done.

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117. RN E worked the 8am to 4pm shift on 5 August. She stated that she read the clinical notes and noted RN D's assessment that Mrs A could rotate both legs, and that no shortening in her legs was noted. RN E stated that, at breakfast time during the medication rounds, she asked Mrs A if she was experiencing pain, which she denied. However, RN E did not document this conversation in the clinical notes.

118. Mrs B stated that when she and her father visited Mrs A on 6 August, her mother was incoherent and her whole leg down to the ankle was bruised, swollen, and cold. That day, EN C assessed Mrs A in response to her family's concerns. However, no assessment of Mrs A by a registered nurse or GP was arranged. Mrs B advised HDC that when she telephoned EN C to request that her mother be seen by a doctor; EN C assured her that her mother was "fine on pain killers".

119. Ms Milligan advised that "as an EN, EN C should have called an RN or GP in to perform an appropriate assessment and then followed their plan". Ms Milligan stated:

> "The EN is also required to observe, report, record and document health status and this did not occur. If an RN was not available the GP or ambulance should have been called so that an appropriate qualified health professional could assess [Mrs A]. As mentioned previously as [Mrs A] was able to walk independently prior to her fall and was not able to walk afterward, this fact would immediately signal the need for further assessment and treatment."

120. According to Ms Milligan, EN C's failure to seek appropriate clinical assessment for Mrs A after she saw her on 6 August 2011 was a severe departure from expected standards.

121. In accordance with her job description, which required her to have prime responsibility for the health and well-being of residents, EN C had a responsibility to ensure that there was a system in place to ensure that care planning, a falls risk assessment, and admission documentation were completed and documented. EN C failed to obtain a registered nurse or GP assessment of Mrs A between 5–8 August 2011. Furthermore, EN C also had a responsibility to ensure that, where appropriate, Mrs A's family or attorney (if the EPOA had been activated) were informed of her falls, in accordance with the Health and Disability Services Standards.

122. In my view, EN C failed to provide appropriate services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: Breach, Killarney Rest Home (2009) Limited

123. On 7 July 2011, Mrs A entered Killarney for respite care. Following a fall and subsequent hospital admission, Mrs A was assessed as requiring full-time care and, on 14 July 2011, she was admitted to the rest home for long-term care.

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124. The New Zealand Health and Disability Sector Standards (see above) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely, appropriate, and safe services to consumers.

125. Mrs A had the right to expect that Killarney and its staff would carry out appropriate assessments, closely monitor her health, communicate effectively with each other and with Mrs A and her family, and take prompt action once Mrs A fell and injured her hip. The care provided to Mrs A did not meet the required standard.

126. In response to my provision opinion, Killarney submitted that the rest home was run by staff who were thought to be "all capable in their different jobs". Killarney also submitted that it was not aware until after RN D left that she had not completed the assessments and documentation. I have considered the extent to which the deficiencies in Mrs A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational issues. Having considered the submissions made, I remain of the opinion that Killarney failed to meet its duty of care to Mrs A, in that it failed to ensure a staff culture of compliance with its policies and procedures. For the most part, Killarney's policies and procedures appear to be satisfactory. However, there appears to have been inadequate systems for ensuring that staff were complying with the policies. Without staff compliance, policies become meaningless. Killarney had a responsibility to ensure that all staff complied with policies and provided services of an appropriate standard. Killarney must take responsibility for ensuring that appropriate care is provided by its staff. I do not consider that Killarney fulfilled its obligations in this regard.

127. Killarney staff failed to obtain a detailed history on 7 July 2011 or 14 July 2011, and did not complete the admission documentation and a care plan. Consequently, caregivers had no plan to follow or guidance on actions they should take. No falls risk assessment was completed, even after Mrs A had fallen on 10 July 2011 and 24 July 2011, and no plan was implemented to address the issue of falls.

128. The status of Mrs A's EPOA was not clarified, and there was no documentation on the record suggesting that the EPOA had been activated. Despite believing that there was an EPOA, Killarney failed to advise the attorney or family members of Mrs A's falls on 24 July 2011 and 3 August 2011.

129. In my view, the care provided to Mrs A was very poor. Of particular concern is the fact that she was left from Wednesday, 3 August 2011 until Monday, 8 August 2011 with a fractured hip and in considerable pain.

130. Killarney has ultimate responsibility to ensure that its residents receive appropriate, timely, and safe care. Killarney failed to ensure that a detailed history was recorded, a care plan, falls risk assessment and admission documentation were completed, and a plan implemented to address the issue of falls. By failing to ensure that staff were complying with its policies and procedures, Killarney failed to comply with the Health and Disability Sector Standards and breached Right 4(2) of the Code.

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131. In addition, Killarney failed to ascertain Mrs A's legal status or respond appropriately following Mrs A's fall. Accordingly, Killarney did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Adverse comment: RN E

132. RN E advised HDC that 5 August 2011 was her first day of work at Killarney, and that she was a new graduate.

133. RN E does not recall any formalised handover from RN D about Mrs A, and said she was informed about Mrs A's fall by the care staff. RN E said that she read Mrs A's clinical notes but does not recall seeing the note made at 3.15pm by RN D, which states, "[P]lease reassess [Mrs A] tomorrow for mobility for possible X-ray. Give 20mls regular paracare." As mentioned above, I am unable to determine whether this note was present when RN E reviewed the clinical notes on 5 August 2011.

134. RN E stated that during the breakfast medication round she asked Mrs A whether she was in pain, and Mrs A said she was not. However, RN E did not document this, and did not carry out any assessment of Mrs A. RN E stated that she was reassured by RN D's assessment that Mrs A could rotate both legs, and there was no shortening in her legs.

135. I note that RN E has advised HDC that as a matter of course she would now undertake a comprehensive nursing assessment of a resident in such a situation, and that she now completes accurate and current assessments on all residents, and documents information in the clinical notes.

136. I accept that RN E was newly qualified, had commenced her role at Killarney only on 5 August 2011, and that her orientation to Killarney was poor. However, I consider that RN E's actions contributed to the poor quality of care provided to Mrs A.

Recommendations

137. I recommend that Killarney Rest Home (2009) Ltd, RN D, and EN C each provide an apology to Mrs A and her family. The apologies are to be sent to this Office within three weeks of this opinion being issued for forwarding to Mrs A's family.

138. I recommend that RN E provide an apology to Mrs A and her family for failing to assess Mrs A appropriately. The apology is to be sent to this Office within three weeks of this opinion being issued for forwarding to Mrs A's family.

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139. I recommend that the Nursing Council of New Zealand carry out a competence assessment of RN D.

140. I recommend that the Nursing Council of New Zealand review EN C's competence, and ensure that she is practising within her scope of practice.

Follow-up actions

141.
- Killarney Rest Home (2009) Ltd, RN D, and EN C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report with details identifying the parties removed, except the expert advisor who advised on this case and Killarney Rest Home (2009) Ltd, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN E, RN D, and EN C. As noted above, I have also recommended that the Nursing Council carry out a competence assessment of RN D and EN C.
- A copy of this report with details identifying the parties removed, except the expert advisor who advised on this case and Killarney Rest Home (2009) Ltd, will be sent to the District Health Board and the Ministry of Health, and they will be advised of RN D and EN C's names.
- A copy of this report with details identifying the parties removed, except the expert advisor who advised on this case and Killarney Rest Home (2009) Ltd, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

142. The Director of Proceedings decided to issue proceedings against the rest home, RN D and EN C.

143. The Director brought a successful prosecution against EN C before the Health Practitioners Disciplinary Tribunal. EN C is no longer practising as a nurse but, should she seek to resume practice, she must undergo a competency review before being reissued with an annual practising certificate. She will also be subject to supervision conditions for a period of six months upon resumption of practice, and she will not able to engage in sole practice or a management role in the aged care sector for 12 months. Costs were also ordered against her.

144. The charge against the registered nurse was withdrawn.

145. The Human Rights Review Tribunal made a declaration that Killarney Rest Home breached Rights 4(1) and 4(2) of the Code. Issues relating to damages and costs were resolved between the parties by negotiated agreement.

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Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from Ms Kay Milligan:

"[Mrs B] — Killarney Rest Home C11HDC00940

I have been asked to provide advice to the Commissioner on case number C11HDC00940.

My qualifications are Registered Nurse, Master of Arts (Hons), Bachelor of Arts (Nursing), Diploma of Teaching (Tertiary). I have worked as a registered nurse for approximately 34 years in clinical practice and in nursing education. My teaching experiences include undergraduate nursing students (including teaching in older person's health) and teaching registered nurses about the management of pain (with a surgical focus). My clinical practice as a registered nurse includes surgical services and also Assessment, Treatment and Rehabilitation of Older Adults.

The aim of this report is to provide the Commissioner with advice about whether the care provided by Killarney Rest Home to [Mrs A] was reasonable in the circumstances, and also on the response provided by Killarney Rest home to the complaint.

List of documents and records reviewed

Copies of:

- the complaint from [Mrs B], dated […]
- the response by Killarney Rest Home to the complaint, dated […]
- the documentation held by Killarney Rest Home on [Mrs A] dated between 7 July 2011 and 9 August 2011. Medications charts are not included.
- patient clinical records from [the Hospital] dated between 9 August and 21 September 2011.

List of resources referred to

Code of Health and Disability Services Consumer's Rights, Health and Disability Commissioner
Competencies for the Registered Nurse Scope of Practice, Nursing Council of New Zealand, 2009
Competencies for the Enrolled Nurse Scope of Practice, Nursing Council of New Zealand, 2010
Enrolled Nurse Scope of Practice, Nursing Council of New Zealand (http://www.nursingcoucil.org.nz/index.cfm/1,43,0,0,html/Enrolled-Nurse)
Health and Disability Services Standards, Ministry of Health, 2008

Advice on the issues raised

Was the care reasonable in the circumstances?

In my opinion, from the information provided, there were key areas of care that were not appropriately provided to [Mrs A].

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NB: I have used the Health and Disability Services Standards as well as the Competencies for Registered Nurses and Competencies for Enrolled Nurses to identify areas of concern.

1) No detailed history was obtained on either 7 July (initial admission for respite care) or 14 July 2011 (on return from hospital following a fall and subsequently becoming unresponsive). There is a brief assessment on the Resident Admission Form documented however I consider this to be inadequate. Assessment is required to meet NZ58134.[3.6.1] and is part of the Registered Nurse (RN) responsibility.

2) No care plan was completed during the time [Mrs A] was at Killarney Rest Home. Care givers and other staff therefore had no plan to follow and no plan for the cares they were required to provide or actions they should take. Daily notes are written however they do not constitute a plan of care. Completing an assessment and writing an individualised care plan is a requirement in this environment and is the responsibility of the RN. The manager also has responsibility for ensuring standards are met. Planning is required as per NZS8134.[3.7] and NZS8134.[3.8.] and is part of the RN responsibility.

3) No falls risk assessment was completed even after [Mrs A] had fallen on [10] July and 24 July 2011. No plan was implemented to address the issue of falls. The RN and manager would have responsibilities to put a plan in place that would help to minimise or prevent future falls.

4) The family were not informed of the fall on 24 July when [Mrs A's] left hand became injured nor on 4 August 2011 following a fall overnight when her left leg and hip were injured. Communication is expected as per standard NZS8134.[1.10] and [2.7] (a family member had POA).

5) Timely and competent care was not provided as [Mrs A] was not adequately assessed on 5, 6, 7 and 8 August 2011 (as required by Standard NZ58134.[2.5]).

On Thursday 4 August at 0920 hrs, following her fall, [Mrs A] was noted by the RN to have 'pain in L) hip area', and to be 'very reluctant to move and straighten her leg.' Then at 1050 hrs the RN recorded that [Mrs A] could 'rotate & lengthen x2 legs' (the meaning of 'lengthening her legs' is not clear but may refer to straightening her legs). At 1415 hours the caregiver documented that [Mrs A] was unable to walk. At 1515 hrs the RN requested a reassessment the following day 'for mobility for possible X-ray'. As [Mrs A] had been able to walk independently prior to the fall and was unable to walk afterwards, this major alteration should have initiated a GP or other medical assessment. The pain assessment is brief and refers to the area of pain only, with no pain scale being used as would be expected.

According to [Mrs B] a friend visited on 4 August and was informed that [Mrs A's] injuries would be looked at however the timing of this visit is not clear and so it may have been prior to the RN's assessment.

On Friday 5 August there is no documentation in [Mrs A's] clinical notes of any re-assessment by a RN or GP. The caregiver documented that [Mrs A] seemed much better (the meaning of this comment is not clear and whilst this is an

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appropriate comment in the context of daily care a care giver is not appropriately qualified for this to be considered an assessment). In her letter of response to the complaint the manager / Enrolled Nurse (EN), [EN C], stated that an assessment had been carried out by the RN however there was no documentation. In this situation the clinical notes are considered the accurate record. Therefore care of an appropriate standard did not occur as an assessment was not completed. An assessment was particularly important on the Friday as it was a day following the fall and access to GP services at the weekend is less than on week days.

[Mrs B] stated that [Mrs A's] family requested the GP be called however this did not happen (the timing of this request is not clear).

On Saturday 6 August [EN C] saw [Mrs A] as her family were concerned. However her documentation at 1235 hrs is inadequate and no assessments were made. [EN C] requested that [Mrs A] receive 'paracare 4–6 hrly for pain over next 48 hours for reassessment on Monday 8/8/11'. At 1400hr the caregiver had noted [Mrs A] was 'very sleepy & delirious' and the manager had been called. At 2125hrs [Mrs A's] mobility was noted to be very poor and she required a wheelchair. In her letter of response [EN C] noted that [Mrs A] was able to talk and that she assessed [Mrs A] (there is no evidence of this in the clinical notes).

On Sunday 7 August 2200hrs it is documented that [Mrs A] was unable to stand and mobility was via a wheelchair.

On Monday 8 August 1445 hrs she was still unable to stand and needed 2 persons to assist. At 2200hrs it was documented that the pain in her left hip and leg was constant, very painful and occurred on all movement despite panadol.

On Tuesday 9 August [Mrs A] was assessed by the RN, an ambulance called and she was transferred [to Hospital]. On admission on 9 August the medical assessment has identified that [Mrs A's] left leg was slightly flexed, externally rotated and shortened.

A RN or GP assessment would be expected in this situation but did not occur on any of the 4 days 5–8 August and therefore the care provided fell below what I consider to be reasonable. The EN practises under the direction and delegation of the RN as required by the regulatory body, the Nursing Council of New Zealand (NCNZ). In this instance, as an EN, [EN C] should have called a RN or GP into perform appropriate assessments and then followed their plan. The NCNZ state in the Competencies for the Enrolled Nurse Scope of Practice that the EN is required to seek guidance from the RN when encountering situations beyond their own knowledge, competence or scope of practice and this did not occur. The EN is also required to observe report, record and document health status and this did not occur. If a RN was not available the GP or ambulance should have been called so that an appropriately qualified health professional could assess [Mrs A].

As mentioned previously as [Mrs A] was able to walk independently prior to her fall and was not able to walk afterward, this fact would immediately signal the need for further assessment and treatment.

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Comments on Killarney Rest Home's response to the complaint

In my opinion the response from Killarney Rest Home does provide a little extra information to that documented in the clinical notes, however these comments are recollections after the events and therefore I consider them to be unreliable.

Overall I consider the response to be inadequate.

[EN C] takes no responsibility in regard to the lack of documented care planning and whilst this is the responsibility of the RN it would seem reasonable that a system would be in place to ensure this was completed.

It is not clear to me why there is an explanation mark after the RN assessment of a sore knee. [EN C] takes no responsibility for omitting to obtain a RN or GP assessment of [Mrs A] during the 5–8 August dates and this does not show recognition of this error or recognition of the scope of practice of the EN.

There is no recognition of the distress that the delay in assessing [Mrs A] caused to [Mrs A] and to her family which I consider to be inadequate. Noting that [Mrs A] could talk shows an inadequate assessment and lack of appropriate follow up.

In both roles as the Manager and [EN C] would be expected to ensure a RN/GP completed an assessment of [Mrs A] following her fall and there is no recognition that this should have happened.

[…]

Summary

In summary I consider that the care provided by Killarney Rest Home to [Mrs A] fell below what was reasonable and that the response by Killarney Rest Home does not recognise or address the key areas of concern."

Additional advice

Ms Milligan was asked to clarify the degree of departure from expected practice of each of the areas of inappropriate care identified in her report — specifically, whether the care provided in this case would be viewed by peers as mild, moderate, or severe departures from the expected standards of the profession.

The following further advice was provided:

"As requested, further information regarding the standard of care provided to [Mrs A] at Killarney Rest Home in July/August 2011.

I have identified whether in my opinion any departure from expected standard is mild, moderate or severe.

1. Failure by RN to obtain detailed history/assessment on initial admission (7 July) for respite care and on re-admission (14 July) as permanent resident.

A severe departure. The rest home should have an admission process that the RNs should have followed to ensure the assessment was completed for [Mrs A].

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2. Failure by RN to complete an individualised care plan during [Mrs A's] time at Killarney Rest Home.

A severe departure. The rest home should have a process that the RNs should have implemented to ensure an individualised care plan was completed for [Mrs A].

3. Failure by rest home manager to ensure care planning standards were met.

A severe departure. The contract with the DHB would stipulate the requirements of the rest home.

4. Failure by RN to complete a falls risk assessment even after falling on [10] July and 24 July 2011.

A severe departure. This should have been one of the assessments completed.

5. Failure by RN and rest home manager to implement a plan to minimise or prevent future falls.

A severe departure.

6. Failure by rest home staff to inform [Mrs A's] family/EPOA of the fall on 24 July or the fall on 4 August 2011.

A moderate–severe departure. The relatives should have been notified at the time of the fall if this was their preference or when they visited. In practical terms it can be difficult to ensure as relatives may not be readily available however there is no documentation that any attempts were made to notify the family.

7. Whether [RN D's] assessments of [Mrs A] and management decisions/plan on 4 August 2011 (following [Mrs A's] fall) were reasonable? If not, the degree of departure from expected standard.

A mild–moderate departure. Some relevant assessments were made however they were not sufficiently in-depth or descriptive. A review was requested for the following day.

8. The failure by [EN C] to seek appropriate clinical assessment for [Mrs A] after she saw her on 6 August.

A severe departure. A RN, GP or ambulance should have been called to assess [Mrs A]."

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