New Vista Rest Home Ltd

Registered Nurse, RN E

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00812)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. On 21 Month1 2011, Mrs A was admitted to hospital with a fractured femur. That day, she had a total hip replacement. By 10 Month2 2011, Mrs A was mobilising using a stroller (walker) under supervision. She was discharged home into the care of her daughter, Ms C, on 12 Month2.

2. Mrs A suffered a fall at home and was returned to the Emergency Department. The hospital arranged for short-term respite care for Mrs A at New Vista Rest Home (NVRH), and she was admitted there on 16 Month2.

3. Mrs A had blisters on her heels and a reddening on her sacrum when she arrived at NVRH. The District Health Board (the DHB) District Nursing service was responsible for caring for Mrs A's wounds.

4. Mrs A's regular medications included lorazepam.[1] On Friday, 10 Month3, Mrs A ran out of this medication and was without it until Monday, 13 Month3.

5. During her stay in NVRH, Mrs A had four falls, the last of which was on 13 Month3, when she fell backwards and struck her head.

6. On 14 Month3, a district nurse visited Mrs A at NVRH. The nurse found that Mrs A's legs were oedematous and fluid was oozing from them.[2] Mrs A was sent to hospital.

7. Mrs A was discharged home and referred for community palliative care. She died a short time later.

Findings

8. As a result of poor oversight and communication, NVRH did not ensure that Mrs A received the medication she was prescribed. Accordingly, NVRH failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

9. There were lapses in communication between staff and Mrs A's family, and sub-optimal documentation of Mrs A's condition and care. NVRH staff failed to communicate effectively with one another and with the family to ensure that Mrs A received continuity of care, and breached Right 4(5)[4] of the Code.

---

[1] Lorazepam (Ativan) is in a group of drugs called benzodiazepines, and is used to treat anxiety disorders.
[2] Oedema refers to swelling from excessive accumulation of watery fluid in cells, tissues, or serous cavities.
[3] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[4] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

Complaint and investigation

10. The Commissioner received a complaint from Mrs B, about the services provided to Mrs A by New Vista Rest Home Ltd (NVRH).

11. An investigation was commenced on 21 September 2012. The following issues were identified for investigation:

- *Whether New Vista Rest Home Ltd (trading as New Vista Rest Home) provided Mrs A with an appropriate standard of care between 16 Month2 and 14 Month3 2011.*
- *Whether clinical manager, RN E[5] provided Mrs A with an appropriate standard of care between 16 Month2 2011 and 14 Month3 2011.*

12. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

13. The parties directly involved in the investigation were:

Mrs A (now deceased)	Consumer
Mrs B	Complainant and Consumer's daughter
Ms C	Consumer's daughter
EN D	Manager NVRH
RN E	Care Manager NVRH
Ms F	Director NVRH
Dr G	Consumer's GP

Also mentioned in this report:

Ms H	Facility Manager
RN I	Registered nurse
Ms J	Senior caregiver
Ms K	Quality Manager

14. Information was reviewed from: Mrs B, Ms C, NVRH, RN E, the DHB, and Dr G.

15. Independent expert advice was obtained from a registered nurse, Mrs Margaret O'Connor (**Appendix A**).

[5] It was subsequently established that RN E's job title at New Vista Rest Home was "Care Manager", not "Clinical Manager".

Information gathered during investigation

Background

16. Mrs A, aged 87 years, lived at home and was cared for by her daughter, Ms C. On 21 Month1 2011, Mrs A fell at her home and was admitted to hospital, where she was diagnosed with a fractured neck of femur (hip).

17. On admission it was recorded that Mrs A was taking lorazepam, triazolam, and diazepam.

18. That day, Mrs A had total hip replacement surgery. From 21 to 26 Month1, pressure relieving measures for Mrs A included elevating her heels on pillows, turning her, and using a mattress with high pressure relieving qualities.

19. On 26 Month1, Mrs A was transferred to the Assessment Treatment and Rehabilitation Unit. The nursing notes of 27 Month1 record that Mrs A's right heel had blistered. It was suggested that her time in a wheelchair be "limited", as this was "probably a causative factor [of the blister]".

20. Nursing notes also reveal that, at that time, Mrs A had a skin tear to her left arm, bruising on her shin, left buttock, and arms, and a blister on her right heel. By 9 Month2, Mrs A had blisters to both heels, and "reddening on her sacrum". It was noted that the right heel blister had burst and the left heel blister was still intact.

21. By 10 Month2, Mrs A was mobilising under supervision, using a stroller.

Discharge into daughter's care

22. On 12 Month2, Mrs A was discharged into the care of Ms C. The discharge summary, dated 12 Month2, noted Mrs A's blisters on both heels, the dressings, and the reddened sacrum. Arrangements were made for the blisters to be treated and dressed in the community by a district nurse. There is no record of the DHB having provided pressure relieving equipment for Mrs A's use.

23. The discharge summary noted: "[Mrs A] came to us on 3 benzodiazepines. She is considered a high falls risk and we have slowly reduced these and on discharge she is on Lorazepam 1mg [twice daily]." The medications recorded on discharge were:

- Aspirin 100mg OD 3 months script given
- Paracetamol 1g QDS (1 month script given)
- Oxycontin 5mg CD (1 month script given)
- Lorazepam 1mg BD (3 months, script given)
- Nicotine Patch.

24. On 14 Month2, Mrs A had another fall at home. She attended the hospital's Emergency Department. A referral was made to the DHB's Rapid Response team to follow up with Mrs A on 16 Month2, with a view to her being admitted to a rest home for respite care. Care was arranged for Mrs A at NVRH and she was admitted there on

16 Month2. Mrs A's hospital discharge summary from 12 Month2 was forwarded to NVRH.

New Vista Rest Home

Staffing

25. In Month2 2011, RN E, a registered nurse, was the Care Manager at NVRH,[6] and EN D, an enrolled nurse, was the Facility Manager. RN E's responsibilities as Care Manager, as set out in her job description, included care planning for residents and providing direction in the management of residents, medicine management, clinical care delivery, and ensuring staff compliance with policies and procedures.

26. Until mid 2011, RN E was one of two registered nurses who had responsibility for care plans (the other registered nurse was RN I). NVRH originally advised HDC that most, if not all, care plans were completed by RN E. In response to my provisional opinion, NVRH stated that RN I had completed a number of resident care plans at that time and, therefore, RN E had not completed them all. NVRH also submitted that an enrolled nurse can complete resident care plans and have them signed off by a registered nurse, although NVRH acknowledged that there was no attempt by EN D to do this.

27. RN E worked from Monday to Thursday. RN I worked Thursdays and Fridays. Two other registered nurses had been appointed in Month1 2011, but initially they worked as caregivers and did not take over registered nurse duties until the hospital wing opened in mid 2011.

Occupancy

28. The Director of NVRH, Ms F, stated that at the time of these events, NVRH was licensed to provide rest home care for up to 46 residents.

29. NVRH advised that for most of 2011, its occupancy rate at any given time ranged from 23 to 35 residents.

Admission documentation

30. The Intermediate Care Referral document from the DHB to NVRH, dated 16 Month2, noted that Mrs A was not able to be managed at home as she had had another fall. The referral also noted that the period of Mrs A's stay at NVRH would be from 16 to 30 Month2.

31. NVRH's Care Plan Policy required an Initial Nursing Assessment to be completed on admission with the resident or his or her relative and/or agent, and that an Initial/Short term care plan be developed utilising information from the resident, the resident's nominated representative, and the referring agency. NVRH's Management of Resident Falls Policy also required that on admission residents be assessed for their risk of falling, and that an individual falls management plan incorporating appropriate interventions be developed for each resident.

[6] RN E finished working at NVRH in late 2011.

32. In addition, according to the Intermediate Care Services Agreement between the DHB and NVRH (the agreement), NVRH is required to complete an integrated care plan, including outcomes, for new residents within 24 hours of admission. NVRH is also required to ensure that residents and/or their family have the opportunity to participate in developing the care plan. According to the agreement, care plans need to include the following:

> "A personal safety plan that articulates specific assessed risks including risk assessments for falls, pressure ulcer prevention programme, and medication management with an action plan for the risks identified as a minimum requirement."

33. The agreement also notes:

> "This service also excludes the following items and services, although the Service Provider will ensure people will have access to them."

34. Items listed are:

> "• Prescribed pharmaceuticals including pharmacy dispensing fees or co-payments
> • Visits to and from a General Practitioner (GP) for usual (i.e. routine and non urgent)
> • Transport to the client's home from the residential care facility."

35. The NVRH Short Stay Assessment and Lifestyle Care Plan for Mrs A is incomplete and is not signed or dated. However, RN E said that she completed the initial assessments. RN E completed a Falls Risk Assessment and concluded that Mrs A was a moderate falls risk, despite the hospital's 12 Month2 discharge summary stating: "She is considered a high falls risk."

36. RN E did not weigh Mrs A on her admission to NVRH. RN E said she did not do so at that time because Mrs A was very weak, and she forgot to weigh her at a later date, as she had intended. RN E also did not complete a skin integrity assessment, and there is no evidence that Mrs A's pressure area risk was identified. However, all pressure relieving measures were implemented the day after Mrs A's admission.

37. The Residents Summary document states that Ms C was to be the contact person. There is no evidence on the file to suggest that Mrs A was incompetent.

38. Mrs A's care plan was not updated during her stay at NVRH.

39. There is no record of any Admission Agreement or that any information in relation to the responsibility for transport or medications was given to Mrs A or her family during her stay at NVRH. Ms C stated that she found it difficult to know what was her responsibility, and what was NVRH's responsibility, with regard to transportation and her mother's medication.

40. On 16 Month2, EN D noted that Mrs A required assistance with Activities of Daily Living (ADL) but her independence was to be encouraged. It was noted that Mrs A was very deaf. It was also recorded that she had "broken skin — heel, leg, and buttocks", which the district nurse was treating. Mrs A was put on a "repose air mattress". She was seen by a district nurse on 17 Month2, and the advice given was to elevate Mrs A's heels off the bed.

41. Mrs A's general practitioner, Dr G, faxed a list of medications to NVRH on 16 Month2.

Falls

42. On the evening of 17 Month2, Mrs A had a fall. The notes state that she did not want the fall recorded as she was worried that her daughter would not want her back home. At Mrs A's request, the family was not notified. On 21 Month2, Mrs A had another fall, resulting in a skin tear to her right elbow. A dressing was applied. Again, the family was not notified.

43. On 8 Month3, a caregiver found Mrs A outside her room on the floor. She had a large skin tear to her right lower arm. The family was not notified, and the section of the incident form relating to informing the family was not completed.

Orthopaedic appointment

44. On 25 Month2, NVRH staff took Mrs A to an outpatient orthopaedic appointment. The outpatient record for the appointment noted that "clinically everything [was] ok" but Mrs A needed to start mobilising more, with supervision. Mrs A was to be seen in six months' time with a new X-ray and, if everything was well, it was likely she would be discharged.

Further care 25 to 27 Month2

45. On 26 Month2, RN E contacted Dr G about Mrs A's medication because Mrs A was anxious and not sleeping overnight. RN E questioned how long Mrs A had been using lorazepam and requested a GP review.

46. On 27 Month2 2011, Ms C was making arrangements to take Mrs A home on the following Monday, 30 Month2. EN D told Ms C that the assessment team had not yet finalised the discharge. EN D recorded that despite this Ms C was still organising to take her mother home.

47. The district nurse saw Mrs A again on 27 Month2. The nurse recorded that she dressed the wound on Mrs A's sacrum. Mrs A's right heel was noted to have "odourous exudates — a small area of necrotic tissue". The district nurse also noted that Mrs A was convinced she was going home on Monday 30 Month2. However, the district nurse expressed concern as to whether Ms C would be able to cope with caring for her mother.

48. The district nurse requested that, if possible, Mrs A's intermediate care package be extended, owing to her concerns about of the extent of the wounds. Mrs A's stay at NVRH was extended until 30 Month3.[7]

Administration of lorazepam

49. The medication administration record notes that Mrs A was administered lorazepam at 8am on 9 Month3. The next recorded administration is 8am on 10 Month3. On 11 Month3 2011, the record states "none in stock". Mrs A did not receive her regular doses of lorazepam over the weekend of 11 and 12 Month3. Two senior caregivers[8] were responsible for administering the lorazepam on Saturday 11 Month3 and Sunday 12 Month3.

50. NVRH's Policy and Procedures on Medicine Management does not record a procedure for obtaining medications after hours; however, it states that it is the responsibility of the registered nurse to order all medications from the pharmacy. RN E confirmed that it was her job to ensure that regular medication scripts were filled, and that residents had all their regular medications in stock. She said that her normal practice was to conduct a medication check every Thursday to ensure there was adequate stock for the weekend. RN E said she does not know why this was not done on that occasion. There are no records of her having made the check. However, she advised, "Every RN and senior care giver knew how to order medication as this was part of our staff training and staff regularly did this. I was also on call 24/7 if they needed any help in doing so."

51. NVRH stated that a senior caregiver, Ms J, was due to administer the lorazepam on the evening of Thursday 9 Month3 2011. Ms J reported that she was unable to give the lorazepam as it was out of stock, so she rang EN D, who was on call, to make her aware of the problem. According to Ms J, EN D told her that if Mrs A got upset over the weekend then her daughter was to be called. However, in contrast, EN D stated that she was not contacted by Ms J.

52. Despite Ms J's recollection that she did not administer lorazepam on 9 Month3 because it was out of stock, records show that RN I administered lorazepam on the morning of Friday 10 Month3. There is no record of RN I having arranged a further supply of lorazepam. NVRH stated that it would have expected RN I either to have arranged a repeat prescription herself or asked the family to do so.

53. On 11 Month3, Ms C received a call from her mother, who was in a distressed state. Mrs A told her daughter that she had not received her medication as it had not been ordered. Ms C recalled that she telephoned NVRH to ask about her mother's medication, and the staff member she spoke to told Ms C that she did not know what Ms C was talking about, said she could not help Ms C, and hung up. Ms C visited her mother and found her upset, in bed, and undressed from the waist down. Ms C stated

[7] An Intermediate Care Plan Extension/Discharge Notification was signed on 15 Month3. This extended Mrs A's stay to 30 Month3. A note on the form indicated that it was faxed from the DHB to NVRH on 27 Month2. However, it was also noted that it was faxed to the wrong number.
[8] Both have resigned from NVRH and were not able to be contacted.

that she had visited her mother on Friday 10 Month3, and could have organised more medication if it had been brought to her attention.

54. Ms C advised HDC that when she visited her mother that day she found out about her mother's falls. Ms C stated that she was concerned that her mother had lost weight.

Further fall

55. On 13 Month3 at 4.45am Mrs A had another fall and hit her head on some drawers, causing a small cut. In the morning, Mrs A reported feeling sick and hot. Her morning medications were withheld, and RN E informed Ms C and the GP of the fall. The GP suggested supervision and an appointment if required. Later that day, the nursing notes record that Mrs A was commenced on antibiotics and frusemide because of her "infected wounds and oedema in legs".

56. By the time of the fall on 13 Month3, Mrs A had extensive pressure sores on her sacral area and both heels. Her legs and heels were bandaged, and it was recorded that the sores on her heels were gangrenous.

Deterioration

57. On 13 Month3, the district nurse saw Mrs A. Mrs A told her that she had had a fall in the night and was not able to move as well as previously. The nurse also recorded that RN E had telephoned, as she was concerned about the amount of exudate coming from Mrs A's wounds, and NVRH staff were having to change the bedding during the day. The district nurse noted that she had not noticed heavy exudate but found that, when she visited, the dressing was very wet from Mrs A's shower. The wounds were described as "sloughy and darkish in colour". The district nurse recorded that RN E asked whether Mrs A should be on antibiotics, and that she (the district nurse) confirmed that this would be a good idea. RN E contacted the GP and recorded in the progress notes that a script for an antibiotic and a diuretic had been faxed to the pharmacy.

58. Mrs B advised HDC that on that date she telephoned from overseas and spoke to EN D, who said that Mrs A was fine. Mrs B said that when she started asking specific questions, it seemed that EN D did not have the answers.

59. EN D stated that she is "deeply concerned and sincerely apologetic" about this matter. She said that it is difficult to remember the conversation exactly, but that as Manager she tried to keep up with daily changes and read all progress notes, but relied on information from staff being in the files. EN D noted that she had spoken to Ms C on several occasions when she had visited, and was aware that Ms C had been contacted that day regarding Mrs A. EN D apologised for any ongoing stress felt by Mrs B at that time.

60. On 14 Month3 2011, Mrs A was again reviewed by the district nurse, who found that Mrs A's skin was very fragile. The district nurse noted that both of Mrs A's lower

legs were leaking clear fluid and her fingers were cyanosed. Her pulse was 48 beats per minute.[9] The decision was made to return her to hospital by ambulance.

61. On 14 Month3 2011, the hospital queried whether Mrs A had had a stroke, and recorded that she was likely to have concussion. It was agreed with Mrs A that she would return home for supportive cares, rather than remain in hospital for further treatment. Community hospice care was arranged.

62. Mrs A died at home a short time later.

Further information from NVRH

63. NVRH confirmed that Mrs A's medications should have been checked on arrival.

64. NVRH stated that at the time of these events, RN E was responsible for reordering the medication; however, changes have been made following this complaint. A registered nurse is now available at all times and so, if medication is required from the out-of-hours pharmacy, the registered nurse can arrange it.

65. On 2 October 2012, Ms H, the new NVRH Facility Manager, provided a further response on behalf of NVRH. She supplied NVRH's internal investigation into Mrs A's care. Ms H confirmed that, following an audit in June 2012, it became apparent that a more experienced Clinical Nurse Leader was required for the facility to provide clinical oversight and safe practice.

66. Ms H advised that NVRH has taken the following remedial actions:

- Short-term residents are to supply NVRH with the full amount of medication required for the duration of their stay.
- Medication Management Policy and Procedures have been reviewed and updated.
- Structured verbal and written handovers have been implemented at every shift change. Registered nurse and enrolled nurse shift start and finish times have been adjusted to allow an overlap of shifts for formal handovers.
- Education and training for staff has been provided on documentation in residents' notes, individual lifestyle plans, and assessments.
- Individual progress notes are now written for each resident on every shift. A prompt card has been developed to assist staff when writing in progress notes.
- Emphasis has been placed on following NVRH policies and procedures including Family/Whānau communication with accident and incident reporting. Medication competencies and training are carried out annually for all staff who administer medications.
- Monthly meetings and staff training are conducted. The medication competency has been replaced with an improved, more in-depth questionnaire, to be signed off by the Clinical Nurse Leader or a competent registered nurse.

[9] Normal heartbeat rate for adults, including seniors, is 60–100 beats per minute.

- The Clinical Nurse Leader is to liaise with a district nurse or wound specialist nurses assigned to the resident's wound care.
- Medication incidents are now recorded separately from other incidents.

Orientation and support for RN E

67. RN E advised HDC that, looking back at Mrs A's initial assessments, she was extremely disappointed with the lack of information she documented. She stated:

> "Unfortunately this was simply a result of the very limited time and support that I had available to me. At this time I was under extreme pressure from [NVRH] as before my employment they had failed the care plans in the audit so at this time I was redoing over 46 care plans and assessments by myself despite informing [management] that I needed help with this as I was not coping. Their response to this was I was the only person to be doing them. … I know how important initial assessments are and how they ensure the appropriate cares are provided."

68. In response to my provisional opinion, NVRH submitted that its occupancy fluctuated between 23 and 35 residents, so there were not, as RN E stated, 46 care plans to complete.

69. RN E stated that she was oriented to her role at NVRH by the registered nurse who had incorrectly completed the care plans and assessments, as identified in the audit. RN E advised HDC that she completed the orientation booklet she received from NVRH, but she had very limited support. She said that she felt the job was too much for one person, as she was overseeing the entire rest home and hospital wing, and the well-being of every patient, as well as completing all admissions, assessments and care plans.

70. In response to my provisional opinion, NVRH noted that the hospital wing did not open until mid 2011, after the events outlined in this report. NVRH also stated that it provided 48 registered nurse hours per week, which exceeded the requirements of the Health and Disability Standards.

71. RN E's orientation document — "Role specific orientation and competency check for registered nurses" is undated and incomplete.

72. RN E advised HDC that, during the period in question, she was not coping and was working overtime to get her work done. She said that she had spoken to EN D on several occasions to request another registered nurse to assist her with the care plans. She said that EN D could not assist her because she is an enrolled nurse and therefore unable to do care plans.

73. RN E said that after she spoke to EN D, she raised the issue of her workload and her need for assistance with the care plans with the NVRH Director, Ms F. RN E said this was declined, because NVRH appreciated the quality of RN E's care plans. There is no written record of RN E's request for assistance, or EN D's or Ms F's response.

74. EN D confirmed that she discussed RN E's heavy workload with her and subsequently discussed it with Ms F. However, no solution was proposed. EN D stated that the heavy workload was an issue for both herself and RN E. Ms F does not recall any conversation with RN E about the care planning requirements or her request for assistance.

75. NVRH advised that from September 2010, RN E was given one full day each week to assist her to do paperwork, such as care plans.

Response to Provisional Opinion — New Vista Rest Home

76. Information from NVRH's response to my provisional opinion has been incorporated above. The Directors of NVRH noted the following additional comments:

- NVRH provided more than the required registered nurse hours and, by allowing RN E one full shift specifically to work on resident care plans, it had provided more than adequate registered nurse cover for a facility the size of NVRH.

- At around the time of these events, NVRH took in a lot of Intermediate Care residents. The short-term care plans required for these residents were not as extensive as the full resident care plans.

- The full-time manager at the time was an experienced enrolled nurse. NVRH would have expected her to support RN E in her role, and to oversee the completion of care plans and to assist with these if necessary.

- NVRH is now under a new management structure, it has an experienced Clinical Nurse Leader, and extensive corrective actions have been undertaken to address the issues that led to this complaint. NVRH is currently in the process of reviewing its policies and procedures, and intends to have these independently reviewed.

77. NVRH provided a written apology for forwarding to Mrs A's family.

Responses to Provisional Opinion — The DHB and RN E

78. The DHB advised that it considered my provisional report to be a fair assessment of the care provided to Mrs A, and that it related accurately to the findings of the DHB's own review of her care.

79. RN E did not respond to my provisional report.

Opinion: Breach — New Vista Rest Home Ltd

80. Rest homes have an organisational responsibility to provide a safe healthcare environment for residents. This includes ensuring that staff work and communicate effectively together, policies and procedures are consistent with relevant standards,

and staff are trained in, and comply with, the policies and procedures. The systems within which a team operates must function effectively in order to provide an appropriate standard of care to the residents.

81. In addition, the Age Related Residential Care (ARRC) Services Agreement (District Health Boards New Zealand 2001) sets out certain requirements with regard to admission assessments and care planning, including that: each resident's health and personal care needs are assessed on admission in order to establish an initial care plan with registered nurse input;[10] the care plan is reviewed and evaluated when there is a significant change in the resident's clinical condition;[11] short-term needs and planned interventions are documented;[12] and all residents have a care plan that is available to staff and that staff follow.[13]

82. Mrs A, aged 87 years, was admitted to NVRH for short-term respite care to assist with her rehabilitation following hip surgery. There were several areas in which Mrs A's care was sub-optimal, in particular NVRH's management of Mrs A's medication and care planning, and the communication of her care and care needs. I do not believe that NVRH met its responsibilities to Mrs A.

Medication

83. The agreement between the DHB and NVRH requires NVRH to ensure it has access to residents' prescribed pharmaceuticals. NVRH was responsible for ensuring that Mrs A had sufficient medication while in its care. There is no evidence that either Mrs A or her family was advised by staff that they were responsible for providing all medicines to NVRH. Until 27 Month2, both Mrs A and her daughter believed that she would be going home on Monday 30 Month2. While Mrs A may have been admitted to NVRH with sufficient medication for a two-week stay, there is no evidence that this was checked again when her stay was extended.

84. Mrs A's regular medication regimen included lorazepam. This was to be administered twice daily. Mrs A did not have this medication administered from Friday evening 10 Month3 to Monday lunchtime 13 Month3. RN E accepted that she did not check Mrs A's lorazepam as she would normally have done each Thursday, and is unable to remember why she did not do so.

85. I have been provided with conflicting information as to whether caregiver, Ms J contacted EN D, who was on call on the evening of 9 Month3, to arrange an out-of-hours supply. Given that the medication records show Mrs A was given lorazepam the following morning, I am inclined to think Ms J is mistaken. However, irrespective of whether Ms J contacted EN D, the response to the issue of Mrs A's medication supply was inadequate.

[10] See: 16.2 of the ARRC.
[11] See: D16.3 and D16.4 of the ARRC.
[12] See: D16.3 of the ARRC.
[13] See: D16.3 of the ARRC.

86. The last dose of lorazepam was used on Friday morning 10 Month3. RN I, who administered the last dose of lorazepam, failed to arrange a further supply. NVRH stated that it would have expected RN I either to have arranged a repeat prescription herself or asked the family to do so.

87. NVRH had a responsibility to ensure that it had adequate procedures in place. While NVRH had policies and procedures for medication management, there was no procedure outlined in that policy for obtaining medications out of hours. In addition, it is apparent that the staff either did not know what to do after hours when a resident's medication had run out, or did not communicate effectively with one another to ensure that Mrs A received her medication.

88. In my view, this was a systems problem, which resulted in sub-optimal care being provided to Mrs A. This was a serious departure from expected standards.

Care plan

89. The Short Stay Assessment and Lifestyle Care Plan for Mrs A was incomplete and not signed or dated. No skin integrity or pressure area risk assessment was made and, although Mrs A's heel pressure areas were recorded in the pain section, no pain intervention was planned. Mrs A was not weighed. The care plan was not subsequently updated, despite Mrs A's changing health status.

90. Care plans allow for care continuity and are essential to the provision of quality, consumer-centred care. Mrs A was a resident at NVRH for approximately four weeks. It is inadequate that her short stay documentation and care plan were not completed. In addition, NVRH missed an opportunity to review Mrs A's care when her stay was extended from 30 Month2 to 30 Month3.

91. My expert advisor, Mrs Margaret O'Connor, advised that, other than the incomplete care plan, the care interventions implemented by NVRH as evidenced in the progress notes were appropriate. However, NVRH should have ensured that an adequate care plan was completed and updated to reflect Mrs A's changing health status.

92. Although responsibility for care planning lay with the two registered nurses, NVRH stated that most care plans were completed by RN E. RN E said that during the period in question she was not coping, and she requested assistance with the care plans. EN D confirmed that she and RN E discussed RN E's heavy workload. EN D stated that she raised this with Ms F, but no solution was proposed. RN E said that she also spoke with Ms F, although Ms F does not recall this.

93. NVRH submitted that it provided adequate registered nurse cover to meet the needs of the rest home. It also stated that its occupancy fluctuated between 23 and 35 residents, so there were not, as RN E stated, 46 care plans to complete. However, I note that NVRH also advised that at this time it took in a lot of Intermediate Care residents, each of whom required a short-term care plan. I have considered NVRH's submissions. However, while I have some concerns about RN E's actions (see below), it remains clear that she was experiencing work pressure and that she raised this with NVRH management, to no apparent effect.

Communication

Family

94. Mrs A's family had no legal entitlement to information about Mrs A's well-being, unless Mrs A consented to her family receiving the information. After her fall on 17 Month2, Mrs A said that she did not want that fall recorded, as she was worried that her daughter would not want her back home. Mrs A's daughter was her contact person, and the fall on 17 Month2 was the only occasion on which Mrs A advised that she did not want her daughter to be informed.

95. As discussed below, there are several areas where NVRH's communication with Mrs A and/or her family was inadequate, including Mrs A's falls, her medication management, and her care plan.

96. According to RN E, Mrs A's first three falls were minor and, as Mrs A did not sustain any serious injuries, the carers did not contact family as they did not think it was required. RN E notified Mrs A's daughter about the fourth fall. However, I note that the second and third falls had resulted in skin tears. NVRH's policy on open disclosure states that "open discussion of incidents that result in harm to a patient" will occur. It also identifies adverse events as events where a person receiving healthcare results in unintended harm. The policy is not specific as to which events are to be notified, who is to be notified, and whose responsibility it is to disclose events.

97. It is important for staff at residential care facilities to talk to residents and their families about their expectations with regard to communication. There needs to be a shared understanding and agreement between the resident, his or her family, and the facility about the circumstances in which family will be contacted, and the reason for this.

98. In addition, NVRH was required to ensure that Mrs A had access to her prescribed medication and to taxis or an ambulance for her medical needs. NVRH was also required to ensure that Mrs A and her family were advised that this was at their cost.

99. There is no evidence that Mrs A was told that she and her family were responsible for arranging her medication and transportation to medical appointments.

100. Furthermore, it is clear that Mrs A's family was concerned about, and involved in, her welfare. However, there is no evidence that the family (with Mrs A's consent) was included in the development of the care plan.

101. NVRH should have discussed with Mrs A the extent to which she wanted her condition to be discussed with her family. That conversation should have been adequately recorded, to ensure that staff knew how much information about her health status should be discussed, and when the family should be contacted.

Staff

102. The incomplete care plan failed to communicate Mrs A's needs to the care staff. Although new interventions are documented in the progress notes, the care plan should have been updated as circumstances changed.

103. Communication between the health professionals was inadequate, and there was no structured verbal or written handover to communicate information between staff. Overall, NVRH's processes were inadequate, from ensuring that the care plans were completed and communicated to the care staff, to updating the care plan.

Care manager

104. RN E stated that, despite having a rostered shift each week to complete paperwork, she was not coping with having to rewrite care plans. This was not followed up by her manager, EN D, even after it was discussed with the NVRH Director, Ms F.

105. RN E also stated that her orientation was poor and provided by a registered nurse who was subsequently found to be incorrectly completing care plans. RN E's orientation document — "Role specific orientation and competency check for registered nurses" is undated and incomplete. In my view, it was NVRH's responsibility to ensure that RN E was adequately oriented to, and supported in, her role as Care Manager at NVRH, and it failed to fulfil that responsibility.

Summary

106. Aspects of the services provided to Mrs A were sub-optimal. While NVRH had policies for care planning and medication administration, it appears that staff failed to comply with those policies consistently, and the medication administration policy did not adequately provide for obtaining medications out of hours. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggest an environment and culture that do not sufficiently support and assist staff to do what is required of them.[14] As this Office has also previously stated, without staff compliance, policies become meaningless.[15]

107. NVRH had a responsibility to ensure that staff complied with its policies and provided services of an appropriate standard, and it failed to do so in this case.

108. As a result of poor oversight and lack of communication, Mrs A was left without her medication for a weekend. Mrs O'Connor's advice was that lorazepam, which was prescribed for anxiety, should not have been withdrawn in that manner. By failing to ensure that Mrs A received the medications she was prescribed, NVRH failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

109. There were lapses in communication between staff and with Mrs A's family, and sub-optimal documentation of Mrs A's condition and care. In my view, NVRH staff failed

[14] Opinion 07HDC16959 (20 May 2008) and Opinion 10HDC00308 (29 June 2012).
[15] Opinion 09HDC01974 (21 June 2012).

to communicate effectively with one another to ensure that Mrs A received quality and continuity of services, and breached Right 4(5) of the Code.

Adverse comment — RN E

110. RN E was responsible for developing Mrs A's care plan. I am concerned about the deficiencies in RN E's care planning and communication. Furthermore, RN E was responsible for ensuring that residents had all their regular medications in stock. If RN E had carried out a medication check on Thursday 9 Month3, it is unlikely that Mrs A would have been left without her medication over the weekend.

111. However, it is acknowledged that, at that time, RN E was experiencing work pressure and had advised her manager of her concerns without effect. In my view, the primary responsibility rests with RN E's employers. However, I consider that RN E should reflect on the issues raised in this report.

Adverse comment — The District Health Board

112. My expert advisor, Mrs O'Connor, stated that the DHB did not carry out and record a formal risk assessment, and carry out sufficient care planning for Mrs A during her hospital admission between 21 and 27 Month1. In particular, Mrs O'Connor noted that there is no information in Mrs A's Nursing Assessment from the DHB recording her then existing pressure areas, or that a pressure risk assessment was completed. The Nursing Assessment is not dated or signed, and Mrs A's Patient Care Plan, completed from 21 to 27 Month1, does not mention specific risks and actions taken to address Mrs A's needs in relation to pressure area risk or care.

113. Mrs A was 87 years old, weighed approximately 43kg, and was at risk of developing pressure areas. I share Mrs O'Connor's concern that, during Mrs A's admission, no preventative equipment is recorded as being used, and there is evidence of only 24 hours of preventative care. I am also concerned that Mrs A was discharged home without pressure relieving devices, despite having pressure areas.

114. The DHB stated that an air mattress was not used until 26 Month1 because of the difficulty for Mrs A in mobilising off an air mattress. The DHB acknowledged that its documentation of assessment and subsequent care planning of interventions for Mrs A's pressure ulcer prevention was inadequate.

115. In addition, in my view, the DHB should have done more to assist Ms C to care for her mother at home. I recommend that the DHB review its forms to clarify staff responsibilities for assessing patients in the community for their needs for pressure

relieving equipment, and provide prompts to ensure that this is not overlooked in future.

Recommendations

116. In my provisional report, I proposed that NVRH undertake the following:

- Apologise to Mrs A's family for its breaches of the Code.
- Obtain an independent review of its policies and procedures.
- Ensure that all staff receive adequate orientation and undergo regular training on its policies and procedures.
- Audit all care plans.
- Report to HDC on its compliance with these recommendations, within three months of issue of this final Opinion.

117. As noted above, NVRH has provided Mrs A's family with a written apology. It has undertaken a review of its policies and procedures, and obtained an independent review of these.

118. Accordingly, I recommend that NVRH undertake the following:

- Ensure that all staff receive adequate orientation and undergo regular training on its policies and procedures.
- Audit all care plans.
- Report to HDC by **11 December 2013** on its compliance with these recommendations.

119. I recommend that the DHB review its documentation to clarify staff responsibility for assessing patients in the community for their needs for pressure relieving equipment, and, by **11 November 2013**, report to HDC on its compliance with this recommendation.

Follow-up actions

120.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and New Vista Rest Home Ltd, will be sent to the Nursing Council of New Zealand, and it will be advised of RN E's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case and New Vista Rest Home Ltd, will be sent to HealthCERT and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

Expert advice was obtained from Mrs Margaret O'Connor, Nurse Practitioner Candidate for Older Persons Health.

Preliminary advice

The following advice was obtained from Mrs O'Connor to assist with the initial assessment of the complaint.

"**Complaint: New Vista Rest Home**
Reference: C11HDC00812

I have been asked to provide an opinion of whether New Vista Rest Home provided an appropriate standard of care to the late [Mrs A] at New Vista Rest Home (NVRH) for the period of [16 Month2 2011 to 14 Month3 2011]. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile

Since registering as a Comprehensive Nurse in 1988 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2009). My initial nursing experience was as a Public Health Nurse after which I moved to the hospital setting first in orthopedic nursing then acute/general medical in a rural hospital. Following this I embarked on an overseas trip where I worked firstly as an agency nurse in various hospital wards then in the community setting as a district nurse in London. Also in London, I worked for 9 months in a Nursing Home for older people before returning to New Zealand and commencing nearly 5 years in Assessment, Treatment and Rehabilitation. In this setting, I coordinated a 12 bed unit and completed needs assessments for older people in a large geographical area. From 1997 to 2011 I worked for a non-profit charitable organization managing various aged care facilities. Most recently I managed a retirement village of 60 beds; residential, hospital and dementia levels, and 21 cottages. I was chair of the facility's Quality team and the organizations Clinical Practice Group and managed my facility through many changes in care provision and enjoyed successful audits. Currently I am a Nurse Practitioner Candidate for Older Persons Health in a joint initiative between a District Health Board and a non-profit charitable organization. I am a member of the New Zealand College of Nurses and enjoy providing education and insight into care of the older person for various groups in my region.

Background

On [21 Month1 2011] [Mrs A], 87 years old, fractured her femur and received a total hip replacement at [hospital]. She received physiotherapy and was beginning to walk again. She was discharged on [12 Month2] from the Assessment, Treatment and Rehabilitation ward to home where she lived with her daughter. After several days of caring for [Mrs A] at home, and [Mrs A] having a fall, her

daughter was unable to continue to look after her so she was transferred to [the] Emergency Department (ED) on [16 Month2 2011]. She was then transferred to New Vista Rest Home for intermediate care, initially for 2 weeks, but it was extended until [30 Month3].

On [11 Month3 2011] [Mrs A] apparently called daughter in a distressed state advising she hadn't received her medication as it had not been ordered by the rest home. When the daughter visited she found her distressed in bed, she appeared to have lost a lot of weight and found she had had 3 falls. The rest home had not advised the daughter of these falls at the time. Another daughter [overseas] rang the Manager of the facility to ask about her mother and she was advised she was fine. The Manager did not mention the falls or lack of medication. On [13 Month3] [Mrs A] had another fall during the night.

On [14 Month3] the District Nurse visited [Mrs A] at the rest home and arranged for her to be admitted to hospital. She had extensive pressure sores on her sacral area and both heels. Her heels and legs were bandaged and the heels were supposedly gangrenous. The daughter was advised by the hospital there was nothing more they could do for her. She was transferred to her daughter's home for terminal care with local hospice input. [Mrs A] died [a short time later].

The documentation I have reviewed includes
1. The complaint from [Mrs B].
2. Response from NVRH Manager, [EN D], and Clinical Manager, [RN E], dated [mid 2011].
3. All personal documentation from [Mrs A's] time at NVRH.
4. A response from [the] District Health Board.
5. [Mrs A's] notes from [the hospital] for period [Month1 to Month3 2011].
6. Open disclosure policy from NVRH.

Expert Advice required

1. Please comment on the standard of care provided to [Mrs A] by NVRH including —
   a) Was [Mrs A's] risk for pressure sores assessed?
   b) Was [Mrs A] walking before going to the rest home?
   c) How was the physiotherapist monitoring her condition?
   d) Why did the rest home not order medications for her?
   e) Why were the relatives not informed of what was going on?

(a) Pressure area risk assessment

[21 Month1 2011–27 Month1 2011] (from [the hospital's] documentation)
On [Mrs A's] Nursing Assessment, which indicates usual function and actual function on admission, it is indicated that [Mrs A's] skin is not intact on her right shin. There is no information recorded for existing pressure areas and no evidence of a pressure risk assessment having been completed. The nursing assessment is not dated or signed. The Patient care plan completed from [21 Month1 2011 to 27

Month1 2011] makes no mention of specific risks and actions taken to address needs in relation to pressure area risk or care. During this period [Mrs A] was commenced on a pressure ulcer prevention turning schedule, which is undated and appeared to be maintained for approximately 24 hours only. This notes that she had a blister on her right heel and a reddened sacrum. It is also noted that for this time her feet were elevated on pillows and she was positioned off her sacrum area with pillows.

[27 Month1 2011–12 Month2 2011]
On [28 Month1 2011], upon admission in to the Rehabilitation ward, [Mrs A's] weight was listed as 43kg. It was recorded in the progress notes that [Mrs A] had a blister on her right heel and she requires regular repositioning as her 'PUP' score is 18. Her Braden score was 18 — Low (18 or below indicates at risk of developing an ulcer). This was repeated on [8 Month2 2011] with an outcome of 19. Also on [28 Month1 2011] she is recorded as having a red sacrum and was requiring specialized pressure relieving equipment for this. She was commenced on a daily turning and movement regime which was maintained till [7 Month2 2011]

Subsequent entries note

[29 Month1 2011] — left heel blister became evident
[30 Month1 2011] — serous output from legs was noted
[3 Month2 2011] — broken areas on buttocks were noted and a Roho cushion was supplied
[4 Month2 2011] — heel blister aspirated 7mls fluid
[6 Month2 2011] — left foot swollen
[9 Month2 2011] — 2cm blister burst on right heel. Left heel 1cm intact.
[9 Month2 2011] — Right heel had infected looking discharge.
[10 Month2 2011] — Graze on sacrum area. Heel still infected looking. Referral to District nurse/Wound nurse done

In the discharge summary, dated [12 Month2 2011], she was noted as having blisters on both heels with dressings and a reddened sacrum and a wound nurse referral had been sent on [10 Month2 2011]. This discharge summary was faxed to NVRH on [16 Month2 2011]. The Rapid Response service sent the Assessment Treatment and Rehabilitation Plan which records skin broken and asks for 'monitoring for further breakdowns'.

In summary, there is a lack of evidence of formal risk assessment and care planning for this lady during her time in orthopedic care, [21 Month1 2011 to 27 Month1 2011], in hospital. Given her age, weight of approximately 43kg and her need for surgical intervention she was at risk of pressure area development. Indeed she did develop pressure areas possibly during this time. It is of concern that during this time no preventative equipment is recorded as being used and there is only evidence of 24 hours of preventative care. I would consider this a severe departure from required standards of nursing care especially given the outcome for this lady. Possibly of concern was the serous output from her legs noted on [30

Month1 2011] while in the A T & R unit, however, no further investigation or intervention is recorded for this. There appears to be no evidence of [Mrs A] being discharged home with pressure relieving devices despite having pressure areas.

[16 Month2 2011–14 Month3 2011] (from NVRH documentation)
NVRH has an uncompleted Short stay assessment and lifestyle Care Plan for [Mrs A]. Under the 'Skin Integrity' section no assessment is completed and all that is recorded under intervention is 'PA Sacrum B heels. Skin tears to shins'. The heel pressure areas are also recorded under the 'Pain' section and no pain interventions are planned. I find this Care Plan incomplete despite [RN E] having stated in her response that she completed all other admission paperwork other than recording [Mrs A's] weight.

The need for specialized pressure relieving equipment was recognized by both the Intermediate care team and staff at NVRH. [Mrs A] was put on a 'repose air mattress' the day after admission and on [31 Month2 2011] the Intermediate team organized a Roho mattress which was supplied on [1 Month3 2011] and a Roho cushion which was supplied by an Occupational Therapist on [2 Month3 2011].

On [17 Month2 2011] a District nurse entry advised NVRH staff to 'elevate heels off bed with pillow' and that there is a 'new air mattress' on the bed. Also to encourage regular changes of position as 'several PA on sacrum'. The Wound Care nurse was recorded as having visited on [27 Month2 2011] and [7 Month3 2011] in progress notes. No entries record presence of infection. On [12 Month3 2011] [Mrs A's] legs began weeping and there was discharge noted from her heels with a possibility of infection suggested.

During the morning of [13 Month3 2011] [Mrs A] reported that she was feeling sick and hot and NVRH staff contacted the GP. Antibiotics and a diuretic were prescribed 'due to infected wounds and oedema in legs'. The Wound Care nurse is recorded as having dressed the wounds on this day. The following day the Wound Care nurse returned to dress wounds and after discussion with NVRH staff [Mrs A] was sent to hospital.

NVRH's short stay documentation should have been completed as [Mrs A] was a resident there for approximately 4 weeks. Evidence of pressure area risk has not been found however NVRH were well aware of [Mrs A's] established wounds and preventative measures were used. Possibly of concern is the lack of holistic assessing and planning particularly around pain management should it have become an issue. The care plan appears to be incomplete with some of the interventions appearing to be assessments.

The current Age Related Residential Care (ARRC) services agreement requires providers to contractually comply with the following in relation to care planning

D16.2 Assessment on Admission
You must ensure that:

a. The assessment on admission covers the physical, psycho-social, spiritual and cultural aspects of that Subsidised Resident;
b. Each Subsidised Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 3 weeks, and that Registered Nurse input and agreement is sought and provided in developing and evaluating the initial Care Plan in order to ensure continuity of relevant established support, care and treatments;

D16.3
a) Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status;
g) The Care Plan addresses the Subsidised Resident's current abilities, level of independence, identified needs/deficits and takes into account as far as practicable their personal preferences and individual habits, routines, and idiosyncrasies;
h) The Care Plan addresses personal care needs, health care needs; rehabilitation/rehabilitation needs, maintenance or function needs and care of the dying;
j) Each care plan focuses on each Subsidised Resident and states actual or potential problems/deficits and sets goals for rectifying these and detail required interventions;
k) Short term needs together with planned interventions are documented by either amending the Care Plan or as a Short Term Care Plan attached to the Care Plan;
l) Care plans are available to all staff and that they use these care plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

The Initial Care Plan is important for staff as outlined in (l). I find that the level of care planning is lacking, some assessments were recorded as an intervention and some areas were not completed, this falls short of the required standard to a moderate level. The care interventions implemented by NVRH and evidenced in the progress notes were appropriate. They did not have any responsibility for the wounds as this belonged to the Wound Care Nurse who visited 3 times a week. The level of information left for the NVRH staff appeared to be minimal.

(b) and (c) Physiotherapy input

On [3 Month2 2011] [Mrs A's] A T & R progress notes made by the Physio state that she declined therapy on this day and again on [6 Month2] this being the last entry made. The discharge summary from the A T & R unit says [Mrs A] was requiring a low frame with supervision for mobilizing short distances and a wheelchair for longer distances. On discharge it is not clear whether she was placed on the community wait list for Physio follow up or was classed as an ACC patient. The [District Health Board (the DHB)] procedure indicates that ACC referrals are urgent, if [Mrs A] fitted this category she would have been given the next available time slot. If not then a Senior Physiotherapist would have been

responsible for screening her to a waiting list of low, medium or high level of risk. I assume that [Mrs A's] daughter would have been notified of the waiting time (in weeks) as per procedure if this was the case?

According to [RN E], Clinical Manager, and confirmed by notes a falls risk assessment was completed on admission with a moderate risk result. [RN E] states that the Physiotherapist visited only once with the Intermediate Care team on [26 Month2 2011]. This is corroborated in the Progress notes where it states she 'walked a short distance with frame with lots of hyperventilating and 1 assist'. No other instructions are given.

(d) Ordering medications

[RN E], Clinical Manager, reports in her response that [Mrs A] did not have her regular twice daily dose of Lorazepam administered from Friday evening to Monday lunch time. Possibly 5 doses of a medication essential for [Mrs A] given her history of benzodiazepine use (see hospital A T & R discharge summary page 4) and the obvious anxiety conveyed to her daughter when she phoned her. [RN E] admits that stock was not checked as she normally does on a Thursday and the last dose was used Friday morning when the RN administering didn't notice that there was no more stock either. Given that this was a regular medication and was not administered for at least 5 doses this is not acceptable. This is a severe departure from expected standards of care. The question that needs to be asked is what provision does NVRH have for out of hours pharmacy service and why was this not done for a regularly prescribed medication?

(e) Informing family

On [18 Month2 2011] it is recorded in the progress notes that [Mrs A] didn't want an incident form filled out in relation to a fall as 'her daughter won't want her back home'. Assuming that [Mrs A] thought her daughter wouldn't want her back home if she knew she was having falls. According to [RN E] the first three falls that occurred were very minor and [Mrs A] did not sustain any serious injuries therefore the carers did not contact family as they did not think it was required. The daughter was notified by [RN E] in the morning about the fourth fall as was the GP to request a review.

The ARRC services agreement requires providers to

D16.4 Evaluation
b. You must notify the Subsidised resident's family members, with the Subsidised Resident's consent, as soon as possible, if the Subsidised resident's condition changes significantly;

NVRH's policy on open disclosure states that 'open discussion of incidents that result in harm to a patient' will occur. It also identifies adverse events as events where a person receiving healthcare results in unintended harm. This meets the

criteria set out in standard 2.4.4. However the policy is not specific in what events are to be notified to whom and by whom.

Standard 1.9 — Communication — states that 'consumers have a right to full and frank information and open disclosure from service providers'. According to the 'Family Communication Form' no communication was held until [13 Month3 2011]. [EN D], Manager NVRH, has stated that she answered questions as they were asked by the daughter [overseas]. However, given that communication to date may have been limited, a more open discussion with the appropriate person could have been facilitated.

Given that [Mrs A] was initially capable of making decision and able to inform staff that she did not want her daughter notified of her fall was acceptable for this incident. However in my experience with the auditing process against the ARRC and the Standards, auditors expect to see a paper trail as to why nominated others are not informed. This may be documented on an incident form or within progress notes.

Given that [Mrs A] was a short term resident whose care had a rehabilitation focus regular communication with the family around progress, and the falls, would have been accepted practice especially as the falls were reoccurring. Perhaps NVRH, and to a lesser extent the Intermediate Team, should have considered taking a more informed approach with family given that there was more than 1 fall and plans for future care may have needed to be discussed. I find this a mild deviation from accepted standards of care.

Margaret O'Connor, RCpN, MN"

Further advice

Following the Commissioner's decision to notify an investigation, further advice was obtained from Mrs O'Connor:

"**Nursing Advice to Health and Disability Commissioner**

Complaint: New Vista Rest Home
Reference: C11HDC00812

I have been asked to provide an opinion of whether New Vista Rest Home provided an appropriate standard of care to the late [Mrs A] at New Vista Rest Home (NVRH) for the period of [16 Month2 2011 to 14 Month3 2011]. I have also been asked to comment on the care provided to [Mrs A] by [the] District Health Board. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile
[As above]

Background

On [21 Month1 2011] [Mrs A], 87 years old, fractured her femur and underwent surgery at [hospital]. She was transferred from a surgical ward to a rehabilitation ward on [27 Month1 2011]. She received physiotherapy and was beginning to walk again. She was discharged on [12 Month2] from the Assessment, Treatment and Rehabilitation ward to home where she lived with her daughter. After several days of caring for [Mrs A] at home, and [Mrs A] having a fall, her daughter was unable to continue to look after her so she was transferred to hospital Emergency Department (ED) on [16 Month2 2011]. From there she was transferred to New Vista Rest Home (NVRH) for intermediate care, initially for 2 weeks, but it was extended until [30 Month3].

While at NVRH, [Mrs A] was seen by [the District Health Board's (the DHB)] District Nursing/Wound Nurse Specialist service (DN). She had pressure areas on her right and left heels and her sacrum, these were present on admission. She also had further falls on [17 Month2] (no injuries reported), [21 Month2] (skin tear to right arm), and [8 Month3 2011] (large skin tear to right arm). Family was not informed.

On [11 Month3 2011] [Mrs A] apparently called her daughter in a distressed state advising she hadn't received her medication as it had not been ordered by NVRH. Records show [Mrs A] missed six doses of Lorazepam (for anxiety) between [9 Month3 and 12 Month3 2011].

On [13 Month3] [Mrs A] had another fall during the night. That day, another daughter [overseas], [Mrs B], rang the NVRH Facility Manager (FM), [EN D], to ask about her mother and she was advised she was 'fine'. [Mrs B] states she was not told about the falls or lack of medication.

On [13 Month3] the Care Manager (CM) contacted the DN service to discuss [Mrs A's] wounds and exudate from legs. The CM then contacted the GP for new treatment including antibiotics. On [14 Month3] the DN visited [Mrs A] at the rest home, noted deterioration in her condition, and arranged for her to be admitted to hospital. She was taken by ambulance to hospital's ED. It was initially thought [Mrs A] may have had a stroke, but a CT scan showed no bleeds or lesions. [Mrs A's] condition was considered to be terminal, and [Ms C] asked to take her mother home. [Mrs A] was discharged home later that evening, and referred to the hospice service. [Mrs A] died [a short time later].

The documentation I have reviewed includes that previously provided (11 January 2012)

1. The complaint from [Mrs B].
2. Response from NVRH Manager, [EN D], and Clinical Manager (CM), [RN E], dated [mid 2011].
3. All personal documentation from [Mrs A's] time at NVRH.
4. A response from [the] District Health Board.

5. [Mrs A's] notes from hospital for period [Month1 to Month3 2011].
6. Open disclosure policy from NVRH.

And additional information (26 and 31 October 2012, 22 and 26 November 2012, and 18 January 2013)

1. Further correspondence from [the] DHB (letter dated 25 April 2012)
2. [The] DHB's District Nursing/Wound Nurse Specialist service records
3. Response from NVRH to preliminary expert advice
4. HDC letters of notification of investigation
5. Further response from NVRH, with enclosures
6. Response from [RN E]
7. Copy of agreement (and variations) between [the] DHB and NVRH for Intermediate Care Services
8. Information from [Ms C]
9. GP records
10. Further emailed responses from [Ms H,] current Facility Manager dated 21/11/2012 and 22/11/2012.
11. Summary of [HDC investigator's] telephone conversations with [Ms F] and [EN D] on 16.1.13.
12. Email information from [Ms K], Quality Manager, and 18.1.13.

[The] DHB

Lack of evidence of formal risk assessment and care planning for [Mrs A] while she was under the care of the orthopedic team.

There is no evidence that a head to toe skin assessment was completed on admission, [21 Month1 2011], and the DHB have stated that they cannot determine if this was done however in the care plan there is a pressure ulcer risk assessment that was carried out on admission and subsequent days noting the risk to be high (p001). On [26 Month1] there was a blister noted on [Mrs A's] right heel and documentation shows her heels were then elevated on pillows and a turning schedule implemented. An incident form was completed at this time. the DHB have confirmed that even though [Mrs A's] risk assessment outcome put her at high risk no other preventative measures were recorded as being used until 26 Month1 except mattresses with 'high pressure relieving qualities'. They state these are used on every bed in clinical areas (p002). the DHB's response states that they also have 'air mattresses readily available and used in all clinical areas' (p002) but one was not utilized for [Mrs A] possibly because of the difficulty for her to mobilize off it. There is neither documentation to support this decision nor any to evidence that it was discussed in the surgical ward post surgery.

[The] DHB are to be commended on their utilization of pressure relieving mattresses which certainly in [Mrs A's] case would have lessened her risk. However, despite the use of this mattress, she still developed pressure areas possibly while she was an inpatient. Given the content of the pamphlet for Clinicians on Pressure Ulcer Prevention (p004–5) it appears the DHB can offer more than what was implemented for [Mrs A]. It mentions consultation with an

Occupational Therapist (OT) and other equipment such as bed cradles, heel wedges or fiber inflatable boots among other measures such as early mobilization and promoting dietary needs. I find very little evidence of these interventions in [Mrs A's] care plan despite her 'high risk' and well documented co morbidities that predispose her to ulcer development including: peripheral vascular disease and femoral/popliteal bypass, atrial fibrillation and ischemic heart disease (Anesthetic record).

I acknowledge the DHB's commitment to further educate staff on their pressure ulcer prevention strategy and policy and hope that they have other initiatives in mind to protect elderly vulnerable patients.

I agree with the DHB's response that their documentation of assessment and subsequent care planning of interventions for [Mrs A's] pressure ulcer prevention is lacking despite a strategy and policy for this. I find that this is a moderate deviation from an expected standard of care as perhaps these pressure areas could have been prevented.

Serous output noted on [30 Month1 2011] may have been a concern but no further investigation or intervention was recorded for this.

[The] DHB state that it is possible that the serous output from [Mrs A's] legs was a result of bruising and swelling, her age and presentation. I assume this is the opinion of the Geriatrician; however it would have been expected to see some ongoing nursing assessment and interventions of this even if it was just monitoring.

There appears to be no evidence of [Mrs A] being discharged home with pressure relieving devices.

The District nursing care plan for general wounds was completed on [15 Month2 2011] (p007). The notes show that on [15 Month2 2011] [Mrs A's] daughter was educated on how to elevate her mother's heels over a cushion for pressure relief, no mention is made of the use of pressure relieving equipment.

[The] DHB have not provided any response to this concern and the OT assessment for discharge planning does not mention the presence of pressure areas as a problem. The documents I have reviewed: Home visit report, Personal Activities of Daily Living report assessment and Initial assessment report appear to have no specific prompts for assessing the need for pressure relieving equipment and as such this may have been neglected for [Mrs A]. I do note that a roho cushion was provided in the AT&R unit on [3 Month2 11] to [Mrs A] and assume this was not required to be transferred home with her. I would recommend that if at the DHB it is the OT's brief to assess for pressure relieving equipment in the community some of their forms are reviewed to prompt this.

New Vista Rest Home

The adequacy of NVRH's policies and procedures in relation to care planning, medicine management, falls management and incident reporting.

I have reviewed the following policies and procedures
1. Medicine management (p051–7) revised June 2012
2. Care plans (p058–9) dated October 2012
3. Accidents and Incidents (p061–2) dated January 2012
4. Management of Resident Falls Policy (p062–3) dated January 2012

Regarding the adequacy of these policies and procedures I have the following comments to make

1. The Medicine management document appears to meet both legislative and contractual requirements however there is no recorded procedure evident for obtaining medicines after hours other than to say it is the RN's responsibility to order all medications from the pharmacy. NVRH have now clearly stated the procedure for obtaining medicines for their short stay residents in that they are to bring the full amount required with them and if they are to stay longer than a week they must be blister packed (p053). I assume residents and their significant others are informed of this in their admission agreement or prior to admission verbally.

2. The Care plans policy appears adequate in reflecting the care planning needs for both long term and short term residents. It states the Nursing Manager or her designate is responsible for reviewing and updating care plans (p059). It would be useful to have written confirmation for registered staff as to who is responsible for which care plans. In this case there were 2 registered nurses working as registered nurses in [Mrs A's] area, CM and [RN I], until [mid] 2011 ([Ms K], 18.1.13). I have not evidenced any division of responsibility except that the CM has stated she was responsible for rewriting 46 care plans plus new admissions yet the RN job description states that RN I had care planning responsibility also.

3. The Accidents and Incidents policy appears to be adequate and includes the quality aspect.

4. The Management of Resident Falls Policy identifies risk assessment and a procedure for dealing with frequent falls i.e. action to be taken after a resident experiences more than 4 falls in a month. It also states that the relatives and GP are notified if appropriate (p083). Some guidelines around what is 'appropriate' would be useful as with [Mrs A's] first 3 falls staff said they didn't notify family as she specifically requested them not to and there was no injury. However, 3 falls should have been prompt enough for discussion with family.

The extent to which care provided to [Mrs A] by nursing and care staff was in accordance with relevant policies and procedures

1. It has been established that [Mrs A] did not have her regular twice daily dose of Lorazepam administered from Friday evening to Monday lunch time. The CM

admits that stock was not checked as she normally does on a Thursday and cannot remember why this was not done. The last dose was used on the Friday morning when the RN administering either didn't notice that there was no more stock or subsequently forgot to arrange more. Subsequent administering staff have provided conflicting information as to whether the on call person, [EN D], was contacted and asked to provide an out of hours supply. Regardless it was not sourced and administered as prescribed. [Ms H], current Facility Manager, states that she believes that the RN admitting [Mrs A] had responsibility for ensuring there was enough stock, compounded by subsequent staff not following up (p018). I feel that all of these staff are in some way accountable however, with no formal procedure for the obtaining of medications out of hours evidenced, staff may not have been aware of their responsibilities. This then becomes a systemic problem.

2. [The DHB's] Intermediate Care contract states that an integrated care plan must be developed within 24 hours (p186). NVRH has an uncompleted Short stay assessment and lifestyle Care Plan for [Mrs A]. Under the 'Skin Integrity' section no assessment is completed and all that is recorded under intervention is 'PA Sacrum B heels. Skin tears to shins'. The heel pressure areas are also recorded under the 'Pain' section and no pain interventions are planned. I find this Care Plan incomplete despite the CM having stated in her response that she completed all other admission paperwork other than recording [Mrs A's] weight. NVRH's short stay documentation should have been completed as [Mrs A] was a resident there for approximately 4 weeks. Evidence of pressure area risk has not been found however NVRH were well aware of [Mrs A's] established wounds and preventative measures were used. Despite an incomplete care plan the care interventions implemented by NVRH and evidenced in the progress notes were appropriate.

3. Incident and Accident forms were filled out as required per policy and seem to have been dealt with in accordance with the policy also.

4. The CM has followed policy in not only dealing with each individual fall but in identifying the risk on admission. Unfortunately this was not adequately transferred to the care plan. The CM also followed procedure by requesting a GP review after 4 falls in the month from admission. Staff followed the physiotherapist's instructions for mobilizing.

The standard of communication by nursing and care staff.
Standard 1.9 of the Health and Disability Standards (Core) states that service providers must 'communicate effectively with consumers and provide an environment conductive to effective communication'. 1.9.1 supports this by stating 'consumers have a right to full and frank information and open disclosure from service providers'.

There seem to be a number of issues involving communication with staff at NVRH with [Mrs A's] care.

1. The incomplete care plan has failed to communicate [Mrs A's] needs to care staff and although new interventions are clearly documented in the progress notes usual procedure would be to update the care plan by the RN planning the interventions. However senior staff, CM and FM, have made numerous appropriate entries into the progress notes providing information for staff following other provider's visits.

2. Facility Manager, [EN D], failed to communicate effectively with [Mrs A's] daughter [overseas] when she rang enquiring after her mother.

3. There appears to be some confusion as to whether the on call person, [EN D], was contacted around the out of stock Lorazepam. The senior caregiver, [Ms J], states she did contact her however [EN D] denies this (p26). Other staff members who were involved are unable to be contacted due to resignation or retirement or cannot remember.

4. I have found no evidence that [Mrs A] or her family were advised by staff that they were responsible for providing all medicines to NVRH. An email response (21.11.12) from current facility manager, [Ms H], confirms this.

The standard of communication and co-operation with other providers

Staff at NVRH appear to have cooperated with the Intermediate Care team and Wound Care Nurses in their planned interventions as evidenced in the progress notes:

- [17 Month2 2011] — CM summarised the visit from the DN and documented planned interventions in the progress notes.
- [25 Month2 2011] — FM, [EN D], took [Mrs A] to an outpatient's appointment and reported outcome and further intervention.
- [26 Month2 2011] — Intermediate care team suggested a need for night sedation which the CM followed up by requesting GP to review poor sleep.
- [8 Month3 2011] Request from Intermediate care team to document clearly what needs to be done for [Mrs A]. The following entries into the progress notes seem to have responded to this request.
- Where other providers have discussed issues verbally it appears the FM and CM have recorded these appropriately in the progress notes.

However, on [31 Month2 2011], the Intermediate care team requested a urinalysis to be done. There is no subsequent mention of this in progress notes.

Any systemic or organizational issues that may have impacted adversely on the ability of staff to provide [Mrs A] with appropriate care

[The DHB's] Intermediate Care contract states that the contract excludes, but must ensure access to, prescribed pharmaceuticals and the cost of any taxi or ambulance transport for a client's medical needs (p189–90).

[Ms H], current facility manager of NVRH, advised on 21 November 2012 that they were 'unable to find any evidence of an admission agreement or any other information in relation to responsibility for transport or pharmaceuticals having been given to [Mrs A] or her family during her stay'. There is no other evidence that [Mrs A's] daughter was informed that she was responsible for providing pharmaceuticals and transport to appointments. Therefore, it appears, pharmaceuticals were not provided in a timely manner and staff failed to ensure that there was enough to cover future needs. This began with CM when she failed to complete the Thursday check, then the subsequent RN of Friday morning when she failed to see there was none left and subsequently organize medications from [Mrs A's] daughter for the weekend. Subsequent staff then failed to obtain further medication whether or not the On Call person was contacted as per procedure that has not been evidenced. NVRH not having a clear policy/procedure around supply of short term residents' medications and procedure for obtaining medications out of hours has contributed to this problem.

The CM has alluded to difficulties in communication of information with hospital and rest homes involved in Intermediate care (letter 31.8.11). Many health professionals were involved in this lady's care and not all the information pertaining to her was maintained at NVRH for immediate reference. It appears that sometimes information was passed on only verbally. No assumption can be made as to whether or not this compromised care.

[Ms H], in her investigation on 2.10.12, indicates that there was no structured verbal or written handover to communicate between staff (p029). This is a concern as it is a requirement under the Age Related Residential Care Services Agreement, D9.1:

> 'You must ensure that at the commencement of a shift, each Care Staff member who will be responsible for providing care to a particular Subsidised Resident receives a report on the status of, and care required for, that Subsidised Resident' (p37).

The corrective actions taken by NVRH (now NVRH Home and Hospital) as outlined in its report dated 2 October 2012.

I have read the corrective actions that NVRH have taken on pages 30–31. I find these to appropriately cover areas of concern that have been identified with this investigation. NVRH owners are to be commended on recognizing the need for a more experienced Clinical Nurse Leader.

[Ms H] advised on 21 November 2012 that a new Short term admission agreement has been developed and implemented.

Subsequent auditing completed by the new manager appears to be showing acceptable compliance rates and identifying areas for continued improvement.

The overall standard of care provided to [Mrs A] by NVRH

My opinion from the documentation that has been provided to me to review is that, despite poor care planning, the care [Mrs A] received was of an adequate standard except in medication management. Unfortunately I feel that this has stemmed from an organizational flaw where family may not have been notified of their responsibilities on admission and staff may not have been aware of procedure to obtain out of hours medications.

Clinical Manager, [RN E]

The current facility manager of NVRH has advised that [RN E] was responsible for 1 other RN who was employed for 4 duties per week and [RN E] reported to the Rest Home Manager and Directors (email 21 November 2012). She also advises that both [RN E] and [RN I] were responsible for care planning and evaluation. [RN E] worked from Monday to Thursday only.

Standard of care provided to [Mrs A] by CM.

From the documentation I have reviewed I have found no evidence that the standard of care provided by [RN E] to [Mrs A] was below expected standards. There is evidence that she has responded appropriately to changes in health status on at least 2 occasions;

[17 Month2 2011] — [RN E] followed up visit from District Nurse regarding pressure area care and equipment.
[18 Month2 2011] — [RN E] followed up following fall.
[26 Month2 2011] — Following discussion with DN [RN E] contacted GP regarding [Mrs A] not sleeping at night and requested review.
[13 Month3 2011] — [RN E] reviewed [Mrs A] as she reported 'feeling sick and hot'. Contacted District Nurse to inquire whether [Mrs A] required antibiotics as concerned about amount of exudates from her wounds/legs (p015). She subsequently contacted [Mrs A's] GP and antibiotics and a diuretic were prescribed. [RN E] also contacted [Mrs A's] daughter regarding a fall overnight and sustained injury.
[14 Month3 2011] — Discussed health status with District Nurse and organized transfer to hospital. [RN E] also contacted daughter and GP.
I agree with [RN E] (p136) that the progress notes show 'evidence of correct interventions being completed'.

Whether [RN E] took appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mrs A] with specific reference to

i. Care planning

NVRH has an uncompleted Short stay assessment and lifestyle Care Plan for [Mrs A]. NVRH's short stay documentation should have been completed as [Mrs A] was a resident there for 4 weeks. Evidence of pressure area risk has not been found. The care plan appears to be incomplete with some of the interventions appearing to be assessments. This short term care plan appears to have been [RN E's] responsibility to complete.

According to information from [Ms H], dated 21.11.12, both [RN E] and the RN were responsible for the updating of care plans and evaluations. Evidence shows neither staff member updated [Mrs A's] care plan during her stay despite her being there for nearly 4 weeks and a changing health status. As previously stated, although [Mrs A's] care plan was not up to date, an appropriate standard of daily assessment and intervention appears to have been recorded as provided in the progress notes. [EN D] states that procedures have since been put in place to ensure that more than one person is responsible for completing admission file paperwork (p018).

Mention needs to be made of [RN E's] comments regarding responsibilities requested of her to 'redo' over 46 care plans and assessments during this time due to 'recent audit results' (p036). [EN D] has advised that it was [RN E's] role to complete these assessments and care plans, approximately 35–40, and it was a directive from management (telephone conversation 16.1.13). [EN D] can't recall if the RN was completing any at this stage but maybe one or two (telephone conversation 16.1.13). [Ms F] has advised that she can't specifically recall a conversation with [RN E] advising her to complete all the careplans (telephone conversation 16.1.13).

[Ms K], Quality Manager, has provided information that both [RN E] and [RN I] were rostered together each Thursday so that the RN could provide release for [RN E] to complete paperwork (Email 18.1.13). She has also advised that when the new hospital wing was opened in[mid 2011] three more RN's were employed and the number of residents for care planning at this time was approximately 34–35 residents. [Ms K] has also supplied information that the number of residents requiring care planning for the period [six months] to [Month3 2011], when [Mrs A] was a resident, varied from 31 to 36 residents.

[RN E] has stated that despite verbally requesting assistance with the 'redoing' of care plans she was given none. [RN E] feels that her poor care planning for [Mrs A] is a result of 'very limited time and support' during this period. [EN D] has recalled that she did discuss the heavy workload with [RN E] and subsequently discussed it with [Ms F]. However, no solution was proposed and things continued to get worse/busier (telephone conversation 16.1.13). [Ms F] does not specifically recall any conversation with [RN E] about the care planning requirements and a request for assistance (telephone conversation 16.1.13).

ii. Pressure area management

The progress notes show evidence that [RN E] ensured all pressure relieving measures were implemented on the day after [Mrs A's] admission. [RN E] wrote an entry in the progress notes on [17 Month2 2011] stating that the DN had been and air mattress was on the bed (same day application) and gives instructions to elevate heels and encourage regular 'change of position' due to sacral pressure areas; all appropriate and timely interventions.

Wound care was the responsibility of the DN's yet [RN E] contacted the DN regarding the wounds on [13 Month3 2011] to discuss whether further treatment was required.

iii. Falls prevention

[RN E] completed a falls risk assessment on admission with a moderate risk result. [RN E] states that she reported [Mrs A's] falls to the GP as per policy (p136) after 4 falls. [Mrs A] was admitted to hospital the next day pre-empting any further review (as required by NVRH p029).

iv. Incident reporting

Incident reports were followed up as follows:

[17 Month2 2011] followed up on [18 Month2 2011]
[21 Month2 2011] followed up on [31 Month2 2011]
[8 Month3 2011] followed up on [15 Month3 2011]
[13 Month3 2011] followed up on [15 Month3 2011]. [RN E] documented that she notified family on [13 Month3 2011] of fall and the GP and this is confirmed in his notes. The GP was also aware of falls occurring from a phone consultation on [24 Month2 2011].

v. Medication management

[RN E] was only employed to work Monday to Thursday and another RN would have been responsible for giving the last of the medication on the morning of [Friday 10 Month3]. [RN E] admits she did not complete the routine Thursday audit to ensure there was enough stock for the weekend. She does not know why the RN, who gave the last of the medication on the Friday morning, did not request more. [EN D] outlines whose responsibilities these were in her response (p018) from the admitting RN (in this case [RN E]) to request stock from the family for the residents stay, CM to check medications on arrival from the Pharmacy, RN administering medications on a Friday and subsequent administering staff over the weekend to contact On Call person for assistance. [EN D] (p018) believes that the RN admitting [Mrs A] had responsibility for ensuring there was enough medication for her stay however there is no evidence that written information was given to [Mrs A's] daughter outlining her responsibilities for supplying medications.

vi. Documentation of care

This has been covered in previous comments. I have found that [RN E's] documentation in progress notes reflects the care that she provided to [Mrs A]. She has accurately recorded discussion and planned interventions with other providers and left documented instructions to staff in progress notes on numerous occasions. However, her documentation of planned interventions in the care plan is lacking (as per i) and should have been updated as required. This is a requirement of any Registered Nurse.

vii. Communication with family
I agree with [RN E] that her family communication could have been better (p036) not just in the event of falls but advising family of any changes to health status. Also family should have been updated, as per the DHB Intermediate Care Service Specifications, on treatment and progress.

Was there anything else the CM could have done in the circumstances?
It may have been prudent for [RN E] to provide her employers at NVRH with a written request for more assistance with the care planning requirements following the conversation she had with [Ms F] and [EN D].

Was there any systemic or organizational factors impacting on the CM's ability to ensure appropriate care was provided to [Mrs A]?
As outlined above [RN E] states she was not coping with having to rewrite over '46' care plans and assessments by herself (p036) assuming that this was as well as her usual work load and despite having a rostered shift each week to complete paperwork. This was not followed up by [EN D], her manager, even when it was discussed with [Ms F].

[RN E] alludes to the poor quality of her orientation in her response 8.10.12 (p037). She states that her formal orientation was given to her by an RN that had been found, by audit, to be incorrectly completing care plans. [RN E's] orientation document — 'Role specific orientation and competency check for registered Nurses' (p068) is undated and appears to be uncompleted. Therefore you could assume that [RN E's] orientation was perhaps not complete. It is the responsibility of her employer to ensure she has had adequate orientation to her responsibilities.

[RN E] graduated in 2007 as a Registered Nurse and was appointed to the position of Care Manager in September 2010 (p27). She states that she had worked in Rehabilitation for 2 years and as a casual in the medical ward then did some private nursing inpatient homes in England (p0136–137). [RN E] has therefore had less than 3 years nursing experience and no specific residential aged care experience when she was appointed to the role of Care Manager at NVRH. She states that despite asking for assistance it was not granted and felt that the job was too big for one person particularly when the hospital wing opened (p137) on [mid 2011] and received its first resident [two months later] (email [Ms H] 22.11.2012). [RN E] has advised that she was appointed to the position of Clinical Manager when the hospital wing opened but NVRH have no record of this occurring. [RN E] left NVRH [late in 2011].

Margaret O'Connor"