Rest Home Company
Registered Nurse, RN D
Registered Nurse, RN E

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00655)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a woman by a rest home company during her admission for rest-home-level care. During her residency, she had multiple clinical events, and her overall condition deteriorated in her final months. There were a number of oversights in relation to her assessment, care planning, documentation, monitoring of deterioration, falls management, escalation of care to a GP, and systems for oversight of clinical care. In addition, there was a lack of oversight from the Manager in relation to the care provided by care staff.

2. This case highlights the importance of aged-care residential facilities ensuring that managers and clinical leaders have the skills and expertise in aged care to deliver appropriate services, lead care staff, and assess residents' health needs. It also reinforces the importance of nursing and support staff being alert to a resident's changing health status. Staff must assess, think critically about, and respond appropriately to, deterioration in the resident's condition.

Findings

3. The Deputy Commissioner found that the rest home company breached Right 4(1) of the Code. In her view, a number of failings by the rest home meant that the woman was not managed appropriately, and did not receive the specialist care she required in a timely manner. The Deputy Commissioner also considered that the services provided to the woman did not comply with relevant standards, and that the rest home company breached Right 4(2) of the Code.

4. The Deputy Commissioner found a nurse in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the nurse did not provide appropriate oversight of the clinical documentation, and failed to complete the necessary needs assessment and corresponding care plans. The Deputy Commissioner was also critical that the nurse did not respond to the caregiver's file notes, which referred to the woman's concerning symptoms, and that the nurse did not alert a GP to the woman's deteriorating health in a timely manner.

5. The Deputy Commissioner was critical that the Manager of the rest home did not provide appropriate oversight of the staff and residents, and for the lack of co-operation with this Office during the investigation. The Deputy Commissioner was also critical that staff were led to understand that the Manager was able to provide clinical advice that was outside the scope of his clinical practice as a registered mental health nurse, and that as a Director of the rest home company he did not retain copies of the relevant clinical records.

6. The Deputy Commissioner was critical that another nurse did not complete the woman's care plan and assessments in a timely manner.

7. The Deputy Commissioner referred the rest home company to the Director of Proceedings.

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Recommendations

8. The Deputy Commissioner acknowledged that the rest home is now closed, and that no relevant recommendations can be made in relation to its service provision. However, it was recommended that the rest home company provide a formal written apology to the family.

9. The Deputy Commissioner recommended that the Nursing Council of New Zealand carry out a competency review of the first nurse and consider a period of supervised practice, that the nurse apologise to the family and undertake training on documentation, care planning, assessment of a deteriorating condition, interpretation of caregiver findings, supervision of caregivers, delegation to caregivers, and reflective practice.

10. The Deputy Commissioner recommended that the Nursing Council of New Zealand give consideration to a review of the second nurse's competence and conduct, and that the nurse apologise to the family.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Ms B concerning the care provided to her late mother, Mrs A, at the rest home. The following issues were identified for investigation:

- *Whether the rest home company provided Mrs A with an appropriate standard of care between Month2[1] and Month11.*
- *Whether RN D provided Mrs A with an appropriate standard of care between Month2 and Month11.*
- *Whether RN E provided Mrs A with an appropriate standard of care between Month2 and Month11.*

12. This report is the opinion of Rose Wall, 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:

Ms B	Consumer's daughter/complainant
Ms C	Consumer's daughter/complainant
RN D	Provider/registered nurse
RN E	Provider/owner-operator
The rest home company	Provider

[1] Relevant months are referred to as Months 1–11 to protect privacy.

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14. Further information was received from:

RN F	Registered nurse
Dr G	General practitioner
District health board	

15. Independent expert advice was obtained from Registered Nurse (RN) Anna Blackwell (Appendix A).

Information gathered during investigation

Mrs A

16. Mrs A, aged in her nineties at the time of these events, was admitted to the rest home in 2016 for rest-home-level care. The rest home is privately owned and operated by the rest home company. Mrs A had transferred from a facility that had closed.

17. Mrs A had a number of health conditions, including hypertension,[2] meningioma,[3] a VP shunt,[4] and intermittent atrial fibrillation.[5] Mrs A was independent with dressing and toileting; however, she required supervision with showering, toileting at night, and all transfers from bed to chair. She was alert and responsive, and able to assist in the planning of her care.

18. On 3 Month11, owing to shortness of breath, Mrs A was transferred to the public hospital. She was diagnosed with congestive heart failure and a lower respiratory tract infection. Mrs A remained in hospital until 11 Month11, when she was transferred to a private hospital for palliative care. Mrs A died on 14 Month11.

The rest home

19. The rest home company was contracted by the District Health Board (DHB) to provide rest-home-level care for up to 21 people in the region. In 2016, an audit of the rest home was undertaken by the provider's designated auditing agency. The audit stated that RN E was a registered nurse and the owner/operator responsible for overseeing the facility, and that another registered nurse supported the Manager. The audit found that improvements were required in relation to communication, corrective actions, adverse event follow-up, staff training, service provision, general practitioner (GP) reviews, medication management, equipment, and infection control training. On 16 May 2018, the rest home closed.

[2] Abnormally high blood pressure.
[3] A slow-growing, typically benign brain tumour.
[4] A device used to divert the cerebrospinal fluid (CSF) from the ventricles in the brain to the abdominal cavity.
[5] Very rapid uncoordinated contractions of the atria of the heart resulting in a lack of synchronism between the heartbeat and pulse beat.

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RN E

20. RN E's scope of practice states that he may practise only in mental health nursing. RN E, the sole director of the rest home company, stated that he offered support to staff around staffing issues or day-to-day business, but did not provide any clinical oversight or nursing care, or undertake on-call duties at the rest home, as this was outside of his scope of practice. RN E told HDC that he was working out of town during the time of these events.

RN F

21. RN F[6] was employed by the rest home company as a registered nurse from 2015 until Month4. RN F said that her hours of work were Monday to Friday 7.00am to 3.30pm, and she was the only registered nurse on duty during these hours. She stated that following Mrs A's admission to the rest home in Month2, the Clinical Nurse Manager resigned, and no one was employed to cover her role and responsibilities. As a result, RN F said that she had to cover the responsibilities of completing all residents' assessments, care plans, GP reviews, and wound dressings, and the ordering of medications, medical supplies, incontinence products, and dressing supplies.

RN D

22. RN D[7] was employed by the rest home company as a registered nurse from Month4 until 2018. RN D said that she worked at the rest home Monday to Thursday from 7.00am to 3.30pm, and on Fridays she worked from home to complete administrative tasks. She did not work weekends, and was not on call after hours. RN D said that she was unaware of what was happening during the weekend, and that it "was hard to pick up what was done or not done, or what had been happening," and there was no proper communication in handover.

23. RN D told HDC that her responsibilities as a registered nurse included handovers, medication rounds, assisting the caregivers with cares, ordering medication and dressings, arranging informal and formal education for caregivers, ensuring that assessments and care plans were completed, assisting with planning activities for the residents, ensuring that staff medication competencies were up to date, and co-ordinating hospital appointments with family and staff.

Staffing and leadership

24. At the time of these events, one registered nurse was responsible for monitoring 21 residents, with the support of two caregivers who reported to the registered nurse. The rest home company told HDC that RN F, and then following her resignation, RN D, was the senior person responsible for managing and providing clinical oversight at the rest home. RN F told HDC that following the change of ownership, the Clinical Manager resigned, and no one was employed to cover her role and responsibilities. RN F said that she had to assume additional responsibilities. RN F and RN D stated that RN E was the Manager of the rest home. However, RN E stated that he did not provide any clinical oversight, and was not employed by the rest home company.

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[6] RN F registered with the Nursing Council of New Zealand in 2014.

[7] RN D registered with the Nursing Council of New Zealand in 2014.

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Registered nurses on call

25. The rest home company told HDC that the role of registered nurse included on-call duties at the facility. It said that RN D was aware that she was expected to be available to work on call and to attend when requested by caregivers. The rest home company said that in light of the on-call duties, RN D worked from home one day a week on a safe and secure laptop, to complete the paperwork. In contrast, RN F and RN D told HDC that RN E was the on-call registered nurse when their shifts ended, and was on call on the weekend. In response to the provisional opinion, RN D stated that when the caregivers recorded in the clinical notes that a registered nurse was notified, the nurse referred to was RN E. As stated above at paragraph 20, RN E asserts that he did not provide on-call care at the rest home.

Policies and employment information

26. HDC sought further information from the rest home company; however, it did not provide the information requested in respect of relevant policies, job descriptions, employment information, and education and training records. RN E, on behalf of the rest home company, told HDC that at the time of the rest home's closure, the computer was "broken", and the information requested by this Office could not be retrieved. The rest home company said that having sent the original copies of the information requested to this Office, it no longer holds relevant information about the facility. The information requested from the rest home company was not received by this Office.

Admission assessment and care plan

27. When Mrs A was admitted to the rest home, RN F completed an initial care plan, a nursing assessment, a Coombe assessment,[8] and a falls prevention plan. The Coombe assessment scored 9, indicating that Mrs A had a low risk of falls. An "Initial Care Plan" was completed for Mrs A on 21 Month2, as per contractual requirements[9] for new admissions to rest homes. It was recorded that Mrs A was alert, bright, and coherent, her long-term and short-term memory were good, and her risk of falls was slight. There is no record of Mrs A's relevant medical history in the care plan.

28. RN F told HDC that on admission she took Mrs A's vital signs, including temperature, heart rate, respiratory rate, blood pressure, and weight, and recorded these in Mrs A's observation chart. RN F said that she assessed Mrs A to complete the admission forms, as there was no clinical file or referral note from Mrs A's previous facility.

interRAI assessment

29. An interRAI assessment for Mrs A was completed at another rest home on 13 Month1, but there is no evidence that the assessment was updated during her residency at the rest home. The Age Related Residential Care Services Agreement between the DHB and the rest home company required the rest home to ensure that every resident had an interRAI assessment completed within 21 days of admission to the facility.

[8] Falls risk assessment.

[9] The Age Related Residential Care Services Agreement.

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30. RN F stated that owing to the lack of information on admission, she obtained a copy of Mrs A's most recent interRAI assessment for her clinical record. RN F said that she found it difficult to keep interRAI assessments and care plans up to date for the 21 residents because she was required to cover other duties. She stated that she told the owner of the rest home about her concerns regarding her workload and the interRAI assessments and care plans. In contrast, the rest home company told HDC that RN F did not raise any concerns about her workload, or about completing interRAI assessments, and it believed that the interRAI assessments were up to date and completed as required.

GP review

31. On 20 Month2, Mrs A was reviewed by GP Dr G at a medical centre. It was recorded in the Medical Assessment/Continuation notes that Mrs A was reviewed by Dr G, but there is no record of this consultation in Mrs A's clinical notes.

32. Between Month2 and Month11, Mrs A was reviewed by a GP three monthly,[10] and following changes in her health condition.[11]

First fall — 26 Month2

33. The clinical notes on 26 Month2 record that at 5.45am, Mrs A had an unwitnessed fall. An incident form was completed by a caregiver, who found Mrs A on the floor next to a commode. The caregiver assessed Mrs A for injuries, and although none were noted, it was recorded that Mrs A might develop bruising on her bottom. Mrs A was assisted back to bed, but was not reviewed by a registered nurse.

34. RN F told HDC that at the morning handover, a caregiver stated that she had telephoned RN E to ask him to attend because of the fall, but had been unable to contact him. RN F reviewed the incident form and completed the post-falls assessment. She reviewed Mrs A and took her vital signs and neurological observations,[12] and these were normal. RN F updated the Coombe assessment and categorised Mrs A as a medium risk for falls. The individualised falls intervention plan was also updated for the caregivers. RN E told HDC that he has no recollection of any discussions with any staff about Mrs A's fall on 26 Month2, and that he was not the on-call registered nurse for the rest home.

Handover of registered nurse position

35. In Month4, RN F resigned and handed over to the incoming registered nurse, RN D. Regarding the handover, RN F stated that she told RN D the due dates and pending interRAI assessments and care plans for Mrs A and the other residents. RN D stated that when she commenced her role in Month4, not all of the residents had completed interRAI assessments.

36. On 27 Month4, the format of the clinical records at the rest home was changed, and the column for designation and signature of staff was removed. From this date, only the

[10] On 20 Month2, 20 Month5, and 12 Month8.
[11] On 23 Month9 and 3 Month11.
[12] Including a Glasgow Coma Score.

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registered nurse was required to verify entries in the clinical notes with a stamp. All other entries by caregivers had no designation or signature. RN D told HDC that she told the caregivers on multiple occasions to document their designation in the clinical notes.

Second fall — 4 Month6

37. At 5.45am on 4 Month6, Mrs A was found on the floor outside her bedroom by another resident. The clinical notes state that a caregiver found a bump on the right-hand side of Mrs A's head, and that she was assisted back to bed. The caregiver recorded that the plan was to "keep an eye on her for other signs". There is no evidence that a registered nurse reviewed Mrs A following her fall. RN D told HDC that she was working from home when Mrs A sustained the fall on 4 Month6.

38. Between 5 and 9 Month6, the clinical notes record that Mrs A complained to caregivers that she had a sore head and generally did not feel well. Caregivers noted that Mrs A had bruising on her thigh and her head, and administered Panadol for a headache on 8 Month6.

39. On 8 Month6, RN D recorded that Mrs A was independent with her cares, had a good appetite, and was compliant with medication. RN D did not document any follow-up regarding Mrs A's fall on 4 Month6, or Mrs A's ongoing complaints to staff in the days following her fall.

40. On 15 Month6, the clinical notes record that Mrs A reported "excruciating pain" in her right arm as a result of her fall on 4 Month6. Her pain was assessed as 9 out of 10, and she was given codeine. The next entry by a registered nurse was on 28 Month6, when RN D recorded that Mrs A required assistance with showering, her appetite was good, and she was compliant with her medication.

41. RN D said that although she was informed by staff about any falls, sometimes this was days after the fall had occurred.

Third fall — 9 Month8

42. At 10.00pm on 9 Month8, a caregiver found Mrs A on the floor outside the sunroom. The caregiver checked Mrs A for injuries, and found a bump on the back of her head. The clinical notes record that an ice pack was applied to the bump, and that RN E was telephoned, but there is no documentation of any advice given by RN E. The caregiver recorded that Mrs A was monitored for signs of concussion throughout the shift, but she reported that she felt "okay", and was administered codeine for pain relief. RN E maintains that he did not provide any on-call duty care.

43. RN D told HDC that she was not on duty when Mrs A had a fall on 9 Month8. She stated that she understood that RN E had performed all the necessary checks following the falls. She said: "Sometimes I only know they had a fall [a] few days after from HCA [the healthcare assistant] or our activity co-ordinator."

44. On 10 Month8, a caregiver recorded that Mrs A reported that her head was sore.

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45. On 12 Month8, Dr G performed Mrs A's three-monthly GP review. Dr G recorded that Mrs A had elevated blood pressure, and prescribed blood pressure medication. He also noted that she had had a recent fall and had been suffering a few headaches at night time.

46. Dr G told HDC that he was informed that Mrs A had had a fall on 9 Month8, and that this had left a contusion on her head, but there were no new neurological symptoms. He stated that the onset of Mrs A's headaches in the evening had developed prior to the fall on 9 Month8. He said that on this occasion he had prescribed medication for Mrs A's raised blood pressure.

47. Between 16 and 21 Month9, caregivers recorded in the clinical notes that Mrs A was "still hallucinating" and "seeing things on wall", and a urine specimen was taken. There is no record of a nursing review of Mrs A.

48. On 22 Month9, RN D reviewed Mrs A and noted that she verbalised that she was feeling "potty". RN D noted that the results of Mrs A's urine sample from the previous week were negative for a urinary tract infection. RN D took Mrs A's observations and noted that her blood pressure was 190/60mmHg.

49. Dr G reviewed Mrs A on 23 Month9, owing to concerns about her high blood pressure, headaches, and visual hallucinations. Dr G recorded: "[On examination] no focal neuro signs, [blood pressure] 180–190/80–90. Pulse 72 … Add small dose of risperidone. Neurology opinion, I will get back to [Mrs A]." Dr G told HDC that Mrs A was "well orientated", and risperidone was prescribed for the hallucinations, which Mrs A described as "non-threatening". He stated that the codeine prescribed previously provided relief for Mrs A's headaches. Mrs A's quinapril[13] dose was increased. Dr G said that several days later he was told by a registered nurse at the rest home that Mrs A had responded positively to the risperidone.

50. Dr G told HDC that shortly after the 23 Month9 consultation, he spoke to Mrs A's daughter, Ms C, and told her that there was a possibility that the shunt could be malfunctioning and causing intracranial pressure, which could be causing Mrs A's raised blood pressure. It was agreed to proceed with symptomatic treatment and review the possibility of a neurosurgical referral if Mrs A's quality of life was affected further by her symptoms.

Communication with GP

51. RN D stated that she had discussions with Mrs A's family and the GP about Mrs A's shunt, but acknowledged that she did not document these discussions. RN D told HDC that when she was on duty at the rest home she would inform the GP about Mrs A's symptoms. She said that delays in informing the GP about Mrs A's falls occurred on the days she was not at the rest home, or when there was a delay in notifying her about the falls. RN D stated that she did not document all of her discussions with the GP.

[13] A medication used to lower high blood pressure.

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52. On 24 Month9, seven months after Mrs A's admission, RN D completed a long-term care plan for Mrs A. The plan records under the section "Orientation and Attention Span" that Mrs A had good orientation. The "problem" part of the "Mental Ability/Awareness and Confusion including Anxiety and Depression" section records: "[Mrs A] [t]ends to be confused. Tends to be anxious [related to] constipation, visual hallucination, lack of sleep and not able to see or speak with family." On the same day, Mrs A's falls risk was assessed, and a score of 11 was recorded, indicating a medium risk of falls.

53. Between 25 Month9 and 3 Month10, caregivers recorded on five occasions that Mrs A was feeling dizzy or not her usual self. RN D reviewed Mrs A on 27 Month9, and noted "no new concerns".

54. Between 14 and 19 Month10, caregivers recorded on five occasions that Mrs A felt dizzy and tired, and was observed to be confused. On 15 Month10, Mrs A's observations were recorded as: temperature 36.6°C,[14] blood pressure 170/114mmHg, pulse 93 beats per minute, respiration rate 24 breaths per minute, and oxygen saturation 97%. Mrs A had an elevated pulse and continuing hypertension, but there is no evidence that this was reported to a GP.

55. RN D assessed Mrs A on 20 Month10 and recorded:

> "[Mrs A] is independent with her cares. Good appetite. Mobilises with her walker. Was complaining of constipation, PRN laxsol[15] given. Compliant with her medication. Dressing [on] left foot changed."

Deterioration

56. Between 25 and 28 Month10, it was documented by caregivers on three occasions that Mrs A complained of nausea, giddiness, or feeling generally unwell. Caregivers recorded that Mrs A was breathless and anxious. There is no evidence of a request for a review by a GP.

57. RN D reviewed Mrs A on 28 Month10 and recorded:

> "[Mrs A] was grumpy this morning … Denies any pain but verbalises feeling unwell. Obs[ervations], T[emperature] = 37.1, P[ulse] = 96, R[espiratory rate] = 20bpm, B[lood] P[ressure]140/70, SPO [oxygen saturation] = 91%. Before lunch verbalised felt a bit better, had a nap."

58. On 29 and 30 Month10, a caregiver recorded that Mrs A complained that she was tired and was not feeling well. Staff documented that Mrs A was anxious and very upset, and that her appetited had decreased.

59. On 30 Month10, RN D recorded Mrs A's observations as: temperature 37.1°C,[16] pulse 92 beats per minute, blood pressure 130/60mmHg, respiratory rate 24 breaths per minute,

[14] Within normal range.

[15] A laxative medication for constipation.

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and oxygen saturation 92%. The clinical record does not refer to the concerns about Mrs A's condition noted earlier that day.

60. On 31 Month10, a caregiver documented that Mrs A was anxious and upset. The notes recorded at 6.00am state: "[H]ot and clammy, found it easier sitting up. Wanting to see a Doctor, RN notified." On the same day, caregivers made three further entries in the progress notes, and recorded that Mrs A was sweating, clammy, anxious, breathless, and agitated. At 1pm, a caregiver recorded Mrs A's observations as oxygen saturation 90% and pulse 130 beats per minute, and at 2pm as oxygen saturation 89%, pulse 120 beats per minute, and temperature 37.4°C. There is no evidence that a GP review was requested on 31 Month10.

61. On 1 Month11, a caregiver noted that Mrs A was coughing and looked very unwell. The caregiver recorded Mrs A's observations as "blood pressure 160/90, O_2 sat [oxygen saturation] 87%, [pulse] 150, temp[erature] 36.6." Later that day, a caregiver noted that Mrs A was anxious and sweating, her appetite had decreased, her feet were swollen, and she wanted to sit upright rather than to lie down. There is no evidence that a registered nurse reviewed Mrs A on 1 Month11.

62. On 2 Month11, a caregiver documented that Mrs A was anxious and coughing frequently, and that she was assisted by staff with full cares. There is no evidence that a registered nurse reviewed Mrs A that day.

3 Month11

63. At approximately 1pm on 3 Month11, staff noted that Mrs A required assistance with cares, was refusing to walk, was hyperventilating, and appeared anxious. RN D recorded Mrs A's observations as temperature 36.9°C, pulse 72 beats per minute, respiratory rate 28 breaths per minute, blood pressure 168/88mmHg, and oxygen saturation 90%. Staff requested a GP review owing to Mrs A's rapid breathing and anxiety.

64. In response to the provisional opinion, Ms C stated that she arrived at the rest home and observed that Mrs A was "in a bad state". Ms C stated that she insisted that the staff arrange a GP to review Mrs A that day.

65. In response to the provisional opinion, RN D told HDC that she reviewed Mrs A and noted that her condition had deteriorated since her review four days previously. RN D said that following the handover, she arranged for a GP to review Mrs A. RN D stated that Mrs A's daughter was present when the GP visit was arranged.

66. At 2.45pm, Dr G attended the rest home and reviewed Mrs A. He told HDC that he observed that "her symptoms were worse than [he had] expected". Dr G stated that Mrs A had moderate respiratory distress, with an oxygen saturation of 90% and an irregular heartbeat, and appeared confused. Dr G said that her lung base did not ventilate well and no fever was present, and he decided to request an ambulance. Supportive measures continued, and the family was advised of the plan to transfer Mrs A to hospital.

[16] Within normal range.

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67. RN D recorded retrospectively that Dr G had seen Mrs A that day for her three-monthly review. However, Dr G told HDC that Mrs A's next routine check-up was not due until 6 Month11.

68. At 4.17pm, the ambulance service Care Summary records Mrs A's observations as: heart rate 120 beats per minute, respiratory rate 28 breaths per minute, blood pressure 96/73mmHg, oxygen saturation 95%, and temperature 35.8°C. The summary also notes: "Final patient status: 2 — potential threat to life."

69. Mrs A was transferred to the Emergency Department at the DHB and diagnosed with heart failure with superimposed lower respiratory tract infection. She was transferred to a private hospital for palliative care.

70. The rest home company stated that Mrs A had a number of episodes of anxiety, and that staff supported her through these. The rest home company said that it is completely satisfied with the response by its staff in relation to Mrs A's breathlessness.

Further information

RN F

71. RN F told HDC that it was her understanding from RN E that she would work from home one day a week to complete the paperwork required. She said that working from home did not eventuate, and she had to complete the paperwork after hours. RN F stated: "It was this overwhelming situation that [led] me to the decision to resign and leave the aged care sector."

RN D

72. RN D said that she gave instructions to caregivers to report any documented concerns about any residents who required a review by a registered nurse, because "there were 21 of them [and she] may not [have been] able to thoroughly assess all of them every day".

73. RN D said that if she attended a resident's fall she would conduct an assessment, document that assessment, and take observations in accordance with nursing protocols. She told HDC that on reflection it was very unsafe to work in a small rest home with inadequate staffing levels. RN D stated that she now documents all the care she provides.

The rest home company

74. On behalf of the rest home company, RN E stated: "I feel that there may have been some miscommunication, and as the owner I take part responsibility for that, but I never worked as an RN." He said that he was saddened by the standard of documentation, because a three-year audit of the rest home reported that its policies and procedures were up to date and appropriate. However, the rest home company did not provide HDC with the policies requested. RN E stated: "I may have shown some naivety in my ownership and my mistakes were maybe trusting my staff too much and not having a closer eye on the running of [the rest home]."

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75. RN E said that he is sorry that Mrs A's family felt that she was not provided with adequate care, and is sorry for their loss. In response to the provisional opinion, RN E stated that he was neither the manager of the rest home, nor did he provide clinical oversight at the rest home. RN E said that the rest home would not have received a three-year audit in 2016 if he had been in the role of either manager or clinical manager.

Policies and documentation

76. HDC requested that the rest home company supply its policies regarding:

1. Completion of nursing care plans.
2. Completion of assessments and interRAI assessments.
3. Documentation.
4. Management of falls.
5. Incident reports.
6. Management of breathlessness.
7. Assessment of a patient's condition.
8. The rest home's management responsibilities.
9. Communication with GPs and escalating care to GPs.
10. Safe transportation, storage, and access of medical records.

77. In addition, HDC requested that the rest home company provide the following information regarding Mrs A:

1. Documentation that recorded communication with family/next of kin/EPOA.
2. Incident reports relating to Mrs A's falls.
3. Copies of the family contact sheet for Mrs A.

78. Further, the rest home company was asked to provide the following information in relation to organisational issues:

1. Details of the Clinical Manager at the rest home.
2. Employment information between the rest home and RN D.
3. The names and designations of staff members.
4. Orientation documentation and records of training information relating to RN D.
5. Employment contracts and position descriptions for staff members.
6. Details of clinical supervision provided to the registered nurses.
7. Details of the registered nurse oversight and on-call arrangements overnight and at the weekends.

79. The rest home company did not provide the requested policies. RN E told HDC that at the time of the rest home's closure, the computer was "broken", and the information requested by this Office could not be retrieved. The rest home company said that it sent the original copies of the information requested to this Office, but, as stated above, the information requested was not received.

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Responses to provisional opinion

80. Ms C, the rest home company, RN E, RN D, and RN F were all given the opportunity to respond to relevant sections of the provisional opinion. Where appropriate, changes have been incorporated into the report.

81. Ms C told HDC that following admission to the rest home, Mrs A was settled, and RN E was on site. However, when RN E's circumstances changed, "he disappeared", and the care towards the residents deteriorated. Ms C said that RN E did not inform her about the change in his circumstances and the subsequent staffing changes at the rest home. Ms C stated that she tried to obtain information from RN E about the changes at the rest home, but it was difficult to do so, and she was unsuccessful.

82. RN E, on behalf of the rest home, told HDC that he does not accept all of the points made in the provisional opinion, but he did not specifically state the points disputed. RN E stated:

> "[I]t was never intended to provide inadequate care to any resident. We were very proud of achieving the audit we did at the time. I admit naivety in running a business and that I hold my hands up for."

83. RN D told HDC that while she accepts responsibility for the poor standard of documentation, she was responsible for maintaining the records for 21 residents. RN D stated that opportunities for training and education were minimal, owing to budget constraints.

84. RN F had no comment to make on the content of the provisional opinion.

Relevant standards

85. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.7 Deliver care based on best available evidence and best practice.
>
> 4.8 Keep clear and accurate records.
>
> 4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.
>
> 4.10 Practise in accordance with professional standards relating to safety and quality health care.
>
> …

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8. Maintain public trust and confidence in the nursing profession.

…

8.4 Document and report your concerns if you believe the practice environment is compromising the health and safety of health consumers.

Escalating Concerns: You have an ethical obligation to raise concerns about issues, wrongdoing or risks you may have witnessed, observed or been made aware of within the practice setting that could endanger health consumers or others. Put the interests of health consumers first."

86. The New Zealand Health and Disability Services (General) Standard (NZHDSS) 1994[17] states:

"NZS 8134.1.2.2 Organisational management

Service Management

The organisation ensures the 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."

Opinion: Rest home company — breach

Introduction

87. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), the rest home company had a duty to provide its residents with services of an appropriate standard. The NZHDSS requires organisations (including rest homes) to ensure that their services are managed in an efficient and effective manner, to ensure the provision of timely and safe services to consumers.

88. The rest home company told HDC that RN F and RN D were employed to manage the rest home and provide nursing oversight to its staff. In contrast, the registered nurses stated that the owner, RN E, was the Manager of the rest home. RN E told HDC that he did not provide clinical services to the rest home, and that during the time of these events he was working out of town. The rest home company has provided HDC with limited information, and this has not provided further clarity on this issue. However, in all the circumstances, the rest home company remained responsible for the services provided in its facility.

89. Mrs A required rest-home-level care. During her residency, she had multiple clinical events, and her overall condition deteriorated in her final months at the rest home. This case highlights the importance of aged-care residential facilities ensuring that managers

[17] The New Zealand Health and Disability Services Standards are mandatory for relevant service-based contracts with facilities that receive health funding, including hospitals, rest homes, and some providers of residential disability care.

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and clinical leaders have the skills and expertise in aged care to deliver appropriate services, lead care staff, and assess residents' health needs. In such circumstances, nursing and support staff need to be alert to a resident's changing health status. Staff must assess, think critically about, and respond appropriately to, deterioration in the resident's condition. In my view, the rest home company failed in its duty to provide an appropriate standard of care to Mrs A.

Documentation, assessment, and planning

90. On 19 Month2, Mrs A was admitted from another facility to the rest home for rest-home-level care. She had a number of health conditions, including hypertension, a meningioma, a VP shunt, and intermittent atrial fibrillation. She required some assistance with showering, dressing, and toileting.

91. Mrs A's initial care plan commenced on 21 Month2. The section regarding past medical history was not completed, because Mrs A's clinical file from her previous facility was not available. A registered nurse assessed Mrs A and obtained a copy of her interRAI assessment to guide staff in her care.

92. On 20 Month2, Mrs A was reviewed by Dr G. The GP notes relating to the consultation were recorded in the Medical Assessment/Continuation Notes, but not in Mrs A's clinical notes, which state only that she was reviewed by Dr G. It was a further seven months from admission before Mrs A's long-term care plan was completed on 24 Month9.

93. There is no evidence that an interRAI re-assessment was completed during Mrs A's residency at the rest home. RN F stated that she told RN E that she was unable to complete Mrs A's interRAI re-assessment or care plans owing to her high workload and the changes in staffing levels. The rest home company said that RN F did not raise any concerns about workload issues or completing assessments and care plans. RN D stated that in Month4, assessments had not been completed for all the residents.

94. On 27 Month4, the format of the progress notes changed, and the column for signature and designation was omitted. My expert advisor, RN Anna Blackwell, advised that this removed the cue to include designation in the progress notes. She noted that the registered nurse used a stamp, and the entries recorded are designated clearly, but all other entries are no longer assigned a designation.

95. RN Blackwell advised that there is a requirement within the Aged Residential Care Agreement with the DHB for facilities to develop care plans, informed by an interRAI assessment, within 21 days of a resident's admission. RN Blackwell stated that although the initial care plan was completed, the seven months from admission until a long-term care plan was completed falls outside professional requirements. She noted that there is no evidence that an interRAI re-assessment was completed. She advised that an interRAI reassessment is "[o]ne of the tools available to RNs to assess deterioration and trigger review and care planning to direct and delegate care to care givers". RN Blackwell considers that overall the standard of the nursing documentation is below acceptable standards, and this represents a serious departure from accepted practice.

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96. I agree. I am highly critical of the seven-month delay to complete Mrs A's long-term care plan to direct the care provided by caregivers. It is unacceptable that staff did not complete an interRAI re-assessment during Mrs A's nine months at the rest home. This was fundamental to the assessment of Mrs A's condition or deterioration, and to guide the care planning. In my view, the poor standard of documentation placed Mrs A's well-being at risk, as staff were not sufficiently aware of her current needs and the care she required. In my view, it was the rest home's responsibility to ensure that it had appropriate assessments and care planning to meet Mrs A's needs. I am critical that this did not occur.

Falls management

97. On admission, Mrs A was assessed as having a slight risk of falls. During her time at the rest home, Mrs A had three documented falls (on 26 Month2, 4 Month6, and 9 Month8). All three falls occurred during the night or early morning, when no registered nurse was on shift, and consequently Mrs A was not assessed by a registered nurse following her falls.

98. Following Mrs A's fall on 26 Month2, a caregiver telephoned RN E to ask him to review Mrs A, but he was not available. In contrast, RN E told HDC that he was not the responsible registered nurse on call for the rest home. RN F commenced her shift that day and reviewed the incident form, completed the post-falls assessments of Mrs A, updated the care plan, and commenced neurological observations. RN Blackwell was critical that no registered nurse was on duty to attend to Mrs A following her fall, but acknowledged that RN F completed the required falls documentation when she commenced her shift the following morning.

99. Following Mrs A's fall on 4 Month6, caregivers documented that she had bruising and complained of a headache, for which pain relief was administered. It was a further four days until a registered nurse reviewed Mrs A and recorded in the clinical notes. However, the nurse's review did not acknowledge the ongoing issues that had been documented by the caregivers following Mrs A's fall. Despite the clinical notes stating that Mrs A had ongoing issues following the fall, no observations were recorded and no medical review was requested, and the clinical notes indicate a period of 20 days between reviews by a registered nurse.

100. Following Mrs A's fall on 9 Month8, a caregiver telephoned RN E to attend. However, there is no evidence that RN E provided any advice, or attended the rest home to review Mrs A following this fall. From 9 to 10 Month8, caregivers recorded that Mrs A had ongoing headaches following the fall. A routine GP review was recorded on 12 Month8, and the GP noted that Mrs A had had "a couple of recent headaches". RN Blackwell noted that following the fall on 9 Month8, there is no evidence that either an incident report was completed or the family contacted, or that a short-term care plan was commenced or Mrs A's falls risk assessment updated.

101. Following the falls on 4 Month6 and 9 Month8, there is no evidence of an assessment for pain or musculoskeletal function, no recording of vital signs, and no recording of a neurological assessment. RN Blackwell advised that staff should have completed an incident form and a physical and neurological assessment, taken observations,

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commenced a short-term care plan, updated Mrs A's falls risk assessment, and contacted Mrs A's family. A long-term care plan was not completed until 24 Month9, and there is no evidence of a short-term care plan to guide carers in their care of Mrs A following a fall.

102. RN Blackwell considers that overall the management of Mrs A's falls represents a severe departure from the required standards of care.

103. I agree. Following each fall, Mrs A required a review by a registered nurse, yet no registered nurse was available to attend on call. I am highly critical of the rest home company that no registered nurse was available to attend to Mrs A following these falls — this placed Mrs A's safety and well-being at risk. The assessment and monitoring of Mrs A's condition on 4 Month6 and 9 Month8 was inadequate. Caregivers recorded Mrs A's ongoing issues following her falls, but this information was not interpreted or acted on by a registered nurse. I consider that this shows a lack of oversight of Mrs A by a registered nurse, a lack of critical thinking by staff, and poor compliance with the assessment and documentation requirements for falls.

Deterioration

104. Mrs A's long-term care plan, completed on 24 Month9, stated that Mrs A had a tendency to be anxious. Between 25 Month9 and 3 Month10, caregivers recorded that Mrs A had breathlessness, and it was noted that she was giddy, nauseous, and anxious. In contrast, a review by a registered nurse on 27 Month9 noted "no new concerns".

105. Between 14 and 20 Month10, caregivers documented daily that Mrs A was dizzy, confused, and tired. On 15 Month10, Mrs A's observations showed continuing hypertension and an elevated pulse rate of 93 beats per minute, but it was a further five days until she was reviewed by a registered nurse. When Mrs A was reviewed by a registered nurse on 20 Month10, the clinical notes did not reflect the concerns about Mrs A's health condition recorded during the previous days. On 25 Month10, caregivers observed that Mrs A was nauseous, giddy, and anxious, but no registered nurse was on duty that day. RN D said that when she was not on duty, caregivers reported any concerns to RN E.

106. Between 29 Month10 and 3 Month11, the records describe Mrs A as being unwell, having a decreased appetite, sweating, coughing, becoming breathless and agitated, having swollen feet (ankle oedema), and requesting to see a doctor. RN D reviewed Mrs A on 30 Month10, but there is no further record by a registered nurse until 3 Month11. RN D reviewed Mrs A again on 3 Month11, and noted that her condition had deteriorated from when she had seen her four days earlier. RN D arranged for a GP review, and Mrs A was seen on 3 Month11. The GP transferred Mrs A to hospital with suspected heart failure, pneumonia, and atrial fibrillation.

107. The rest home company stated that Mrs A had a number of episodes of anxiety, and that staff supported her through these. The rest home company said that it is completely satisfied with the response by its staff in relation to Mrs A's breathlessness.

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108. RN Blackwell advised that from 25 Month9, it is apparent that Mrs A was showing signs of heart failure or pneumonia. However, there is no evidence that a medical review was requested at this time. There is also no evidence that a short-term care plan was produced, or that Mrs A's family were informed of the changes in her condition. RN Blackwell stated: "Heart failure and respiratory illness in the elderly is not rare. Mrs A ha[d] signs and symptoms of both conditions." RN Blackwell advised that the expected management for breathlessness was not followed, and this delayed the detection of Mrs A's condition. RN Blackwell considers that this represents a severe departure from expected practice.

109. RN Blackwell advised that when a resident's condition changes, it would be normal and expected practice to seek a GP review, particularly when the change is significant. Mrs A changed from being independent and comfortable, to requiring increased input from care staff and experiencing breathlessness, dizziness, nausea, ankle oedema, and sustained elevated blood pressure. RN Blackwell considers that the rest home's response to Mrs A's deteriorating condition was a severe departure from professional and industry expectations, and did not meet the duty of care required of the facility or the registered nurse.

110. I accept this advice. It is highly concerning that although staff recorded ongoing concerns in the clinical notes from 25 Month9, they were not alert to Mrs A's actual condition. There was no adequate assessment by a registered nurse or timely referral to a GP. In my view, this shows a lack of critical thinking and an inappropriate delay in referral to specialist care. Further intervention was warranted over this time. In Month10, staff failed to recognise and respond to Mrs A's acute deterioration, despite multiple entries in the clinical record by caregivers. In my view, this demonstrates an environment where there was a lack of oversight of the clinical notes, a lack of critical thinking, and inadequate assessment and action in response to Mrs A's deteriorating condition.

Poor systems for oversight of clinical care

Nursing oversight

111. RN F was employed Monday to Friday from 7.00am to 3.30pm until her resignation in Month4. RN F was replaced by RN D, who was employed Monday to Thursday from 7.00am to 3.30pm, and to work from home on Fridays. Following RN D's appointment, a registered nurse was on site only 32 hours per week. RN D told HDC that the handover was poor, and she did not know what happened at the rest home over the weekends.

On-call registered nurse

112. The Age Related Residential Care (ARRC) Services agreement[18] between a facility and a DHB provides that a facility with up to 30 residents is required to have one care staff member on duty and one care staff member on call at all times.

[18] https://tas.health.nz/assets/Health-of-Older-People/Age-Related-Residential-Care-Services-Agreement-2019-2.pdf

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113. RN F and RN D told HDC that they did not hold an on-call role at the rest home. RN F told HDC that RN E was the registered nurse on duty and on call when her shift ended and on weekends. She told HDC that on 26 Month2, a caregiver advised her that RN E had been telephoned to review Mrs A following a fall, but he was unable to be contacted. On 9 Month8, a caregiver recorded that Mrs A had had a fall and that RN E had been telephoned. There is no documentation of any discussion between RN E and the caregiver. RN E told HDC that he did not provide on-call care at the rest home and that this was outside of his scope of practice as a registered nurse. The rest home company stated that RN F and then RN D had on-call duties as part of their responsibilities as the registered nurse at the rest home, but no information was provided to clarify this issue.

114. I note the conflicting evidence on this issue. I also note that on two occasions a caregiver telephoned RN E for advice when no registered nurse was on duty. There is no evidence that caregivers telephoned either RN F or RN D for on-call advice. While I note the paucity of information from the rest home company to clarify this issue, on the evidence available to me I am not able to make a finding on whether RN E was the responsible nurse on duty to provide on-call care to the rest home. Nonetheless, it raises sufficient concern that on two occasions RN E may have been responsible for providing on-call care and did not attend to Mrs A. In all the circumstances, I am highly critical that the rest home company failed to provide adequate arrangements or suitably qualified staff to provide appropriate on-call care and meet its contractual obligations in the ARRC.

Clinical Manager

115. The rest home company told HDC that RN F and then RN D were responsible for managing and providing oversight at the rest home. However, the rest home company did not provide any of the information requested to substantiate this. I note that in Month1 a HealthCERT Aged Residential Care Audit Report states that RN E is a registered nurse and the owner and operator of the rest home company, and that another registered nurse supports the Manager. RN F stated that in Month2, the Clinical Nurse Manager resigned and was never replaced. RN F and RN D stated that RN E was the Manager of the rest home. In contrast, RN E told HDC that he supported staff on a practical level regarding staffing issues or day-to-day business, but he did not act as a registered nurse on duty. He stated that he is not qualified to work in the aged-care sector, and was not employed by the rest home company.

116. I note the conflicting evidence regarding the responsible Clinical Manager and/or Manager at the rest home. On the evidence available to me, I accept RN F's and RN D's account that they were not employed as the Clinical Manager at the rest home. Accordingly, I find that there was no designated Clinical Manager at the rest home between Month2 and Month11.

117. RN Blackwell stated:

> "From the documents I have reviewed it would appear there was no RN available for clinical events, oversight or on call from 1530 to 0700 the next day and across the weekends. Once [RN D] was employed she states she was on site four days per week

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(32 hours). This is completely unsatisfactory for residents and for staff safety. Caregivers require a practice environment with supervision and delegation of tasks. With the RN on site 32 hours a week and the owner/clinical manager unavailable, meaningful supervision is not possible.

This is an extreme breach of industry practice standards for a facility owner and an RN. Also, a breach of the Age-Related Residential Care (ARRC) Services agreement contracted between the facility and the District Health Board."

118. RN Blackwell advised that the ARRC Services agreement in respect of management was not met. She stated:

"ARRC Manager

i. Every Rest home must engage a Manager who holds a current qualification, or has experience, relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home; and

ii. The role of the Manager includes, but is not limited to, ensuring the Residents of the Home are adequately cared for in respect of their everyday needs, and that services provided to Residents are consistent with obligations under legislation and the terms of this Agreement."

119. I agree. It was not sufficient for the rest home company to operate a facility with a registered nurse on site for only 32 hours per week without adequate on-call arrangements. It was the rest home company's responsibility to ensure that its residents had adequate oversight by a registered nurse, and appropriate delegation to its caregivers. I am critical that this did not occur. I am also highly critical that it is unclear from the information available to me who held the responsibility of Clinical Manager at the rest home. It was unacceptable for the rest home company to operate a facility without a clearly designated Clinical Manager. While it is apparent that staff considered that RN E was the Manager and was able to provide nursing care at the rest home, he was in fact not able to do so as it was outside his scope of practice. In my view, this contributed to the lack of clarity about the leadership and management of the rest home. Overall, this demonstrates an environment that did not provide adequate leadership, supervision, delegation, and support to its staff, and compromised the safety of both its residents and its staff. I consider that the rest home company was responsible for this.

Conclusions

120. I am very concerned that aspects of the care provided by the rest home company were suboptimal. In particular:

- Documentation was inadequate, there was a delay in completing care plans, and no interRAI re-assessment was completed.
- Staff failed to manage Mrs A's falls adequately. Her condition immediately following the falls was not assessed by a registered nurse or monitored appropriately, documentation

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of her falls was not completed adequately, and short-term care plans were not completed.

- From Month4 onwards, a registered nurse was employed to be on site for only 32 hours per week, which was insufficient for appropriate supervision and guidance of its caregivers.
- There is no evidence that the rest home had adequate on-call arrangements, and when a review by an on-call registered nurse was requested, there is no evidence that a registered nurse attended to Mrs A.
- On 25 Month9, staff were alerted to Mrs A's change in condition, but she was not reviewed by a registered nurse, and her breathlessness was not escalated to a GP.
- When staff were alerted to Mrs A's deteriorating condition in Month10 and early Month11, an appropriate assessment was not performed, and her care was not escalated to a GP until 3 Month11.
- The rest home company did not have appropriate clinical leadership over its staff and residents.

121. As a consequence of these failures, the care provided to Mrs A was not managed appropriately, and she did not receive the specialist care she required in a timely manner. For these reasons, I find that the rest home company failed to provide Mrs A with services of an appropriate standard, and breached Right 4(1) of the Code.[19] These failures meant that the rest home company did not comply with the NZHDSS and, consequently, that the rest home company also breached Right 4(2) of the Code.[20]

Information requested — adverse comment

122. The rest home company was asked to supply HDC with relevant policies and documentation. It provided the clinical notes and health records for Mrs A. However, it did not supply HDC with the relevant policies and employment information requested, and said that the relevant information had been stored on a computer that had "broken", and the information could not be retrieved. The rest home company then stated that it sent the original documentation to HDC. However, the requested information was not received by this Office.

123. In my view, this response is unsatisfactory. It was the responsibility of the rest home company to retain copies of the relevant records, and I am highly critical that the rest home company did not provide HDC with the required information that was relevant to Mrs A's care. Accordingly, this report has been based on an incomplete suite of information.

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

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Opinion: RN D — breach

Introduction

124. In Month4, RN D was employed by the rest home company as a shift registered nurse. RN D was employed Monday to Thursday from 7.00am to 3.30pm, and on Fridays she worked from home. She was on site only 32 hours per week. RN D had no on-call duties at the rest home, and asserts that she was not the Clinical Manager of the facility.

125. RN D told HDC that her responsibilities as a registered nurse included handovers, medication rounds, assisting the caregivers with cares, ordering medication and dressings, arranging informal and formal education for caregivers, ensuring that assessments and care plans were completed, assisting with planning activities for the residents, ensuring that staff medication competencies were up to date, and co-ordinating hospital appointments with family and staff.

126. Mrs A was admitted to the rest home on 19 Month2. This section of the opinion considers the care RN D provided to Mrs A from Month4 until her admission to the public hospital on 3 Month11.

Clinical documentation

127. RN D completed Mrs A's long-term care plan in Month9. Under the heading "mental ability", the care plan recorded that Mrs A tended to be confused. In contrast, under the heading "orientation", the care plan states "good". RN D acknowledged that her documentation of the care provided to Mrs A was not adequate.

128. RN Blackwell noted the length of time from RN D's appointment (Month4) to the long-term care plan being completed in Month9, and advised that aspects of the care plan around Mrs A's mental ability were poor and contradictory. RN Blackwell observed that there were no ongoing assessments using the interRAI tool to trigger issues for the care plan. She stated:

> "Nursing care plans are designed to map out the care being provided to residents and clearly document what needs to be reported on and acted on. In Resthome only facilities where care givers provide the care RNs and owners need to ensure the care givers are supported and have clear guidelines and plans to follow the delegated tasks they are delivering. I do not see this evidenced in this file."

129. RN Blackwell considers that this represents a serious departure from registered nursing practice and industry requirements.

130. I accept RN Blackwell's advice. It was RN D's responsibility to complete the long-term care plans and assessments, and to ensure that the documentation was adequate. I am highly critical of the lack of timeliness. In my view, the failure to complete the care plans and assessments to guide staff in their care of Mrs A placed her well-being at risk.

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Diagnosis of anxiety

131. On 24 Month9, under the "problem" heading of "Mental Ability/Awareness and confusion including anxiety and depression" in the long-term care plan, RN D recorded that Mrs A tended to be confused and anxious in relation to constipation, visual hallucination, lack of sleep, and not being able to see or speak with family. However, there is no reference to anxiety in either Mrs A's interRAI assessment from another facility, her notes on admission to the rest home, or the GP's clinical notes.

132. RN Blackwell advised that without extra education and competency verification by the Nursing Council of New Zealand, registered nurses are not qualified to diagnose. There is no evidence that Mrs A had a formal diagnosis of anxiety or an anxiety disorder. RN Blackwell noted that Mrs A showed signs of becoming anxious in relation to becoming unwell.

133. I agree. It is highly concerning that RN D diagnosed Mrs A with anxiety and failed to recognise that this was in relation to her deteriorating condition. In my view, this shows a lack of critical thinking by RN D, which placed Mrs A's well-being at risk.

Nursing oversight

134. Mrs A sustained a fall on 4 Month6 and 9 Month8. Over the days following these falls, caregivers recorded that Mrs A had ongoing issues. However, there is no evidence that RN D was alert to Mrs A's ongoing issues or that she acted on the information relating to these falls.

135. From 25 Month9, caregivers recorded that Mrs A was having periods of confusion, visual hallucinations, increased lethargy, difficulty sleeping, and was coughing at night. On 27 Month9, RN D reviewed Mrs A and noted no new concerns.

136. Between 14 and 20 Month10, caregivers documented daily that Mrs A was dizzy, confused, and tired. There is no record that Mrs A received a review by a registered nurse until 20 Month10, and RN D's review did not reflect the concerns from the preceding days. From 25 Month10, caregivers recorded that Mrs A reported that she was feeling nauseous and giddy, and staff observed that she was anxious. RN D reviewed Mrs A on 28 Month10 and took her observations, and noted that she was feeling unwell.

137. Between 29 Month10 and 3 Month11, caregivers recorded daily significant changes and deterioration in Mrs A's condition, and that she had become breathless, giddy, and nauseated, and had ankle oedema and sustained elevated blood pressure. However, there is no evidence that RN D sought a GP review in relation to any of these issues. On 31 Month10, a caregiver recorded that RN D was informed of Mrs A's condition, but there is no evidence that RN D reviewed Mrs A in response to the caregiver's concerns.

138. RN D was not on shift at the rest home for many of Mrs A's clinical events. RN D said that the communication and handovers were inadequate, and often it would be days after a clinical event before she was informed of the event.

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139. RN Blackwell stated:

> "RNs in aged care are required to [interpret] caregiver notes, recognise resident changes and perform objective assessments. These assessments lead to the appropriate, timely referral to the other health professionals, usually the GP or NP (Nurse Practitioner) or after hours emergency care. They also provide learning to the carers so they learn to interpret what they are seeing and hearing to improve the care they are able to deliver."

140. RN Blackwell advised that the documentation does not show that RN D acted on the information provided by the caregivers in the notes. RN Blackwell stated that "[p]rogress notes are the formal communication tool between health professionals and provide the platform for quality care". She advised that had RN D read the progress notes, she would have been alert to the concerns raised, and would have assessed them.

141. RN Blackwell advised that RN D "does not demonstrate insight into her role as an RN to document or report to the Facility Owner or take further action when care is compromised (escalate concerns)" in accordance with the Code of Conduct for Nurses.

142. I agree. It is highly concerning that RN D failed to assess the information in the clinical notes adequately, and subsequently was not alert to Mrs A's actual condition. It was RN D's responsibility to interpret the caregiver notes, ensure that any previous care issues were addressed, and seek specialist intervention if warranted. A GP review was warranted over this time, and I am very critical that this did not occur. I am highly critical of RN D's nursing oversight of Mrs A, and consider that the apparent failure to review the clinical records compromised Mrs A's safety and well-being.

Conclusion

143. As a registered nurse, it was RN D's responsibility to ensure that she monitored the clinical notes and responded to any concerns raised. This was a key function of RN D's position as the registered nurse responsible for developing care plans and delegating tasks to caregivers. RN D did not respond adequately to the caregivers' notes, which stated that Mrs A's condition was deteriorating, and appears to have been unaware that Mrs A had become acutely unwell. RN D's oversight of the clinical documentation was inadequate, and she failed to complete the care plans and assessments in a timely way. In my view, this placed Mrs A's well-being at risk and contributed to the delayed response to her deteriorating condition. Mrs A did not receive the standard of care to which she was entitled. RN D failed to provide services to Mrs A with reasonable care and skill in relation to clinical documentation, care planning, assessment, monitoring, and timely escalation to a GP. Accordingly, I find that RN D breached Right 4(1) of the Code.

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Opinion: RN E — adverse comment

Management of the rest home

144. RN E is the sole director of the rest home company. He has acknowledged that he was the owner of the facility and that he provided support in relation to staffing issues, but he maintains that he was not the Manager of the rest home company. In contrast, the registered nurses employed by the rest home company assert that RN E was the Manager, and this is also indicated in the rest home company's audit in 2016. RN E provided some oversight of staff at the rest home and, as the owner/operator, I consider it was highly likely that he was the Manager.

145. RN E told HDC that during the time of events he took up a role in another town and was absent from the rest home. My expert, RN Blackwell, advised me that with a registered nurse on site for only 32 hours per week and the owner unavailable, meaningful supervision was not possible.

146. I agree. I am highly critical that RN E was absent during these events and was therefore not available as a Manager to provide appropriate oversight of the staff and residents at the rest home. I note that the systems at the rest home in relation to the supervision of staff, support to staff, on-call arrangements, and clinical leadership were inadequate. I consider that as the Manager, RN E must bear some responsibility for these deficiencies. It was RN E's responsibility to ensure that the residents were cared for adequately, and that staff were supported adequately. I am highly critical of RN E that this did not occur.

147. I note RN E's lack of engagement with this Office during the course of my investigation. In my view, RN E's lack of response and co-operation with this Office is unprofessional, and is concerning. I am critical of RN E in this regard.

Clinical care

148. While I have found that it was highly likely that RN E was the Manager of the rest home, on the evidence available to me, I am unable to make a finding that he was more likely than not to have provided clinical care to residents of the rest home.

149. At handover on 26 Month2, a caregiver told RN F that she had telephoned RN E to attend a fall, but was unable to contact him. Mrs A had a fall on 9 Month8, and a caregiver telephoned RN E, but there is no documentation of any advice given by RN E, or that he reviewed Mrs A personally.

150. RN F and RN D told HDC that RN E was the on-call registered nurse when their shifts ended, and was on call on the weekend. I also note that on two occasions caregivers telephoned RN E for on-call advice. This indicates to me that staff at the rest home considered that RN E could provide clinical advice on the care of residents. However, I also note that RN E refutes that he was the responsible on-call registered nurse for the rest home, and there is no evidence in the clinical notes that he gave clinical advice. I am not able to make a finding on whether RN E provided on-call care to residents. Nonetheless, I am very concerned that it was widely understood by staff that RN E was available to

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provide clinical advice, and that, in relation to Mrs A, there was at least one occasion on which RN E was contacted to provide clinical care, which was outside the scope of his practice as a registered nurse.

Information requested — adverse comment

151. The rest home company was asked to supply HDC with relevant policies and documentation. The Director of the rest home company provided the clinical notes and health records for Mrs A. However, he did not supply HDC with the relevant policies and employment information requested, and said that the relevant information had been stored on a computer that had "broken", and the information could not be retrieved. RN E then stated that he sent the original documentation to HDC. However, the requested information was not received by this Office.

152. In my view, this response is unsatisfactory. As the Director of the rest home company it was RN E's responsibility to retain copies of the relevant records, and I am highly critical that he did not provide HDC with the required information that was relevant to Mrs A's care.

Opinion: RN F — adverse comment

153. RN F was the registered nurse responsible for Mrs A between Month2 and Month4. She noted that no interRAI assessment was provided by Mrs A's previous facility upon her admission to the rest home, and a copy of the assessment was obtained to guide the staff in their care. For two months, Mrs A had no long-term care plan or updated interRAI assessment. RN F acknowledged that Mrs A's interRAI re-assessment was not updated, and cited increased workload issues and decreased staffing levels as contributing factors. She said that she escalated her concerns to RN E; however, RN E disputes this point.

154. RN Blackwell advised that RN F's workload was unacceptable, and said that if a registered nurse is falling behind, expected practice would be for the Manager to assist the nurse to meet contractual requirements. RN Blackwell said that RN F did what she could to meet Mrs A's needs, and showed insight and concern into her practice situation. RN Blackwell advised that although the accepted standard of practice was not met, this is ameliorated by the circumstances.

155. I agree. While I am critical that RN F did not complete Mrs A's care plan and assessments in a timely manner, I acknowledge that it is unclear who held the responsibility of Manager or Clinical Manager at the rest home. In my view, the lack of clarity on these issues points towards an environment that did not support its staff sufficiently to do what was required of them. Taking into account all the above factors, I consider that there were systemic issues that contributed to RN F's delays in completion of care plans and assessments, for which the rest home company is responsible.

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Recommendations

156. Acknowledging that the rest home is now closed, there are no relevant recommendations I can make relating to its service provision. In the provisional opinion, I recommended that the rest home company and RN E provide a written apology to the family of Mrs A. RN E has now provided this apology, which has been forwarded to Mrs A's family.

157. In my provisional opinion, I recommended that RN D provide a written apology to the family of Mrs A. RN D has now provided an apology, which has been forwarded to Mrs A's family.

158. I recommend that RN D provide evidence of training she has undertaken since these events on the following topics: documentation, care planning, assessment of acute deterioration, interpretation of caregiver findings, supervision of caregivers, delegation to caregivers, and reflective practice. If this has not occurred already, RN D is to undertake training on these topics within three months of the date of this report.

159. I recommend that the Nursing Council of New Zealand conduct a review of RN D's competence, and give consideration to a period of supervised practice.

160. I recommend that the Nursing Council of New Zealand give consideration to a review of RN E's competence and conduct.

Follow-up actions

161. The rest home company will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

162. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, which has been advised of RN D's and RN E's names.

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

Addendum

164. The Director of Proceedings decided not to issue proceedings.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Anna Blackwell:

"**1 Disclaimer**

I, Anna Celeste Blackwell, have been asked to provide an opinion to the Commissioner on case number C17HDC00655. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

2 Expert's Background

I have been a New Zealand Registered Nurse for twenty-eight years with a background in clinical and nursing management. I have a postgraduate diploma in nursing. I have attended education in quality, leadership and professional supervision. I have been a Career Force assessor for caregivers and diversional therapists. I have a strong background in nursing leadership having worked in Charge Nurse, Duty Nurse Manager, Facility Manager/GM and associate DON positions. I worked in the aged care sector for eight years managing facility, clinical, quality, HR and compliance. Currently I do consultancy and contract work in the health sector providing facilitation, training, leadership, advice, coaching and project management. I am a member of the College of Nurses Aotearoa, the New Zealand Nurses Organisation, the NZ Aged Care Association and the Neuroleadership Institute.

3 Instructions from the Commissioner:

I have been asked to review the documentation sent to me and advise whether I consider the care provided to [Mrs A] at [the rest home] was reasonable in the circumstances, and why.

In particular the Commissioner has asked me to comment on:

3.1 The diagnosis of anxiety.

3.2 Management of [Mrs A's] breathlessness.

3.3 Whether differential diagnoses should have been considered, or advice sought from other health practitioners.

3.4 Any other matters in this case that you consider warrant comment.

For each question, I will consider:

- What is the standard of care/accepted practice?
- If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (i.e. mild, moderate or severe)?
- How would it be viewed by my peers?
- Recommendations for improvement that may help to prevent a similar occurrence in future.

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- If noted there are different versions of events in the information provided, I will advise in the alternative. For example, whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

4 Sources of Information

Supplied by the HDC office:

Letter of complaint dated […].

Further correspondence with [Mrs A's] family, dated 20 [Month11] and 4 [Month12].

[The rest home's response.]

Clinical records from [the rest home].

Clinical records from [the medical centre].

Comments and clinical records from [the DHB].

Comments and clinical records from [a private hospital].

5 Factual Summary

[Mrs A] ([in her nineties]) was admitted to [the rest home] … on the 19th [Month2] as [the facility] where she resided in [another town] closed. [Mrs A] resided at [the rest home] until 3rd [Month11] when she was admitted acutely to [the public hospital] with increasing shortness of breath and found to have heart failure and a lower respiratory tract infection. She was discharged from [the public hospital] on the 11th [Month11] to [the private hospital] with a last days of life care plan in place. [Mrs A] died at [the private hospital] on the 14th [Month11].

On admission to [the rest home] [Mrs A] was assessed as requiring resthome level care and had a past medical history which included:

- Hypertension
- Meningioma plus VP shunt — 12 yrs
- Essential Tremor
- [Amputation] due to locally aggressive SCC (squamous cell carcinoma)

6 Complaint

[Mrs A's] daughters, [Ms B and Ms C], have raised concerns about the care she received at [the rest home]. [Mrs A] was suffering from periods of breathlessness through [Month10]. [Ms B and Ms C] were informed that [Mrs A's] observations were fine, and she had anxiety. On 3 [Month11] [Mrs A] was admitted to hospital, where she was diagnosed with congestive heart failure, sepsis from a lung infection and fluid on the lungs.

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7 Expert Review

7.1 The diagnosis of anxiety.

There is no past medical history of anxiety referenced in the interRai documents provided by [the rest home] from [her previous facility]. [Mrs A's] initial care plan written 19 [Month2] has no management plan for anxiety or any record of a previous history of anxiety. The initial nursing entry on the 19 [Month2] by the admitting RN records '[Mrs A] is very coherent ...' There is no anxiety or anxious behaviour recorded during admission to [the rest home] from [her previous facility].

Under the 'Problem' heading: *Mental Ability/Awareness and confusion including anxiety and depression*[1] it is documented that [Mrs A]:

- tends to be confused
- tends to be anxious related to constipation, visual hallucination, lack of sleep and not able to see or speak with family

There is no formal diagnosis of anxiety documented in [Mrs A's] notes from [Dr G], [Mrs A's] GP or in the [public hospital] documentation. [Mrs A] showed signs of being anxious in relation to her becoming unwell. Without extra education and competency verification by NZ Nursing Council, Registered Nurses cannot diagnose. There is no evidence provided that [Mrs A] had a formal diagnosis of anxiety or an anxiety disorder.

> '*Anxiety is a normal human emotion and most of us experience some degree of anxiety due to a stressful event or misfortune. However, some people find themselves worrying or feeling anxious so often, that it interferes with their day to day life and is formally recognised as one of the anxiety disorders*.'[2]

The care giver progress notes record [Mrs A] as being anxious on the 25 [Month10]. This is recorded in relation to being short of breath, unwell and dizzy.

The diagnosis of anxiety is more likely to be the result of [Mrs A's] condition not the cause of her being unwell. The care giving staff were recording in the notes many symptoms known to be related to respiratory infection and heart failure (see appendix one). The significance of these cues was not interpreted or acted on by the RN. This is not acceptable practice for a registered nurse and is a severe departure from the standard required by Nursing Council.[3]

I would recommend [the rest home] undertakes relevant education around objective and subjective assessments in conjunction with resident rights education for the care givers and RNs. Care givers carry out resident cares under the auspices of delegation

[1] Care Plan written by [RN D] 24 [Month9].
[2] https://www.healthnavigator.org.nz/health-a-z/a/anxiety/
[3] Nursing Council of New Zealand (NCNZ), Code of Conduct (Wellington: NCNZ, 2012).

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and supervision. RNs and caregivers could benefit from education and practising the roles and responsibilities of supervision and delegation[4].

7.2 Management of [Mrs A's] breathlessness.

[Mrs A's] breathlessness was first documented by a CG on 25 [Month10]. This symptom is noted along with being anxious, giddy and nauseous. From the 25 [Month9] [Mrs A] is noted to be having periods of confusion, visual hallucinations, increased lethargy, difficulty sleeping at night and coughing. These are known signs of heart failure[5] or pneumonia[6]. Sometimes confusion is the only sign the elderly show when going into heart failure.

There is no medical review requested to assist in managing these issues. There is no short-term care plan created by the RN to guide the CG's care. There is no evidence the family is contacted by the RN to advise in the change of condition.

Heart failure and respiratory illness in the elderly is not rare. [Mrs A] had signs and symptoms of both of these conditions. There are easily accessible care guides[7] available in the aged care sector to inform care. Expected and standard management for breathlessness was not followed which delayed [Mrs A's] condition from being detected earlier. This is a severe departure from expected practice.

7.3 Whether differential diagnoses should have been considered, or advice sought from other health practitioners.

Resthome level care requires a RN presence to set the care, support and lead the care staff and assess residents' health needs. [Mrs A's] progress notes are predominantly written by the care givers and every shift from admission outline her general state of being eg. happy, settled, tired, unwell, upset. These notes record events such as falls, dizzy episodes, headaches, bruising. It is not uncommon that care givers write these notes colloquially and with a subjective tone. Caregivers are not educationally prepared to interpret what they are observing. Their role is to report findings to the Registered Nurse.

RNs in aged care are required to [interpret] caregiver notes, recognise resident changes and perform objective assessments. These assessments lead to the appropriate, timely referral to other health professionals, usually the GP or NP (Nurse Practitioner) or after hours emergency care. They also provide learning to the carers so they learn to interpret what they are seeing and hearing to improve the care they are able to deliver.

[4] http://www.nursingcouncil.org.nz/content/download/447/1922/file/nursedelegationRN.pdf
[5] https://www.healthnavigator.org.nz/health-a-z/h/heart-failure/
[6] https://www.healthnavigator.org.nz/health-a-z/p/pneumonia/
[7] http://www.waitematadhb.govt.nz/health-professionals/aged-care/registered-nurse-care-guides-for-residential-aged-care/

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The documentation does not evidence [RN D] acting on the information provided by the care givers in the notes. There are several differential diagnoses to be explored with symptoms such as [Mrs A's] which include raised intracranial pressure, respiratory disease, cardiac disease, anxiety, depression.

Please refer to appendix one for the timeline of events during [Mrs A's] residence at [the rest home]. It would be normal and acceptable practice to seek GP review when a resident's condition changes, particularly when that change is significant. [Mrs A] went from being independent and comfortable to requiring increased input from care staff becoming breathless, dizzy, nauseated, with ankle oedema and a sustained elevated BP.

The RN did not follow up with the GP regarding the neurology opinion that was requested on the 23 [Month9]. The GP expressed concern the VP shunt may be blocked causing increased intracranial pressure. There was no plan put in place by the RN for care givers to know the signs of increased intracranial pressure. There was no follow up of this by either the GP or the RN. If no further investigations were to be carried out it would be expected guidance around pain management and comfort would be recorded.

I find the responsiveness by [the rest home] to [Mrs A's] deterioration and seeking alternative explanations for her condition to be a severe departure from professional and industry expectations and does not meet the duty of care required of the facility or the Registered Nurse[8].

7.4 Any other matters in this case that you consider warrant comment.

7.4.1 *Documentation*

The clinical records reviewed from [the rest home] included progress notes, initial care plan, long term care plan, initial and ongoing assessment documents, medication and administration charts, medical consults. Not supplied for review were the incident forms for [Mrs A's] three falls[9] or the family contact sheet which is referenced in the progress notes.

[Mrs A's] initial care plan is commenced on admission and completed on the 21 [Month2]. The initial care plan does not state any relevant past history. The admission notes have no past medical history recorded. The clinical file has no referral or handover from [her previous facility]. The progress notes document [Mrs A] attended a GP appointment with her family on the 20 [Month2]. This consultation is not recorded in [medical centre] documents or the [rest home] clinical record. Having the past medical history informs health professionals' practice and provides relevant information for planning and delegating care. Recording GP consultations in the clinical file is a requirement of the Aged Residential Care Agreement with the District Health Board (DHB).

[8] Nursing Council of New Zealand (NCNZ), Code of Conduct (Wellington: NCNZ, 2012).

[9] See time line — appendix one

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There is a requirement within the Aged Residential Care Agreement with [the DHB] for Facilities to have care plans '... *developed, documented, and evaluated by a Registered Nurse, and informed by interRAI, within 21 days of the Resident's admission*;'[10] The initial care plan was completed as per contractual requirements. The long-term care plan was completed on the 24 [Month9]; this is noted to be seven months from admission and falls well outside contractual and professional requirements. There is no interRai reassessment completed during [Mrs A's] residency at [the rest home]. This is one of the tools available to RNs to assess deterioration and trigger review and care planning to direct and delegate care to care givers. The interRai assessment and re-assessment is a contractual requirement of [the DHB].

On the 27 [Month4], the format of the progress notes document changed, and omitted the column for signature and designation. That removed the cue to include designation in the progress notes. The RN uses a stamp, making this entry legible and designation clear. All other entries are no longer assigned a designation.

I have found the overall standard and contractual requirements of the Nursing documentation to be lacking professional requirements, below acceptable standards[11] and to be a serious departure from accepted practice.

The [rest home's] care planning documents would benefit from having an area added for past medical history. The progress notes would benefit from having a signature and designation column added. Education regarding professional language use in legal records would help the staff raise the standard of the documentation and decrease the level of subjective recordings.

7.4.2 *Falls Management*

[Mrs A] has three falls documented via the progress notes.

1. 26 [Month2] — early am on night shift

Noted to have '... slipped onto floor while going to commode ...' This fall was documented in the progress notes, family contacted on the am shift. Observations (BP, P, T, R and SaO2) recorded on the am shift. There are no observations recorded on admission so no baseline to compare to. The progress notes record an incident report completed, there are no incident forms provided in the clinical file for HDC review). There were no obvious injuries noted, but the night CG has documented '... possible bruising on bottom in morning ...'. It appears from the RN progress note on the morning shift of 26 [Month2] that this fall was unwitnessed.

[10] https://centraltas.co.nz/assets/Health-of-Older-People/Age-Related-Residential-Care-Services-Agreement-2017.pdf

[11] Nursing Council of New Zealand (NCNZ), Code of Conduct (Wellington: NCNZ, 2012).

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2. 4 [Month6] — 0545hrs

[Mrs A] was found on the floor outside her bedroom after [a fellow resident] called for help. She was assisted back to bed by care givers. [Mrs A] stated '... she is alright no pain, just hit her head against the wall …' The care giver (name not legible) records there is a 'bump' on the right side of her head. The care giver records '… so please keep an eye on her for other signs.'

There is no record of the RN being notified, an incident report being completed. There are no observations taken, no neuro obs obtained. There is no documentation indicating the family were notified.

There is no follow up recorded by the RN on the following shift.

The care giver notes following this fall record ongoing issues from the fall:

- 4 [Month6] — 1300hrs: '… says she feels a bit shakey …'
- 5 [Month6] — 0612hrs '… she said her head is still sore. But she is alright …'
- 6 [Month6] — 1400hrs '… has bruise on L thigh from recent fall.'
- 7 [Month6] — 1130 hrs 'Bruising on thigh and head …'
- 8 [Month6] — night report '… asked how she is doing. She said her head is still sore, but she is fine otherwise …'
- 8 [Month6] — 2300hrs '… [Mrs A] complained of headache and requested 2x Panadol at 2245hrs.'
- 9 [Month6] — 1400hrs '[Mrs A] said she didn't feel quite right today …'
- 9 [Month6] — 2000hrs 'Bruise on head not colour but still raised. Said she feels good just wants to rest.'
- 15 [Month6] — 0600hrs '1 codeine given @ mn for excruciating pain in right arm from fall last week. Pain 9 Settled for rest of night …'

There are two recordings during this time in the progress notes by [RN D]:

- 8 [Month6] — 1415hrs '[Mrs A] is independent with her cares, linen changed. Good appetite. Compliant with her medication. Mobilizes with her walker.'
- 28 [Month6] — 1500hrs '[Mrs A] cares assisted, showered, hair washed. Good appetite. Compliant with her medication. Mobilizes with her walker.'

There are routine monthly obs. recorded on the 15 [Month6]. Showing BP 160/60 and pulse 88.

[RN D's] notes do not reflect any information recorded by the CGs. There were no observations recorded throughout the time [Mrs A] was being reported to have ongoing complaints from the fall on the 4 [Month6]. There is no physical assessment undertaken by the RN. No medical review requested during this time. There is a 20-

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day space between RN reviews in the notes during a time when the resident is being recorded as having ongoing issues following falling.

3. 3. 9 [Month8] — PM shift

[Mrs A] was found on the floor outside the sunroom. The progress note was written at 2200hrs. The time of fall is not recorded. It is noted that her injury was '… a bump on the back of her head …' The care giver has documented that an ice pack was applied and [RN E] was rung. The care giver documented '… Monitored [Mrs A] all shifts for signs of concosion [sic] but found nothing of concern. [Mrs A] herself, keep telling me she is ok.'

The CG progress notes document ongoing headaches until 13 [Month8]. No evidence of an incident report being written, the family being contacted. No assessment by an RN, no observations recorded, no neuro obs. obtained.

On the 12 [Month8] the GP visits for the routine three monthly review. Notes a recent fall and that [Mrs A] has had a couple of night time headaches. The plan is to review the BP medication.

The management of these three falls is outside recommended best practice. Of note across the three falls:

- No physical assessment prior to moving from the floor
- No formal assessment for pain or musculoskeletal function, no vital sign recording, no neurological assessment
- No record of an incident form being completed
- No evidence the family contacted
- No care plan in place until 24 [Month9] — no short-term care plan to guide carers post falls
- Falls risk assessment not updated
- No evidence of the RN reviewing [Mrs A]

The management of [Mrs A's] falls is a severe departure from required standards of care both professionally and contractually.

7.4.3 *General Comments*

Reviewing [Mrs A's] file has raised a variety of concerns over and above what is already outlined and may constitute further enquiry. There is evidence throughout the file of accurate, objective information not being passed to the doctor. [Mrs A's] file documents ongoing headaches from 4 [Month6] requiring regular codeine. On the 12 [Month8] the GP notes document '… has had a couple of night time headaches …'

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The quality of the Nursing care plan written seven months after admission is poor and contradictory. [RN D] documents in the care plan under mental ability that [Mrs A] 'tends to be confused'. Under the heading orientation [RN D] documents 'good orientation'. There are no ongoing assessments using the interRAi tool to trigger issues for the care plan. Nursing care plans are designed to map out the care being provided to residents and clearly document what needs to be reported and acted on. They usually are the source of information regarding past history. In Resthome only facilities where care givers provide the care RNs and owners need to ensure the care givers are supported and have clear guidelines and plans to follow the delegated tasks they are delivering. I did not see this evidenced in this file.

I am concerned by the owner [RN E's] and [RN D's] response to this complaint. Retrospection and reflection is where RNs and facilities are able to learn and develop. Their responses indicate the care [Mrs A] received was acceptable to them and there were no learnings. [RN D's] letter states she requested an urgent appointment with the GP. The progress note 3 [Month11] documents the GP came on a routine 3/12 (3 monthly) review. The observations recorded in the facility are significantly different to the observations recorded in the ambulance. The facility observations are similar to previous recordings. The ambulance and ED obs. show a picture of sepsis and a resident acutely unwell. [Mrs A] was a 'Stat 2' call to ED indicating her condition serious and potentially life threatening. Reviewing [RN D's] and [RN E's] response to this complaint raise concerns regarding the assessment of acute deterioration, interpreting care giver findings and reflective practice.

Anna Blackwell"

The following further advice was received on 25 March 2019:

"Thank you for the opportunity to provide further advice on the above complaint by reviewing the statements from [RN F], dated 22 February 2019 and [RN D], undated.

You have asked me to review and advise on two parts:

1. Can you please review the responses from [RN D] and [RN F] and advise if this in any way changes your first advice.
2. If HDC accept that [RN E] (owner-operator) was the clinical manager of [the rest home]. Can you comment on the standard of the clinical oversight between [Month2] and [Month11]?

Can you please review the responses from [RN D] and [RN F] and advise if this in any way changes your first advice?

[RN F]:

In my report dated 4 September 2017 I raised concerns around the **standard of documentation (7.4.1)** and was concerned around contractual timeframes for admission assessments and interRAl assessments not being met. [RN F's] statement

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clearly explains why she was unable to obtain this contractual requirement and that this concern had been elevated to the owner who held the role of Clinical Lead for the facility. [RN D] was made aware this was overdue during the handover when [RN F] resigned in [Month4].

[RN F] outlines how she made sure staff knew how to care for [Mrs A] despite the initial assessment not having been completed. This included accessing the current interRAI assessment from [her previous facility] and printing off for the file. The observations were obtained and recorded on the observation chart.

Under **Falls management (7.4.2)** concerns around the assessment and documentation of falls was identified. [RN F] was the am shift RN following an overnight fall on the 26 [Month2]. I did not receive all the documents she completed including the incident form, but accept these were done.

What I did not realise during my initial review and advice was that both [RN F] and [RN D] were never on call and that RN and owner [RN E] held that responsibility. [RN E] was on call overnight however the CG could not contact him. [RN F] conducted the assessment on the AM shift and has stated an incident form was completed as she saw it and processed it as part of her role with health and safety.

Having reviewed [RN F's] statement I accept she was working with an unacceptable workload and she put in place what she could to meet [Mrs A's] needs. This does not meet the standard expected but is ameliorated by the circumstances. It would be expected practice that the Clinical Manager would have assisted in meeting the contractual requirements when the RN on duty was falling behind.

[RN F] shows insight and concern regarding her practice situation. She managed this by resigning and unfortunately leaving the aged care sector.

<u>[RN D]:</u>

[RN D's] statement has clarified her role as the shift RN with no on call duties, no formal clinical management position and onsite 32 hours per week. I accept [Mrs A's] admission and first fall (26 [Month2]) occurred prior to [RN D's] appointment and has been addressed above. I do note the length of time from [RN D's] appointment (Month4) to the long term care plan being completed [Month9] this remains a serious departure from RN practice and industry requirements despite the circumstances outlined.

[RN D] was not on call or present during many of [Mrs A's] clinical events, however the care givers have clearly documented their concerns and observations in the progress notes. Progress notes are the formal communication tool between health professionals and provide the platform for quality care[12]. [RN D] has reflected that her documentation could have been better. I would add that [RN D] needs further

[12] Guideline: Documentation, 2017 NZNO

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oversight to understand the importance of the clinical/progress notes in her practice as an RN. Had she read the notes by the CGs she could have seen and assessed the concerns being raised. I do not understand what [RN D] is referring to as 'silent heart failure' I am not familiar with that as a condition nor did I refer to that in my report.

[RN D's] statement presents a picture of a RN with no clinical supervision, not having or making time to read progress notes to ensure previous care issues could be addressed and generally unable to deliver Registered Nurse care to a standard required in New Zealand by the Nursing Council[13].

[RN D] was in an unenviable position of trying to carry out the shift duties of an RN while inadvertently carrying out the role of Clinical Manager.

[RN D] does not demonstrate insight into her role as the RN to document or report to the Facility Owner or take further when care is compromised (escalate concerns[14]). This puts her practice at risk and the safety of all residents at [the rest home] at risk during that time. I accept this is not purposeful on her part, but I remain concerned that on reflection this is not an area she has noted as a deficit.

I note that [RN D] is no longer employed at [the rest home]. In addition to my original advice I now add that [RN D] be referred to Nursing Council for a period of supervision to ensure in a different practice environment she can develop reflective practice and demonstrate RN practice of a standard required by NZ Nursing Council.

If HDC accept that [RN E] (owner-operator) was the clinical manager of [the rest home]. Can you comment on the standard of the clinical oversight between [Month2] and [Month11]?

Having reviewed the initial complaint and the subsequent statements from [RN F] and [RN D] I see no evidence of clinical oversight from [RN E] either anecdotally or documented. The initial documents I reviewed in September 2017 indicated the owner was not always living in [the town] as he had taken up a [role in another town].

I have been surprised to read the RNs were not employed with a Clinical Manager function and were not ever on call. From the documents I have reviewed it would appear there was no RN available for clinical events, oversight or on call from 1530 to 0700 the next day and across the weekends. Once [RN D] was employed she states she was on site four days per week (32 hours). This is completely unsatisfactory for residents and for staff safety. Caregivers require a practice environment with supervision and delegation of tasks[15]. With the RN on site 32 hours a week and the Owner/Clinical Manager unavailable, meaningful supervision is not possible.

[13] Code of Conduct. Nursing Council of New Zealand June 2012

[14] See Code of Conduct Document Principle 8: Maintain public trust and confidence in the nursing profession. Page 11 Nursing Council of New Zealand June 2012

[15] Guideline: delegation of care by a registered nurse to a health care assistant. Nursing Council of New Zealand May 2012

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

This is an extreme breach of industry practice standards for a facility owner and an RN. Also, a breach of the Age-Related Residential Care (ARRC) Services agreement contracted between the facility and the District Health Board. This is one extract of the ARRC agreement not being met.

Manager

i. *Every Rest Home must engage a Manager who holds a current qualification, or has experience, relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to managing a Rest Home; and*

ii. *The role of the Manager includes, but is not limited to, ensuring the Residents of the Home are adequately cared for in respect of their everyday needs, and that services provided to Residents are consistent with obligations under legislation and the terms of this Agreement[16].*

I have concerns regarding [RN D] doing paperwork at home. I am not confident [the rest home] would have had policies to keep [RN D's] practice safe with the transportation, storage and access to medical records. It is not best practice to have RNs doing this work from home. It is the facility that is audited and deemed to have the safe storage and access of clinical notes that are required for patient confidentiality.

With the documents I have reviewed for my initial report and the statements written by [RN F] and [RN D] I do not see any evidence of [RN E] providing clinical oversight or an appropriate duty of care given his status of Facility Owner and being a Registered Nurse. This is a serious departure from all legal and ethical standards professionally and contractually.

Yours sincerely,

Anna Blackwell (RN; PGDip)"

[16] Taken from Clause D17.3 ARRC Services Agreement

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