Radius Residential Care Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC01178)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly man following his admission to a rest home in 2017 — in particular, the management of his bowel condition and the preparation of his care plan in relation to this. The report also examines the management of a fall, including communication with his family about the fall.

2. The man was admitted to the rest home in Month1.[1] He was prescribed bowel medications PRN from the public hospital, but the use of bowel medications was not noted in his care plan. From 22 to 27 Month1, the man did not have any bowel movement. On 4 Month2, the man had a hospital appointment and was found to have impacted faeces. On 9 Month2, he was transferred back to the rest home, and suffered an unwitnessed fall. The family was not notified until the following day.

Findings summary

3. The report highlights the importance of appropriate management and planning for patients' health conditions in aged-care services, and of ensuring that families are informed about adverse events in an appropriate timeframe.

4. The Deputy Health and Disability Commissioner found the rest home in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) as it did not provide appropriate care and services in relation to the man's bowel condition in the following ways: (a) his care plan following admission did not identify that he required aperients; (b) his bowel medications were not administered as required; (c) his lack of bowel movement was not managed in a timely manner; and (d) no short-term care plan was prepared for his bowel condition following his return to the rest home after a hospital admission. The Deputy Commissioner attributed the breach of the Code to systemic issues at the rest home.

5. The Deputy Commissioner was also critical that the family was not informed about the man's fall in a timely manner and that there was no record of an InterRAI assessment having been completed. The Deputy Commissioner noted that the rest home had issues relating to the consistency of its care plan preparation reflecting the InterRAI assessment, and that this has been a recurring issue from three previous HealthCERT audits. The Deputy Commissioner was also critical that the man was not assisted to be ready for a hospital appointment despite the family's advance request.

Recommendations

6. The Deputy Commissioner recommended that the rest home apologise to the man's wife for the issues identified in this report; conduct an audit on its patient admission care plans for the last three months; and provide a written update on the steps taken to address an issue identified in the most recent HealthCERT audit.

[1] Relevant months are referred to as Months 1–2 to protect privacy.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by a rest home[2] to her husband, Mr A (deceased). The following issue was identified for investigation:

- *Whether Radius Residential Care Limited provided Mr A with an appropriate standard of care in 2017.*

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

9. The parties directly involved in the investigation were:

Radius Residential Care Limited	Provider
Mrs A	Complainant/consumer's wife

10. Further information was received from:

RN B	Registered nurse
RN C	Registered nurse
RN D	Registered nurse
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
HealthCert	Ministry of Health

Also mentioned in this report:

RN H	Facility Manager

11. Independent expert advice was obtained from Registered Nurse (RN) Julia Russell, and is included as Appendix A.

Information gathered during investigation

Introduction

12. Mr A was aged in his nineties, and had dementia and prostate cancer. In Month1, he suffered a fall at his home, and subsequently he was admitted to Hospital 1. He was diagnosed with a lower respiratory tract infection secondary to falls and progressive

[2] The rest home is owned and operated by Radius Residential Care Limited.

decline in general function. The hospital identified that Mr A required hospital-level care, and he was admitted to the rest home.[3]

13. This investigation concerns the care Mr A received at the rest home — in particular, the preparation of Mr A's care plan in consideration of his bowel condition, the management of his bowel movements, and also the management of his fall on 9 Month2, including the communication with Mr A's family regarding his fall.

Mr A's admission to the rest home

14. Mr A was admitted to the rest home for hospital-level care on 11 Month1. He was identified as having a high risk of falls. Hospital 1's Transfer Form (the Transfer Form) was provided to the rest home at the time of Mr A's admission. According to the Transfer Form, Micolette enemas[4] and Lax-Sachets[5] (the bowel medications) were prescribed as needed (PRN), and one month's supply was provided to the rest home.

15. RN E prepared a care plan for Mr A on the day of his admission. In the continence section, under the statement "aperients are often needed to assist bowel function (refer to med chart)", RN E noted "no". No PRN bowel medications were listed in the care plan. The care plan stated:

> "… Staff will record bowel motions type and frequency each shift.
>
> Staff will report any concerns or changes in ability or habit to nurse.
>
> Nurses will investigate any concerns and discuss with GP if required.
>
> Nurses will commence interventions following discussion and document.
>
> Nurses will evaluate effectiveness of interventions and update care plan."

16. RN E also noted in the care plan that Mr A had a hearing impairment, was incontinent of urine and required continence products, and that he required the assistance of one staff member for transfers, which he could achieve with a walking frame.

17. RN E told HDC:

> "About the care plan that I have done for [Mr A], it must have been incorrectly ticked in the e-case system.[6] It was supposed to be 'Yes' for aperients needed, and that was why a referral to the medication chart was noted with it, because of the laxatives that can be given to the [patient] which have been charted by the doctor."

18. The rest home told HDC that it "accept[s] that [Mr A's] bowel management care plan following admission on 11 Month1 should have included express reference to the PRN aperients (laxatives) that he was prescribed, as recorded in the medication

[3] The rest home provides rest-home and hospital-level care.
[4] Micolette is a fast-acting micro-enema used to relieve constipation.
[5] A laxative for the treatment of constipation.
[6] The electronic documentation system used at the rest home.

documentation". However, the rest home said that otherwise Mr A's care plan was appropriate. There is no evidence that an InterRAI[7] assessment was completed during Mr A's admission.

Lack of bowel movement (22–27 Month1)

19. From 22 to 26 Month1, Mr A's Bowel Chart contains no record of his bowel movement size or type, and the progress notes contain no record of his bowel movements. During this period, more than 10 registered nurses and healthcare assistants documented in Mr A's progress notes.

20. On 27 Month1, RN B noted in the progress notes: "[Mr A] has been noted his bowel not open for 5 days, PRN micolette enema given at [7.15 am] and opened his bowel after." The Bowel Chart records that following the administration of the enema, Mr A had a bowel movement on two occasions.

Visit to hospital (4 Month2)

21. On 28 Month1, the progress notes state that Mrs A asked staff to have Mr A ready and waiting in a wheelchair by 9am on 4 Month2 for an oncology appointment at Hospital 2. Mrs A said that staff at the rest home had been made aware of the appointment several times, and of her request to have Mr A ready by about 9am.

22. Mrs A told HDC that when she arrived at the rest home around 9am, Mr A "was found still in bed, had not had breakfast, had not been dressed and was visibly distressed …".

23. The rest home told HDC:

> "The Registered Nurse on duty remembers handing over to the care team the 9am pick up time for [Mr A]. Following this she commenced the medication round but then became involved with other residents who required her attention, including a transfer to hospital. By the time she had finished [at]tending to these matters, the taxi had arrived and she had not checked [Mr A] was ready."

24. The rest home obtained statements from relevant staff as to why the delay occurred. The interview notes record that the healthcare assistant stated that "it was really busy but could not say what had happened". The investigation report noted that the nurse on this shift, RN B, told the rest home that it was a very busy shift, as another resident had had a nose bleed, and a further two residents had had a fight, and that she then lost track of time and did not check up on the healthcare assistant.

25. However, RN B told HDC that she was not on duty during the morning shift, but was on duty for the afternoon shift. She said:

[7] A comprehensive clinical assessment of an older person's abilities and function to determine the person's care needs. Since July 2015, it has been mandatory for all aged residential care facilities to complete an InterRAI assessment within 21 days of a resident's admission.

> "[M]y manager appears to have inadvertently noted that I was on the morning shift. I was surprised to read these notes as I had no recollection of that conversation with my manager or of the events referred to on that morning."

26. Mr A was admitted to Hospital 2 at 10.50am, following his Oncology Clinic appointment. It was identified that Mr A was suffering from an impacted bowel[8] and a chest infection. The Hospital 2 Clinical Summary recorded that Mr A had constipation, and that a rectal examination had revealed faecal loading.

27. The rest home told HDC:

> "We accept and regret that [Mr A] was found to have impacted faeces upon admission to hospital [on] 4 [Month2] … and acknowledge that this may have been avoided with more frequent use of the PRN laxative medication prescribed."

Events on 9–10 Month2

Transfer back to rest home

28. Around 12pm on 9 Month2, Mr A was discharged from Hospital 2 and transferred back to the rest home. Hospital 2 provided the rest home with Mr A's Clinical Summary, which noted that laxatives were part of Mr A's treatment plan. RN F readmitted Mr A to the rest home and prepared the Medication Reconciliation Form, which included the PRN bowel medications. However, no short-term care plans were prepared, and Mr A's main care plan was not updated regarding his bowel conditions.

29. The rest home told HDC that there was no need to prepare a short-term care plan because Mr A had not been identified as having faecal loading on discharge from hospital.

Unwitnessed fall

30. Around 10.30pm on 9 Month2, Mr A suffered an unwitnessed fall. A bureau nurse noted in the progress notes that there were no injuries. She took observations and settled him back to his bed, then handed over to RN B, whose shift started at 11pm. RN B lodged an incident report regarding the fall, and commenced neurological observations. Neurological observations were conducted at 10.30pm and 11.30pm on 9 Month2, and at 12.30am, 1.30am, and 5.30am on 10 Month2. All observations were recorded as stable.

31. Mr A's family was not informed about the fall until the following afternoon. The rest home told HDC that the bureau nurse felt that it was inappropriate to contact Mrs A at the time of the fall, as Mr A appeared uninjured, and asked that the morning nurse contact Mr A's family. The rest home's investigation notes record that Mr A did not complain of any pain when RN B checked him, and that she told the morning nurse that Mr A had had a fall, had been comfortable and had slept through the night, and that the family had not been contacted.

[8] Bowel condition in which a hard, dry mass of stool becomes stuck in the colon or rectum.

32. According to the rest home's investigation notes, RN G, the Clinical Manager, was informed that the family had not been contacted, and at around 9am she asked the morning nurse, RN D, to contact the family regarding the fall as soon as she had completed the medication round. RN G told HDC that unfortunately she cannot remember the incident.

33. At 9am, RN D checked Mr A and took his observations. The progress notes record that Mr A "could hardly weight bear", and that he was placed on a recliner chair. RN D did not contact Mr A's family about the fall.

34. The rest home's investigation notes record that RN D "got busy with the morning tasks and forgot about phoning [Mr A's] wife which she apologised for". RN D told HDC that she can hardly recall the incident, but remembered being informed by the night nurse that Mr A had had a fall, no injuries had been noted, and he had been settled and had slept well throughout the night.

35. Around 1.15pm, Mrs A visited Mr A at the rest home. Mrs A said that she found him slumped over in his chair in a lot of pain, and he had a black eye. She asked the nurse to take Mr A back to his room, and was advised that he required a hoist. When Mrs A questioned why he required a hoist, she was informed for the first time that Mr A had had a fall the previous day.

36. Mrs A told HDC that she noticed that Mr A's left leg was bent and turned in. RN D called the Clinical Manager, RN G, to examine Mr A. RN D recorded in the progress notes that Mr A was in pain when touched, and that a "suspected fracture [had been] noted on [his] left femur as he could hardly extend nor move his leg".

37. Mr A was transferred to hospital and diagnosed with a fractured hip.

38. The rest home told HDC: "[W]e accept that [Mrs A] should have been advised of her husband's fall much earlier than she was, and sincerely regret the delay that occurred."

Subsequent events

39. On 11 Month2, Mr A underwent surgery to repair his hip. Following Mr A's discharge from hospital, Mrs A arranged for him to be transferred to another rest home, and he did not return to the rest home.

40. Subsequently, Mr A suffered chest and bladder infections, and he died the following month. Mrs A said that she and her family are upset that Mr A "suffered unnecessary and avoidable pain, distress and indignity in his final weeks".

41. Mrs A had a meeting with RN H, the Facility Manager at the rest home at the time. Mrs A expressed concern that she and her daughter had not been informed of the fall on 9 Month2. Mrs A said that her daughter had informed the rest home that she was happy to be contacted 24 hours a day about any issue. However, this was not recorded in any of the

notes. RN B told HDC that she did not know that Mr A's daughter was happy to be contacted at any time.

Further information

42. The rest home advised that at the time of the incident there were two Clinical Managers, RN G and RN C. RN G had just returned from leave, and RN C had covered the Clinical Manager role during RN G's absence.

43. The rest home told HDC that all beds at the rest home are certified for both hospital and rest-home level care. Mr A received hospital-level care throughout his stay at the rest home.

HealthCERT

44. HealthCERT advised HDC:

> "[T]here have been five notifications of [new] Clinical Manager — January 2017, March 2018, May 2018 … September 2018 … A certification audit was undertaken 5 December 2018 and resulted in one standard as partially attained, rated moderate risk it relates to care plans not being developed to meet the needs that have been identified through the interRAI assessment. It is noted this is recurring from the previous three audits."

Changes made since incident

45. The rest home told HDC that as a result of this incident, the following occurred:

a) All registered nurses attended a training session by a nurse practitioner about how to perform a head-to-toe assessment.

b) Registered nurses attended training about care plan evaluation.

c) Registered nurses attended training about eCase, which covered admission, assessments, care planning, charting, and work logs.

d) Registered nurses attended training on guidelines for transfer plans and falls prevention strategies.

e) There is now a Gerontology Nurse Specialist running weekly education sessions at the rest home, covering different topics relevant to clinical assessment.

f) eCase now has a reminder flag that generates prompts to the care team each time they log in, and alerts are now used to remind staff of pending appointments to ensure that they are not missed.

46. The rest home also told HDC that in 2018, it welcomed a new Facility Manager and a new Clinical Manager, and the team of registered nurses is almost entirely new (only one of the current registered nurses was working at the time Mr A was a resident). The rest home stated:

> "[W]e acknowledge and accept that there were shortcomings in the standard of care provided to [Mr A], particularly following his fall on 9 [Month2]. Since that time RNs at [the rest home] have received further training, systems have improved, and new leadership has been appointed. We believe that these steps have improved the quality of care provided to residents, and have significantly decreased the possibility of a similar event happening to another resident in the future."

Policies and training

47. The rest home's Accident/Incident Event Reporting policy (December 2012 version) states:

> "… All [next of kin]/[Enduring Power of Attorney]/Whānau/family must be informed of the incident on that shift or at the nearest appropriate time but must be within 24 hours …
>
> Open disclosure
>
> - Open disclosure is an open and honest discussion of an incident of unintended harm to a resident, staff member, visitor or contractor.
> - There must be acknowledgement of regret to the person involved and the family/ whānau that the incident has occurred."

48. The Falls Prevention policy (January 2017 version) states:

> "In the event of a fall, each client must be assessed immediately for injury prior to moving and first aid given as required. Notify the registered Nurse, Facility Manager or on-call person if the client has sustained an injury requiring more advanced treatment/care or if the client's condition deteriorates …"

49. The rest home provided HDC with a copy of its "Inservice Education Attendance", showing that its registered nurses have received training in care plan preparation.

Responses to provisional opinion

Mrs A

50. Mrs A was given an opportunity to comment on the "information gathered" section of the provisional opinion. Mrs A emphasised that she and her daughter had informed the rest home that the family could be contacted about Mr A's condition at any time, and she was concerned that the family was not contacted immediately following Mr A's fall on 9 Month2. She also said that, in her opinion, the rest home's Accident/Incident Event Reporting policy's time limitation for family to be contacted within 24 hours was too long. Mrs A reiterated that Mr A was in pain when she visited him following the fall on 10 Month2.

The rest home

51. The rest home was provided with an opportunity to comment on the provisional opinion. It stated: "Radius has nothing further to add to the report."

Relevant standards

52. The Health and Disability Services Standards NZS 8134.1.2:2008 (NZHDSS) state:

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> …
>
> Adverse Event Reporting Purongo Takahanga Koaro
>
> Standard 2.4 All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner."

Opinion: Radius Residential Care Limited

Introduction

53. The NZHDSS require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.[9] The rest home had the ultimate responsibility to ensure that its staff were competent and trained adequately, and that Mr A received care that was of an appropriate standard and complied with the NZHDSS and the Code. It needed to have in place adequate systems, policies, and procedures, and then ensure staff compliance with those policies and procedures, so that the care provided was appropriate, and that any deviations from good care were identified and responded to.

54. Mr A was admitted to the rest home because he required additional assistance. He did not receive the support he required to keep him comfortable and to meet his needs. During the month that Mr A was in the rest home, he was found by his family in various states of distress and pain. Mrs A and her family are unhappy that Mr A suffered unnecessary and avoidable pain, distress, and indignity in his final weeks. I acknowledge how upsetting it must have been for Mr A's family to see their loved one in such circumstances. In the brief time Mr A received hospital-level care at the rest home, basic components of his care were deficient. Clearly, he required comprehensive and considerable support, given his age and his prostate cancer, dementia, and progressive decline in general function.

55. I have carefully considered the extent to which the deficiencies in Mr A's care occurred as a result of individual staff action or inaction, as opposed to systemic and organisational

[9] NZS 8134.1:2008, standard 2.2.

issues. The problems that arose with Mr A's care were not the result of isolated incidents involving one or two staff members — they began at the time of Mr A's admission, and involved a number of different registered nurses and healthcare assistants. RN Julia Russell, who provided expert advice about this matter, considers that the issues were "systemic rather than a personal issue for any one RN".

Bowel management and preparation of care plan — breach

Preparation of care plan during admission

56. Mr A was admitted to the rest home on 11 Month1. The Transfer Form from the hospital stated that Mr A required PRN medications to improve his bowel function. This was not reflected in his care plan, and instead it was recorded that Mr A did not require any aperients for his bowel function. RN E said that the error may have occurred because the care plan in the e-case system had been filled in incorrectly, and it should have recorded that Mr A required aperients. The rest home has accepted that Mr A's care plan should have referred to the PRN bowel medications.

57. RN Russell advised:

> "The care plan and associated planning for [Mr A] is acceptable in all areas except bowel management … the recording that no aperients are required is clearly incorrect … this does not meet the expected standard as the care plan did not record the information that was provided in the [Transfer Form]."

58. I accept this advice, and am critical that Mr A's care plan did not note that he required PRN aperients. In my view, this error contributed to the poor management of Mr A's bowel condition and his presentation to Hospital 2 with an impacted bowel.

Poor management of bowel function

59. From 22–26 Month1 (around five days), there is no record of Mr A's bowel movements. On 27 Month1, RN B noted that Mr A had not opened his bowels during this time, so gave Mr A the PRN bowel medications, which resulted in two bowel movements on that day. Mr A was admitted to hospital on 4 Month2, and he was found to have faecal loading. The rest home acknowledged that Mr A's impacted faeces may have been avoided with more frequent use of the PRN bowel medications.

60. RN Russell advised that "the area of bowel management and the medications associated with it are poorly recorded and appear on this occasion not to have been well managed at the rest home". RN Russell also stated:

> "In light of the significant amount of PRN medication prescribed for [Mr A] it indicates this is a health issue for him and needs to be managed. Ensuring appropriate bowel management for people who have dementia and older people in general is a corner stone to managing their health and behaviour."

61. I agree with RN Russell and I am very concerned that despite being reviewed by several healthcare assistants and registered nurses during the five-day period 22–26 Month1, Mr

A was given aperients only on 27 Month1, despite having medications prescribed for use in this circumstance. In my opinion, any reasonable consumer in Mr A's position would have expected his bowel movements to have been monitored regularly, and for the bowel medications to have been given earlier. I consider that this demonstrates systemic issues at the rest home, and that the staff at the rest home lacked the skill and knowledge about adequate monitoring of a resident's bowel movements, and the management of constipation. I am critical about the delay in providing bowel medications to Mr A despite his bowels not having opened for five days.

No short-term care plan or updated care plan following readmission to the rest home

62. On 9 Month2, Mr A was discharged from hospital and transferred back to the rest home. No short-term care plan was prepared for Mr A's bowel condition, and his main care plan was not updated, despite Mr A having been found to have faecal loading. The rest home noted that Mr A was not discharged back to the rest home still experiencing faecal loading. However, the rest home was provided with a copy of the Clinical Summary, which specifically mentioned that faecal loading had been identified at the hospital. It was reasonable to assume that there was a likelihood of this reoccurring, and this warranted further management and careful oversight by staff.

63. Mr A's care plan stated that nurses would investigate any concerns, and that they would evaluate the effectiveness of interventions and update the care plan.

64. RN Russell advised:

> "There is no evidence of any short-term care plan being done about his 9 [Month2] return from hospital … given the potential seriousness of this health issue it would be expected that there would be.
>
> …
>
> [Mr A] was an elderly man with dementia in light of the significant amount of PRN medication prescribed to [Mr A] it indicates this is a health issue for him and needs to be managed. Ensuring appropriate bowel management for people who have dementia and older people in general is a corner stone to managing their health and behaviour."

65. I accept RN Russell's advice. I acknowledge that despite Mr A not returning to the rest home with faecal loading, it was clear that he had bowel issues that had not been well managed prior to the hospital admission. The care plan stated that the registered nurse would update the care plan as necessary, but this was not done when Mr A returned to the rest home from the hospital. I am also critical that no short-term care plan was prepared, given Mr A's bowel condition.

Conclusion

66. I find that Radius Residential Care Limited did not provide appropriate care and services to Mr A in relation to his bowel condition, in the following ways:

a) During his admission on 11 Month1, the rest home did not prepare an appropriate care plan that included reference to Mr A requiring aperients.

b) Bowel medications were not administered as required, and Mr A's lack of bowel movement was not managed in a timely manner.

c) No short-term care plan was prepared, or Mr A's care plan updated, following his readmission to the rest home on 9 Month2.

67. RN Russell advised: "[A]t the time [Mr A's] care did not meet the standards of care and this continues to be identified as a serious departure from the standard." She also advised that this "is considered as a systemic rather than a personal issue for any one RN".

68. I accept this advice. Accordingly, I find that Radius Residential Care Limited breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

Management of fall on 9 Month2 — adverse comment

69. At 10.30pm on 9 Month2, Mr A suffered an unwitnessed fall. The bureau nurse who found Mr A did not inform his family about the fall immediately, as she considered that Mr A appeared uninjured. At 11pm, RN B lodged an incident report and noted that there was no injury. Neurological observations were conducted at 10.30pm and 11.30pm on 9 Month2, and at 12.30am, 1.30am, and 5.30am on 10 Month2. All observations were recorded as stable.

70. RN Russell advised that "the care provided following the fall was acceptable". I accept this advice. I note that Mr A was assessed immediately following the fall, an incident form was completed, and neurological observations were conducted throughout the night.

71. In the morning of 10 Month2, RN B requested that RN D, the morning nurse on duty, contact Mr A's family about the fall. RN G, the Clinical Manager at the time, was also aware of the fall, and according to the rest home's investigation notes, she also asked RN D to contact Mr A's family.

72. RN D said that it was a very busy morning, and she forgot to contact Mr A's family. Mrs A visited Mr A in the early afternoon, and noticed that he was unwell. Mrs A was then told that Mr A had had a fall. Mrs A told HDC that her daughter had informed the rest home that she could be contacted at any time. However, this was not noted in the records, and the relevant nurses were not aware of this. RN G was asked to review Mr A, and she noted that he had a suspected fracture. Mr A was transferred to hospital, and a fractured hip was confirmed.

73. The rest home's policy states that family must be informed of an incident during the shift on which it occurs, or at the nearest appropriate time, and that family must be informed

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

within 24 hours. Standard 2.4 of NZHDSS also states that all adverse events should be reported to family in an open manner.

74. RN Russell advised: "[T]he rationale of the call not being made by the bureau Nurse on the night of the event is understandable however … those calls should have been made." She advised that this was a "mild departure" from the standard of care. In my opinion, there were opportunities for Mrs A to have been informed of the fall prior to her visit to see her husband in the afternoon of the following day.

75. As noted above, the care and assessment following the fall was appropriate, and it appears that Mr A's pain became apparent only in the afternoon of 10 Month2. RN Russell advised that "information from the morning RN [noted] that it was a busy morning which means there is potential for the fracture not to have occurred at that time but as a result of some other event". I acknowledge this possibility, and given the evidence available to me I am unable to make a finding as to whether Mr A's broken hip was caused by the fall on 9 Month2 or as a result of another event.

76. Notwithstanding this, I am critical that Mr A's family was not informed about the fall in a timely manner. An update should have been provided to Mr A's family as soon as practicable after the fall.

Preparation for hospital appointment — adverse comment

77. Mr A was booked for a hospital appointment on 4 Month2. Mrs A asked the rest home to have him ready by 9am, and this was noted in the progress notes. The rest home accepts that Mr A was not ready for his appointment, and said that this was because the nurse was busy, and occupied with other matters.

78. Following the incident, the rest home implemented a new electronic care planning system that includes a reminder flag to generate prompts to the care team each time they log in, and alerts are now used to remind staff of pending appointments to ensure that these are not missed.

79. I am critical that Mr A was not ready for his appointment on 4 Month2. However, I acknowledge the changes that have been introduced by the rest home following the incident.

InterRAI assessment — adverse comment

80. There is no evidence that an InterRAI assessment was completed during Mr A's admission, or that a full assessment was undertaken by another specialist in light of Mr A's condition. RN Russell advised:

> "Given that [Mr A] had been at [the rest home] for nearly one month there is no record of an updated InterRAI (a comprehensive assessment required at 21 days after placement) … despite [Mr A's] limited eating, decreasing mobility, and falling."

81. I am concerned that there is no record of an InterRAI assessment having been completed, given the importance of this tool in providing a comprehensive clinical assessment of a person's needs. I consider that had an InterRAI assessment been completed, more attention would have been paid to Mr A's bowel management needs and the general nature of the support he required.

82. HealthCERT told HDC that the rest home has had issues with the consistency of its care plan preparation reflecting the InterRAI assessment, and that this has been a recurring issue from previous HealthCERT audits. I find this concerning. Appropriate actions should have been taken to address the non-compliance at the outset.

Recommendations

83. I recommend that Radius Residential Care Limited:

a) Provide a written apology to Mr A's family for its breach of the Code. The apology is to be sent to HDC, for forwarding to Mrs A, within three weeks of the date of this report.

b) Audit its patient admission care plans for the last three months, to ensure that they appropriately reflect any transfer forms or notes for patients who were admitted to the rest home, and critique the adequacy of the initial care plan and compliance of care, and report the results of the audit to HDC within three months of the date of this report. If 100% compliance is not achieved, Radius Residential Care Limited is to advise HDC of the further actions that will be taken to ensure 100% compliance.

c) Provide a written update on the steps taken to address the issue identified in the HealthCERT audit report regarding the care plans not reflecting the interRAI assessments, including any changes made by the rest home in relation to this issue in preparation for the upcoming HealthCERT audit in August 2020. This update is to be provided to HDC within three months of the date of this report.

Follow-up actions

84. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Radius Residential Care Limited, will be sent to HealthCert (Ministry of Health), the New Zealand Aged Care Association, the Health Quality & Safety Commission, and the district health board, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Julia Russell:

"8 February 2019

Report to [HDC] re: [Mr A] C17HDC01178

This report is regarding a complaint made by the family of [Mr A] who was a resident at [the rest home]. In preparing this report, various sources of information have been reviewed, including:

- the letter of complaint […];
- responses from [the rest home];
- progress notes; and
- the Falls Policy.

This report will comment on:

1. whether there were sufficient measures in place in light of [Mr A's] falls risk
   a. whether the care following his fall including the notification of his family was consistent with Radius' Falls Policy and expected standards;
2. the adequacy of care planning and implementation of his care plan,
   b. management of the micolette enemas and lax sachets which were prescribed PRN.

For each of these points, consideration is given to the following:

- What is the standard of care/accepted practice;
- If there has been a departure from the standard of care or accepted practice, how significant is this;
- How would it be viewed by our peers; and
- Any recommendations for the future.

Background

[Mr A] was admitted to resthome level care at [the rest home] [as] he was unable to be cared for at home following a fall. Despite having fallen, [Mr A] was mobile and required assistance to get to the toilet.

1. Whether there were sufficient measures in place in light of [Mr A's] falls risk.

[Mr A] was assessed by [the rest home] as a high falls risk due to: hypotension, incontinence, lack of balance, respiratory status, poor posture, and mental condition. The care plan notes a series of interventions including support and assistance to mobilise — it also notes he frequently mobilises without assistance. [Mr A] was on 2 hourly checks due to his postural hypotension which impacts on falls risk. It is the 2

hourly observation chart that records that he has a sensor mat in place on the 22 [Month1]. On the 21 [Month1] the Physiotherapist records seeing him, and, in his words, he is exhausted, therefore no assessment occurs. Further to this in his daily notes on the 30 [Month1] and 2 [Month2] it is recorded that a sensor mat is in place to monitor when he gets out of bed. There is a suggestion that he will have a commode by his bed. Despite not being able to see this planned in the careplan or in the notes it appears a sensor mat was in place to assist staff in knowing when [Mr A] was out of bed. Unfortunately, for the frail elderly, by the time staff respond to a sensor mat a fall may have already occurred.

The assessment regarding his likelihood of falling is accurate — he is a high falls risk and the actions taken to assist in managing him are also adequate. The level of care planned and provided is acceptable.

a. Whether the care following his fall including the notification of his family was consistent with Radius' Falls Policy and expected standards.

Radius Facility Manager, [RN H], states in her 1 September 2017 letter that the family notification by [rest home] Staff did not meet their expected standard. Reading the notes of the 9 [Month2] there appears to be no incident form regarding [Mr A's] fall — this would normally describe what had occurred. [RN H] says that he was assessed by 3 registered nurses regarding his fall. However, the notes provided do not support that at all. Further to this, there was a series of miscommunications across various staff which meant [Mrs A] arrived at [the rest home] not knowing her husband had fallen. The Bureau Registered Nurse, this is an acceptable consideration particularly as there was no apparent injury to [Mr A]. However, no staff were aware that [Mr A's] daughter was happy to be contacted any time in the 24-hour period, so she could have been called. When [Mrs A] arrived the next day at 1:20pm, [Mr A] was in obvious pain. If the phone call to family had been made at the time of the injury, they would have known there was a change in [Mr A's] condition rather than being concerned that he had been like this since the time of his fall. Also, as his condition had deteriorated since the time of his fall when no injury was noted to the time [Mrs A] arrived to see her husband in obvious pain, his family had not been updated which would be expected.

As noted above, this series of events does not meet the policy requirements of [the rest home]. The rationale of the call not being made by the Bureau Nurse on the night of the event is understandable; however there was an alternative person to call and those calls should have been made when it was clear that [Mr A's] situation had changed. [Mr A] was in a resthome bed and area, however, the rest home also has a hospital facility which would mean there are more Registered Nurses and assessment availability than in a stand-alone facility. It appears that no real assessment of the situation occurred until [Mrs A] arrived. This is a serious departure from the expected standard of care and would be considered [so] by most providers of care.

2. Adequacy of care planning and implementation of his care plan

The care plan and associated planning for [Mr A] is acceptable in all areas except bowel management; this includes no short-term care plan being created regarding bowel management upon his 9 [Month2] return to [the rest home]. There are no handover notes in [Mr A's] care plan regarding the transfer of care from the hospital back to [the rest home]. Having the transfer information available would indicate how significant the hospital staff felt that the impacted bowel was on [Mr A's] general health. This is an opportunity for improvement for [the rest home] — to gather and record this material in the progress notes.

Page 4 of [Mr A's] transfer of care letter to the GP records that he is being discharged to private hospital level care — he was transferred to resthome level care. It appears from [Mr A's] notes that he was largely bed bound during his time at [the rest home] which suggests he may not have been resthome level. Given that [Mr A] had been at [the rest home] for nearly one month there is no record of an updated InterRAI (a comprehensive assessment required at 21 days after placement), or any request or action to have a full assessment done by a Gerontological Nurse Specialist, Nurse Practitioner or GP, despite [Mr A's] limited eating, decreasing mobility, and falling. There is an opportunity to increase the skill of the onsite RNs and one that [the rest home's] Management have recognised and acted upon through the education done with [the nurse practitioner] and the staff.

a. Management of the micolette enemas and lax sachets which were prescribed PRN

At the 11 [Month1] admission to [the rest home], [Mr A's] regular pattern of bowel movement was noted as every other day — the care plan records that no aperients are required. Upon review of the bowel chart, it appears [Mr A's] pattern was consistent as every other day whilst at [the rest home]. However, [Mr A's] 4 [Month1] transfer letter from [Hospital 1] includes: Micolette enemas, Laxsol, tablets and Lax sachets each to be used PRN (as required). [Mr A] was given a 1-month supply of each of these medications from hospital. The recording that no aperients are required is clearly incorrect.

In the letter of complaint, the family record that [Mr A] was refused laxatives and that he had one enema, around the 2 [Month2]. Review of:

a. drug charts from the 17 [Month1] to the 10 [Month2] Laxsol, Lax sachets or Micolette enemas are not listed as routine medications and Laxsol was given once PRN on the 30 [Month1]; and

b. the progress notes and medication signing sheets show there is no record of any refusal for laxatives or that an enema was given on or around the 2 [Month2].

Additionally, there is no evidence of any short-term care plan being done about his 9 [Month2] return from hospital with impacted faeces. Given the potential seriousness of this health issue it would be expected that there would be. Following [Mr A's] transfer back from the Public Hospital on the 9 [Month2], there is no record of

administration of these medicines either — there was only a day between his return to [the rest home] and his return to the hospital on the 10 [Month2].

On the 4 [Month1] — at the time of [Mr A's] admission to [the rest home], [a nurse] faxed the [Hospital 1] discharge letter to [the pharmacy]. The discharge letter records medications that were continued as well as new ones started during his hospital admission. Medications included here are: Micolette enemas, Laxsol, tablets and Lax sachets each to be used PRN (as required). The discharge summary records that [Mr A] was given a 1-month supply of each of these medications from hospital.

The area of bowel management and the medications associated with it are poorly recorded and appear on this occasion not to have been well managed at [the rest home]. Given the medications that [Mr A] had recorded on his 4 [Month1] discharge letter, there was an identified potential problem of constipation. Reviewing the progress notes and bowel charts [Mr A] seems to have maintained his normal bowel pattern. However, at the 4 [Month2] hospital admission he was noted to have impacted faeces. As noted previously from reviewing the progress notes, [Mr A's] situation was deteriorating. There was a missed opportunity to have had a full review of him and his notes. This review may have identified that the enemas and Lax sachets were on his drug chart and were not being offered and that the care plan was incorrect as there were aperients charted.

This does not meet the expected standard as the care plan did not record the information that was provided in the 4 [Month1] [Hospital 1] discharge letter. The 9 [Month2] reconciliation process looks like it is incomplete. Moreover, the reconciliation process requires transcribing from a discharge letter to a form which will always be a risky process with the possibility of errors. Given that bowel management is a key function to health, and that it is not well planned for in the care plan this is a serious departure from the care that is expected to be provided. Bowel management is an area that would have been covered by [the nurse practitioner's] assessment training with the [rest home] staff but may benefit with further training on this essential area of practice, particularly in the area of management of the medications commonly used.

In conclusion there are two areas of consideration in this report. Firstly, whether there were sufficient measures in place in light of [Mr A's] falls risk, which there were and whether the care following his fall, including the notification of his family, was consistent with Radius' Falls policy and expected standards. [RN H] acknowledges they did not meet their own standards on this occasion and this is a serious departure from the expected standards.

The other area for consideration was the care plan whether the planning was adequate in all areas except that associated with bowel management. The lack of planning regarding bowel management was a serious departure from the expected standards and areas that require ongoing professional development for staff. As was

also noted in this report, [Mr A] appears to have been a very unwell and frail man whose care needs may have exceeded the level of care that he was placed in and this would require a comprehensive assessment by a nurse(s) with advanced assessment skills — training for this has started with a training session with [the nurse pracititioner] and there will need to be an ongoing training in this area.

Julia Russell RN, M Phil (Nursing)"

The following further expert advice was obtained from RN Russell:

"**Report to [HDC] re: [Mr A] (dec) C17HDC001178**

10 August 2019

The purpose of this report is to review the report provided on the 8 February 2019 and the material provided in April 2019:

1. Statement from [RN D] dated 28 March 2019
2. Job description of:
   a. Clinical Manager, [RN G]
   b. Facility Manager [RN H]
3. Policies:
   a. Care Plan (Manual) form
   b. Policies —
      i. Accident/Incident event reporting 2016 and March 2018
      ii. Serious & Sentinel Events Policy dated March 2018
      iii. Falls Management Policy reviewed Jan 2017
4. Neurological Chart Incident report regarding the 9 [Month2] fall
5. Training lists …
6. Age-related Residential Services Agreement
7. HealthCERT Audit reports Dec 2018 and Jan 2019
8. Letter from the Ministry of Health dated 12 March 2019
9. Radius Care Registered Nurse Leadership Programme

The purpose of this report is to consider if the initial advice provided in the 8 February 2019 [Mr A] (dec) report requires amending or if any further comments are required given the provision of the additional material. Specific responses are provided on the following points from [the Chief Operating Officer's (COO)] 11 April 2019 letter with a determination of the departure from the standards of care for the two areas of family notification and bowel management. Consideration will be given as to whether the overall departures from the standard of care in [Mr A's] case are attributable to an individual or can be attributed to a systematic failure.

General comments

Staffing

The RN statements assisted in clarifying processes and events. Alongside the changes in senior staffing was the implementation of the electronic resident file (E Case) which required a considerable amount of training. Evidence of E Case training and training on other relevant topics is evident in the training records provided. In their statements [RN F] and [RN C] positively comment on the training provided and received at [the rest home]. There were also considerable changes in the RNs working at [the rest home] with 5 of the 6 who worked with [Mr A] having left [the rest home]. This turn-over of RN staffing is representative of aged care and demonstrates the challenges for providers and the importance of ongoing training and skill development for RNs. [The COO] comments that there is a new team with new leadership at [the rest home] and the positive results in the recent audit (only one partial attainment) demonstrate that there have been improvements.

Audit results — The Feb 2019 HealthCert letter indicates there have been significant senior leadership changes and ongoing persistence of findings in the area of service delivery. Radius Residential Care Ltd (Radius) provided the Dec 2018 and Jan 2019 MOH audits; they demonstrate [the rest home] continues to have a moderate finding/partial attainment in the area service planning but is otherwise meeting its contractual requirements. A further review of the Ministry of Health website (which holds all the MOH audits for [the rest home]) notes that [the rest home] underwent an expected surveillance audit in January 2018 with a further surveillance audit taking place in June 2018. The second surveillance audit occurred as the January 2018 identified a number of partial attainments in the areas of service delivery — care planning and medication management. The departures from the expected standards of care identified in this report are in the area of service delivery.

Training planned after [Mr A's] incidents. The 22 [Month2] Quality Manual form [RN H] identifies clinical reasoning training was planned for 6 weeks after these events with plans for 'ongoing education on assessments with incidents picked from handover and discussed with relevant nurses to unpack and work out what else could have been done in the situation'. This speedy action possibly indicates that assessment and clinical reasoning were identified as areas for improvement that had been identified by the Facility and Clinical Managers as they planned training in this area. The outcome of this training was an improvement in clinical assessments. Further development with their E-Case programme and care planning will assist staff to complete tasks with prompting alerts by the E-Case system.

From [the COO's] April 2019 letter — Response to expert advice

Point 12a. Incident form and progress notes

[The COO] comments that the incident form was provided. The original material provided in respect of this file was reviewed and the incident form was not provided. Attached as appendix 1 is a screen shot of the incident form material provided — it

appears this is a report of incidents that had occurred. Given that the incident form has now been reviewed, the incident form and the progress notes of that day and the following shifts provide no evidence that [Mr A] was reviewed by three RNs. [RN H's] letter of [Month2] acknowledges [RN B] did not record the care she delivered but she did provide further information as part of the investigation. However, there is no written evidence of a clinical review or assessment by [RN B] or other RNs. While [RN B's] information is consistent with the neurological observations she had taken, recording information some time after an event is not the same as documenting a situation at the time or within the shift as is the expectation of practice.

Reviewing the incident form identifies that at that time of recording 9 [Month2] 2225 hours there was no apparent injury. This is the information that the night RN, Clinical Manager and the morning RN had. The incident has been identified as without injury and the pressure of the morning's work took precedence over calling [Mrs A]. The position description for the Clinical Manager identifies that the day to day work with the residents is done by the RN so it was her responsibility to contact [Mrs A]. Given the busyness of the morning shift it would be unlikely that a morning RN would reasonably get to making a phone call regarding a fall with no injury that had happened on the previous afternoon shift until after lunch. There is no information about the time frame the Clinical Manager expected the RN to make the call to [Mrs A]. It is also impossible to know what the expectations for hand over back to the Clinical Manager by the RN would have been. It would not be unreasonable to consider the Clinical Manager and RN could have communicated regarding the phone call, however that did not happen. Of course, [Mrs A] arrived before that call could be made.

Points 12b and c

Radius' policy for Accident/Incident Event reporting both the Document 3, Version 3 (due for review 2016) and the more recent document 3, version 03 (due for review 2019) under point 5 — work instruction says '… must be informed of the incident on that shift or at the nearest appropriate time within 24 hours'. Given the expectations of families especially for families that identify they can be contacted at any time and provide an alternative contact there is a potential for improvement to review the time frames for this family/whānau contact in the policy.

[The COO] does not concur with the advice that a series of miscommunications occurred as:

a) no call was made to [Mrs A] about the fall by the Bureau Night Nurse,
b) no contact with an alternative contact who was willing to be contacted at any time (which includes late at night or early in the morning)
c) the Clinical Manager asked the morning RN to call but the call was not made
d) there was no follow up between the Clinical Manager and the RN that identified the call had not been made.

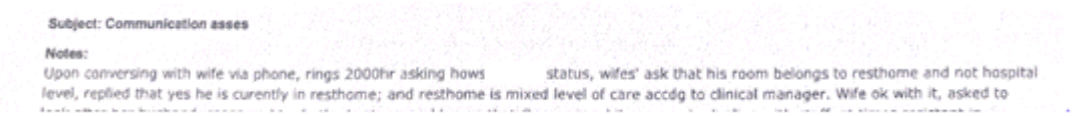
Irrespective of how it is described, there was a failure to contact [Mrs A] or the alternative contact.

The implementation of E-Case had occurred just prior to this series of incidents and this may explain the minimal reporting as the move from paper to computer is a significant difference in the way information is gathered and stored. The Bureau Nurse may not have had access to the alternative contacts details — although this has not been suggested by any person. Evidence is provided of the significant amount of training occurring.

The incident form has now been sited and records no injury; information from the morning RN that it was a busy morning which means there is potential for the fracture not to have occurred at that time but as a result of some other event this is now seen as a mild/moderate departure from the expected standards. Communication did not occur until [Mrs A] arrived at [the rest home] and identified [Mr A's] leg looked unusual.

Point 12d [Mr A's] level of care

[The rest home] provides both resthome and hospital care. The documentation provided meant it was difficult to determine the actual level of care [Mr A] was receiving. It is not unusual to have the public hospital provider refer to a patient as going to hospital level care when they are in fact going to resthome care. The following two pieces of information were used to identify which level of care [Mr A] had. The second piece of information is ambiguous and with the benefit of hindsight it could be read as [Mr A] was hospital level care but initially a resthome area. Given the information below it was determined he was in resthome level care and maybe moved to a higher level of care when he later changed rooms.


Subject: Communication asses

Notes:

Upon conversing with wife via phone, rings 2000hr asking hows status, wifes' ask that his room belongs to resthome and not hospital level, replied that yes he is curently in resthome; and resthome is mixed level of care accdg to clinical manager. Wife ok with it, asked to

Points 15–19 Care planning and bowel management

[The COO] questions comments made in the 8 February 2019 report regarding the care planning of [Mr A's] bowel management. [RN C] notes in her statement regarding [Mr A's] care plan that there is a lack of consideration by the RN to this area.

After reviewing the care plan for [Mr A], I can say that the nurse who developed the care plan had unfortunately overlooked including any interventions pertaining to bowel management. There was lack of consideration given to reflect the PRN aperients prescribed (Micolette Enemas and Lax Sachets) in [Mr A's] care plan.

In point 17 [the COO] refers to a comment made regarding the progress notes recording that a micolette enema was given around the 2 [Month2]. The 18 and 27

[Month1] are 15 and 5 days respectively before the 2 [Month2] which is not considered by the writer as on or around the 2 [Month2].

Point 19 refers to comments that [Mr A] was not discharged back to [the rest home] with faecal loading. It would not be expected that he would have after 5 days in hospital. [Mr A] was an elderly man with dementia in light of the significant amount of PRN medication prescribed for [Mr A] it indicates this is a health issue for him and needs to be managed. Ensuring appropriate bowel management for people who have dementia and older people in general is a corner stone to managing their health and behavior. Training sessions held with [a nurse practitioner] were noted in the 8 February 2019 report as positive steps in ensuring this area of care is expertly attended to.

The 8 February 2019 report identified two areas of care where there was a departure from the expected standards of care for:

a) Notification of the family regarding the 9 [Month2] fall.
   Consideration for this has been ameliorated from a serious departure from the standards to a mild departure
b) Care planning for bowel management.

Bowel management is a fundamental aspect of care and it was identified by the previous Clinical Manager [RN C] that the care plan was not developed. It is evident that work on professional development/training is in place. However, at the time [Mr A's] care did not meet the standards of care and this continues to be identified as a serious departure from the standards. Whether or not this is the responsibility of the nurse who undertook the care planning work, or a systemic issue is difficult to determine. However, as the training for clinical reasoning happened 6 weeks from these events it would appear that this was something a number of staff required, therefore it is considered as a systemic rather than a personal issue for any one RN.

Julia Russell RN, M Phil (Nursing)"

The following further expert advice was obtained from RN Russell:

"… I have read your request above again and am able to comment on it.

Yes I believe that the care provided following the fall was acceptable given what the RNs who had seen it believed had occurred. I decreased the seriousness of the finding based on being able to see the incident form which was not previously available …

Julia Russell RN, M Phil (Nursing)"