The Ultimate Care Group Ltd
(trading as Karadean Court Lifecare)

Ms F, Registered Nurse

Ms E, Registered Nurse

A Report by the

Deputy Health and Disability Commissioner

(Case 10HDC00308)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, aged 93, was a patient in a public hospital. In early 2009, he was transferred to aged care facility Karadean Court Lifecare (Karadean).

2. A few days earlier, family members had contacted the facility's Clinical Services Manager, Ms F, a registered nurse, to discuss room availability and arrange a viewing of a studio unit. RN Ms F formed the impression from discussions with the family that Mr A had a reasonable degree of independence. Mr A and one of his sons met with hospital social workers the next day, and hospital staff contacted RN Ms F to arrange the transfer.

3. The following day, Mr A underwent a geriatrician review and a support needs assessment, which identified that he required hospital-level care. The assessment was faxed to Karadean that day. The studio unit previously selected was not suitable, as hospital-level care could not be delivered in that part of the facility. RN Ms F contacted Mr A's family members to arrange for Mr A to use a rest home room until a hospital-level bed was available. Ms F did not discuss the arrangement with the hospital.

4. Mr A was transferred to Karadean. The admission documentation and assessment completed by registered nurse Ms E was not thorough, lacked detail, and did not reflect Mr A's care needs in relation to suprapubic catheter management, ulcer care, and urinalysis. It did not give specific information and direction to other caregiving and nursing staff.

5. Mr A's care over the next week was substandard. Concerns raised by family members were not fully documented or acted upon. The GP was not called.

6. A few days later, Mr A became very unwell and was transferred back to hospital. Sadly, he passed away that evening from suspected sepsis. Subsequent complaints raised by the family were poorly handled by the facility.

7. RN Ms F exercised poor skill and judgement in admitting Mr A to a rest home level bed in the knowledge that he required hospital-level care, without making adequate arrangements to ensure he received the level of care he required. She failed to adequately oversee the provision of care delivered by other staff. By failing to ensure Mr A received services of an appropriate standard, RN Ms F breached Right 4(1)[1] and, by failing to maintain adequate documentation, she breached Right 4(2)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

8. RN Ms E failed to adequately document the admission in accordance with her job description, admission policy, and professional standards. The admission records did

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

not give clear information and direction to other staff regarding Mr A's care needs, and this affected the continuity and quality of his subsequent care. RN Ms E failed to comply with the relevant standards and breached Right 4(2) of the Code.

9. RN Ms E failed to adequately assess Mr A or evaluate his condition. Accordingly, she failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

10. The Ultimate Care Group Limited (UCG) did not sufficiently support and provide oversight of senior staff, and did not ensure that Mr A was provided with services with reasonable care and skill, and therefore breached Right 4(1) of the Code.

Complaint and investigation

11. On 12 March 2010, the Commissioner received a complaint from Mr A's family about the services provided to him at Karadean Court Lifecare.

12. After a period of assessment, an investigation was commenced on 20 September 2010. During the assessment of this complaint, preliminary expert advice was sought. On the basis of that preliminary advice, the Deputy Commissioner did not identify any significant concerns about the services provided by the district health board.

13. This report is the opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

14. The following issues were identified for investigation:

- *Whether The Ultimate Care Group Limited (trading as Karadean Court Lifecare) provided appropriate care and services to Mr A over a period of eight days in early 2009 (Days 1-8).*

- *Whether The Ultimate Care Group Limited responded appropriately to Mr A and/or his legal representative regarding concerns raised about the standard of care he was provided.*

15. The scope of the investigation was extended on 23 September 2011, to include:

- *Whether Ms E provided services of an appropriate standard to Mr A in early 2009.*

- *Whether Ms F provided services of an appropriate standard to Mr A in early 2009.*

16. Information was reviewed from:

Mr B — Mr A's son, complainant

Mr C	Mr A's son, complainant
Mrs D	Mr A's daughter, complainant
The District Health Board	Provider
The Ultimate Care Group Ltd (UCG)	Provider
Ms E	Registered nurse
Ms F	Clinical Nurse Manager
Ms G	UCG Business Administration Manager
Dr H	General Practitioner

17. Independent nursing expert advice was obtained from Ms Jan Grant (attached as **Appendices A and B**)

Information gathered during investigation

Background

18. In August 2008, Mr A (aged 93) was diagnosed with cardiac problems. In late 2008, he was admitted to hospital in his home town, with abdominal pain. A CT scan showed that Mr A had a kidney obstruction,[3] and a suprapubic catheter (SPC) was inserted because he had difficulty passing urine and catheterisation had failed.

19. Mr A's condition worsened, so he was transferred to a public hospital in a main centre (the hospital). A social worker's assessment noted that discharge to a rest home was imminent once further medical input was obtained. Mr A was awaiting elective surgery to remove the kidney stone.

20. Mr A's care needs and dependency increased while he was in hospital. Following cardiology reviews it was concluded that Mr A was unsuitable for surgery, and conservative management was suggested.

21. Mr A had angina, which responded to glyceryl trinitrate (GTN)[4] spray, and it was noted that he had likely had a non-ST elevation myocardial infarction.[5] He had normal renal function. In the following days, Mr A was stable with no further evidence of pain. His kidney function two days later was normal. The following day, Mr A's SPC site was cleaned and swabbed and his ulcers were redressed. The swab result indicated no significant infection.

Karadean Court Lifecare

22. Karadean is a 53-bed care facility. It has seven studio units,[6] mostly for rest home residents, six small rest home rooms, and another 40 rooms, which can be used for

[3] A kidney stone, known as a calculi.
[4] Glyceryl trinitrate improves the oxygen supply to the heart and decreases the amount of oxygen that the heart needs by making it easier for the heart to pump blood around the body.
[5] A mild heart attack.
[6] One of the studios has two bedrooms and accommodates two residents.

either hospital or rest home care. Karadean has contracts with the Ministry of Health and the district health board to provide aged care services.

23. In May 2008, UCG purchased Karadean and, in December 2008, a new governance structure was put in place. A new business administration manager and clinical services manager were appointed. UCG stated that this structural change was in response to difficulties in recruiting a facility manager and registered nurses.[7] Staffing was under pressure over the Christmas/New Year period because two RNs had failed to renew their practising certificates and were stood down until this was remedied.[8]

Karadean staff roles and responsibilities

RN Ms F

24. RN Ms F was employed as a registered nurse at Karadean from late September 2008 to November 2008. She was the Clinical Services Manager from December 2008 until December 2009. Ms F signed her job description in November 2008. She said that she was not given a copy.

25. The key purpose of the Clinical Services Manager's position was to "provide high level clinical leadership and support to clinical and care staff", and the key objectives were "providing leadership, supervision and direction to staff with active knowledge and practice as per [the Health Practitioners Competency Assurance Act]", and "monitor[ing] the provision of care to residents …" This included managing admissions in accordance with UCG policy. Another key objective was providing oversight of resident clinical records and recordings to ensure they met organisational and legislative requirements.

26. RN Ms F worked full time, Monday to Friday, and was on call at the weekend. She said that her role with regard to admissions was to liaise in the early stages with families and/or the referrer.

Ms G

27. Ms G had some nursing experience, but had not practised since 2000. She was initially employed at Karadean as a caregiver and, 18 months later, in December 2008, was appointed Facility Business Administration Manager. Ms G said she told her employer that she "didn't really feel qualified" for the role, in which she handled business operations and was responsible for the reception office. Her role with regard

[7] Karadean had been reporting monthly to a designated auditing authority and HealthCERT, Ministry of Health, from September 2008 (following an audit) to March 2009 on its ability to employ suitable RNs and obtain 24-hour RN coverage. At times it utilised an enrolled nurse under the direction of an RN. Bureau RNs were also used to cover gaps in the roster. HealthCERT is "responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001. HealthCERT's role is to administer and enforce the legislation, issue certifications, review audit reports and manage legal issues".

[8] HDC enquiries to the Nursing Council of New Zealand confirmed that both RNs were deemed to have an Annual Practising Certificate (under s30 of the HPCA Act) during the period Days 1-8 2009.

to admissions was limited to entering the residents' details on the computer system and ensuring the paperwork was completed.[9]

28. Ms G said that at one point she expressed her concerns about the workload to the UCG Southern Regional Manager, saying that she felt unsure that she could do the job and that she would have been happy to do just the administrative work. The Southern Regional Manager told her she was "doing fine" in the role.

29. In July 2009, Ms G resigned. She said that this was because the role had become a "24 hour job" and was "too much" in light of her family commitments. She said that in the end she felt she could not perform the role any more.

RN Ms E

30. RN Ms E, who was employed as a registered nurse, said that her duties included administering medication, allocating staff, overseeing caregivers, attending to residents' needs, liaising with agencies, filling gaps in rosters, and checking stock and pharmaceutical supplies. She said she had an extremely heavy workload, and felt that staffing availability and levels during Mr A's admission were very problematic.[10]

31. In 2004, when RN Ms E's employment at Karadean commenced, she completed a competency-based orientation programme. She said she was on leave and missed two training modules on documentation held in May 2008 and June 2009. RN Ms E said that on-the-job training was the norm.[11]

32. RN Ms E stated that RN Ms F and Ms G were not experienced. RN Ms E commented that she had been offered the clinical lead role and had accepted it, but the offer was later retracted by UCG. In March 2009, RN Ms E transferred to another UCG facility to take up an RN position followed by a Nurse Manager role. She said that she resigned in 2010, suffering from exhaustion.

33. RN Ms E's job description included a primary objective of meeting all "legal, ethical, financial and professional requirements pertaining to the clinical practice within Karadean Court". A key task was planning, implementing and evaluating the care of all assigned residents including the development of care plans and maintenance of progress notes for residents.

Orientation

34. RN Ms F said that when she and Ms G commenced their new roles, their job descriptions seemed "somewhat blurred" and they received "absolutely no orientation" and, in her view, neither one of them was sure what they should be doing.

[9] Ms G's job description on file was also signed on 25 November 2008 to commence on 1 December 2008. It outlines a key purpose of providing "effective leadership and management to the business, including residents and staff evidencing budget management and controls".

[10] Roster and the time sheets show that RN Ms E was the only registered nurse on duty over that weekend. She worked 56.5 hours over six days. She usually worked 32 hours per fortnight.

[11] RN Ms E submitted to HDC performance appraisals, work history, and correspondence she had previously submitted to the Karadean Manager in July 2008 regarding her concerns that the level of staff expertise was low on a particular shift in July 2008.

RN Ms F said she was taken through the office and shown where the manuals and contracts were, and told to "read [them] when you have time". She could not recall her role including signing off orientation modules.

35. RN Ms F said that she felt on her own and unsupported in the role. She felt unprepared and lacking in knowledge, and suffered a lot of personal stress and anguish. She said that the job was "hell", but she did not approach Karadean/UCG about this, although later she felt she should have done so.

36. Ms G advised HDC that there was not a great deal of orientation for her role. She recalled a Managers' day for Health and Safety, but little else. She said she worked alongside the regional manager in a "learn as you go" style.

37. UCG responded that, in accordance with its *Staff Training Policy* and *Staff Orientation Policy*,[12] all new Karadean staff are expected to complete a full orientation to the facility and ongoing training as set out in its education schedule. As part of the orientation, all new staff are expected to read the relevant policy and procedure manuals and sign the Policy and Procedure Familiarisation signing sheet. Each year, further training is provided, in order to meet mandatory requirements.[13]

38. RN Ms E and RN Ms F signed the following familiarisation sheets: Entry and Consumer Rights Policies on 25 and 26 September 2008; Infection control, Laundry and Housekeeping on 10 September 2008 and 11 November 2008; Care services and Service Delivery on 3 September 2008 and 29 September 2008; and Organisation Management, Human Resources and Quality Assurance on 25 September 2008 and 11 November 2008.

Arrangements for Mr A's admission to Karadean

39. While in the hospital, Mr A expressed the wish to be transferred to a rest home, rather than return to his own home. Mr A's son (Mr C) travelled from his home town to liaise with social workers regarding arrangements for a rest home place for his father. The notes read: "[Mr A] voiced that he would like to go into care. Both [Mr A] and son [Mr C] feel that [Mr A] is not (sic) longer able to cope."

40. Mr A's family members telephoned the Clinical Services Manager of Karadean, RN Ms F, to discuss room availability and arrange to view the rest home. Mr A's family advised HDC that there were very few care choices available and that their father wanted to be near his friends and support network, so the area that Karadean was located was acceptable to him.

41. Mr C advised HDC that he was happy with the double studio unit he viewed at Karadean, as the unit would enable his father to maintain his independence and quality of life while having assistance available.

[12] Issued 20 June 2008.
[13] Staff training and in-service attendance records for 2008 and 2009 were provided to HDC.

42. RN Ms F said she formed the impression that Mr A had a reasonable degree of independence. She said she advised Mr C that residents at the unit end of the facility were largely independent, receiving assistance such as help with showering and medications when necessary from a caregiver, overseen by a registered nurse.

43. RN Ms F had a discussion with Ms G, Facility Business Administration Manager, and UCG management about whether one resident could use a double unit. It was decided to hold the studio unit pending Mr A's discharge from hospital and his needs assessment.

Review

44. The following day, Mr A had a urology review and CT scan at the hospital. A social worker met with Mr A and Mr C. They contacted Mr A's other two children, Mr B and Mrs D,[14] and it was noted in the hospital records that "[Mr A and son] have contacted [Mr A's] other two children and have booked [hospital-level care] at Karadean". A geriatrician's assessment was arranged to finalise the hospital-level care documentation for transfer.

45. A nursing entry at 1.45pm records: "Rang Karadean Court Lifecare to confirm with Manager [Ms F] re arrangements for [patient's] transfer there ? tomorrow [Karadean phone number] …"

46. RN Ms F recalled receiving the phone call from the hospital and said that there was nothing mentioned about Mr A that differed from what the family had indicated to her earlier. Her recollection was that the transfer was arranged for Day 2.

Day 1 — faxed documentation

47. A geriatrician reviewed Mr A at 1.30pm and confirmed that hospital-level care was required. The nursing notes record that the SPC was draining clear urine and the site was intact and dressed. At 3pm the social worker recorded:

> "I have completed [Support Needs Level Assessment] with [Mr A] and have faxed a copy to son [Mr B] and have phoned both sons. Placement documentation completed and faxed to Karadean. Ambulance booked for [Day 2] 1030hrs …"

48. The DHB's Older Person's Health Service stated that the Support Needs Level (SNL) documentation faxed to Karadean identified the requirement for hospital-level care (Level 5)[15] for Mr A. It did not indicate palliative or rest home level care.[16] Other clinical records show no evidence of the hospital indicating that Mr A was for palliative care.

49. At 2.50pm on Day 1, the documentation was faxed to Karadean, including on the cover page:

[14] Mrs D had enduring power of attorney for personal care and welfare for her father. She was also a co-executor of his estate. The power of attorney was not in force because Mr A was competent.
[15] Hospital SNL 5 care indicates full-time care is required to assist with all activities of daily living.
[16] Palliative care would have resulted in Mr A being placed under a different funding stream (Support Care Funding). Hospital care was funded by Older Person's Health division funding.

"SNL '5' [Hospital-level care], [Older Persons Health] Service Plan, OPH [Application] for [Hospital] Care."

Page two of the SNL assessment records: "Now requires 24 hour nursing care."

50. A copy of the documentation was faxed to Mr B.

51. The DHB responded that the social worker followed this up with a phone call to the facility on Day 1 to confirm receipt of the paperwork and the availability of a hospital bed for the next day. This call is not recorded in the notes.

Events after documentation received

52. RN Ms F told HDC that when the fax arrived on Day 1 she was "shocked" to discover that Mr A had been assessed as requiring hospital-level care. Ms G said that they had not met Mr A at that stage and "recognise[d] that the paperwork was through official channels".

53. RN Ms F said she was aware that the reserved studio unit was unsuitable because hospital-level care could not be supplied to it. The rest-home area was staff and skill matched for rest-home level care, and the ratio of staff at the rest-home end of the building was approximately one caregiver to thirteen residents. At the hospital end of the facility, the ratio was one caregiver to five residents, plus the registered nurse on duty.

54. RN Ms F said that there were no hospital wing beds available, but it appeared that one or two could become available over the following few days. One rest-home-level bed was available, and RN Ms F and Ms G discussed the possibility of utilising the rest-home bed for a few days until a hospital bed became available in the hospital wing of the facility. RN Ms F did not contact the referring hospital staff.

55. RN Ms F contacted Mr C to explain that the studio unit was not suitable for Mr A. The possibility of using the room for a few days was discussed. RN Ms F said: "I felt we should allow the family to make the decision." UCG's investigation report, which was sent to the family in September 2009, concluded that an explanation to Mr C about hospital-level care versus rest-home care could have clarified care delivery, and this should have been done prior to his father's admission.

56. Mr C said that he agreed to take the rest-home bed because he felt that his father would be better off out of hospital. Mr C also said that he had relied on Karadean staff to discuss the issue with the hospital and determine the suitability of the studio unit. RN Ms F acknowledged that input was not sought directly from Mr A himself, prior to the admission.

57. RN Ms F told HDC that she felt it was not a wise move on her part to allow the admission of Mr A to a rest-home-level bed, and she regretted it. She stated:

> "In hindsight I realise that it may have been prudent, on discovering that [Mr A] was requiring hospital level care, to have either cancelled his admission to Karadean or to have delayed it until a suitable bed became available."

58. Ms G said that in hindsight, she considered that Mr A's admission should have been declined. She commented that staff usually "bent over backwards" to try to accommodate people. She reflected that they did not want to turn people in need away and wanted to be able to look after everybody.

The studio unit

59. RN Ms F and Ms G advised HDC that the studio unit was situated on the side of a lounge opposite the nurses' office and out of the way of general staff "traffic". The Karadean floor plan indicates that the studio unit is isolated from the main hallways and distant from the hospital wing.

60. RN Ms F and Ms G said that the caregivers would not be able to quickly check the studio unit, as they could with a room off a corridor. Ms G said that the room had a wash basin, but no toilet or ensuite. The toilet and shower facilities were across the corridor, and so a commode was placed in the room.[17] The studio unit had a rest-home mattress and base, but not a hospital-level bed. There was a call bell on a retractable cord. UCG advised that the room was usually given to residents who were, at least, semi-independent.

Discharge from hospital — Day 2

61. At 10am on Day 2, Mr A was transferred from the hospital to Karadean. The discharge prescription, discharge summary, needs assessment, and transfer notice were sent to Karadean. A copy of the discharge summary was faxed to Mr A's daughter.

62. The SPC is recorded as draining clear urine at that time. The hospital discharge summary noted: "Repeat [full blood count] and [urea and electrolytes] next week please. Please [review] meds including Metoprolol[18] dose next week." There is a further comment:

> "Patient was [discharged] to Hospital level care, SPC is NOT [original emphasis] to be removed in the community please."

63. It was noted that an appointment should be made at a urology clinic in 6–8 weeks' time for the SPC to be changed.

64. The DHB later identified that there were some deficiencies in its nursing transfer documentation. There was no specific reference to care requirements for Mr A's SPC site, nor any reference to his left leg ulcers or what dressings had been used. However, the SPC site was swabbed and clear of significant infection prior to transfer, and the nursing notes state that no *Staphylococcus aureus* was isolated.

[17] The room was later converted to a manager's office.
[18] A betablocker heart medication.

65. The DHB stated that, as it was anticipated that Mr A was proceeding to hospital-level care, it was likely that directive information was not included, as hospital-level care facilities would be familiar with catheter management. However, the DHB acknowledged this shortcoming and reminded its nursing staff that this knowledge should not be assumed, and transfer documentation should always include full details.

Karadean's policies

66. UCG provided copies of Karadean's policies and procedures.[19] Karadean's *Admission Policy and Procedures*[20] was in place at the time of Mr A's admission. It provides that admission forms must be completed by the facility manager, registered nurse, or business administrator on or before the day of admission, and that the initial admission documentation must be completed in accordance with the admission checklist. The RN must be involved with the initial assessment and development of the initial care plan.

67. The *Acceptance and decline entry to service policy*[21] states: "Where it is ascertained that Karadean Court Lifecare cannot meet the needs of the potential resident, or the resident has not met the appropriate criteria to allow entry, the Facility Manager will contact the service co-ordinator to notify them. Service co-ordination will be requested to find alternative residential care for the potential resident." RN Ms F and Ms G stated that neither of them was aware of such a policy.

Admission to Karadean — Day 2

68. RN Ms E admitted Mr A but, when later asked, she could not recall him. She was not on duty the previous day when the paperwork was faxed, or when Mr A's son visited the facility.

69. RN Ms F greeted Mr A on his arrival and introduced him to RN Ms E, who undertook orientation to the facility, the admission procedure, and subsequent documentation.

70. The documentation used by Karadean included: an admission checklist; resident's diagnosis list; advance directive form; property list on admission; initial assessment on admission forms (three pages);[22] continence assessment; health status and clinical risk assessment; pain assessment; pressure area risk assessment tool; falls risk assessment; admission food and nutrition information; breakfast order; and drug charts.

Initial assessment documentation

71. The initial assessment form is not complete. The continence area documents that Mr A had a suprapubic catheter, but the site of the catheter is not recorded. No care issues about the catheter are listed, and there are no directions for staff. The word "assist" is all that is documented under "self cares" and "showering and dressing".

[19] UCG responded that a quality management system was in use at Karadean, put in place by the previous owners. The system provides a full set of policies and procedures, which govern care delivery at Karadean. Policies are reviewed annually.
[20] Issued May 2008.
[21] Ibid.
[22] This form allows staff to outline a brief assessment and identify a patient's needs for the short term.

72. Mr A's pressure ulcer was not recorded under skin abrasions/bruises/breaks, etc, but it is mentioned in the health status and clinical risk assessment form. The diet area records "cut up meat". A sensory section circles that Mr A wore glasses and required assistance with hearing aids. Mr A's pain was not assessed. Sections are circled indicating that Mr A needed help settling for sleep; was alert; was able to assist in planning care; had no short-term memory loss; was orientated; and had some anxiety. The Continence Assessment Form does not hold any information other than "No incontinence — SPC".

73. Mr A's blood pressure was 96/70mmHg, his pulse was 48bpm, his oxygen saturation was 96%, and his temperature was 37.3°C. The "weight" and "urine" sections were not filled in, and no urinalysis was undertaken.

74. RN Ms E told HDC that she did not take the baseline recordings, and said that the records were completed later by another staff member.[23] RN Ms E acknowledged that she signed the initial assessment form without performing the baseline recordings.

75. UCG said that it was their expectation that the RN should check the baselines and make contact with the hospital to query these if they differed from the patient's discharge condition.

76. The first part of the Health Status and Clinical Risk Assessment form has a tick in the "Yes" column and a comment "pressure ulcer outside of L) calf (silver dressing)". "No" is ticked on the area of skin irritations and irritations around resident's eyes. "S/P Catheter" is written under the heading of incontinence. A tick indicates that assistance is required with feeding. A gutter frame is recorded as being needed for help with walking. Under Pressure Area Devices it states "looking for air or spenco mattress". The form records that Mr A was last seen by a doctor on Day 2. The form is signed and dated by RN Ms E.

77. The Falls Risk and Pressure Area Risk Assessment show that Mr A was at moderate risk of falls and low risk of pressure areas. The Pain Assessment Form indicates that Mr A had moderate chronic pain and that Panadol decreased his pain.

78. There was no record of the decision to place Mr A in a rest-home bed, rather than a hospital-level bed. The only reference to implementing the recommendations made by the hospital (medication review and a follow-up blood test) is a note in the daily diary for Day 8 that the medical laboratory would be visiting to carry out Mr A's blood test.

79. The progress notes entry by RN Ms E on Day 2 states that:

> "[Mr A] has transferred from [the Public Hospital]. He has a suprapubic catheter in situ — this is not to be changed. An appointment will come for him to go back to hosp. + changed there, or in an emergency he will need to be readmitted. [Mr A] can walk to the toilet with the gutter frame, one assist + belt. He has 2 hearing aids, and partial plates (upper and lower). [Mr A] is cognitively able, but you need

[23] Karadean has not advised the name of this staff member.

to speak up clearly. He can have panadol for pain, which he refused at dinner time + his meds will arrive tomorrow."

80. Karadean's *Documentation and Report Writing Policy*[24] required RNs to develop and document initial assessment care plans within 24 hours of admission, followed by a full nursing care plan within three weeks of admission.

81. There is no initial assessment care plan, wound chart, or follow-up documentation in Mr A's progress notes, nor are there any entries in relation to wound care.

82. RN Ms E made no further entry in the progress notes until Day 8. The family contact sheets show that no information was gathered from the family when Mr A was admitted.

83. UCG acknowledged to HDC that the initial assessments and initial care plan were not comprehensive and "consequently, there was insufficient guidance for caregiver staff to follow to provide adequate care. The admission documentation was incomplete and brief and did not accurately reflect Mr A's care needs." UCG was critical of the lack of a wound management chart or management plan for the SPC and, as a result, the documentation "did not provide sufficient information for ongoing management by staff".

Documentation conflict

84. RN Ms E responded to HDC that she did not believe there was any inadequacy in the initial assessment. She felt it was concise but not inaccurate. RN Ms E claimed that some completed admission documentation was not in Mr A's notes. Specifically, she said that the wound care plan and assessment, fluid balance chart, dietary likes/dislikes, and the prn (as needed) signing sheet (on the reverse of the daily meds chart) were not included with the notes provided to HDC. She also said that some of these forms were stored separately from the notes, elsewhere in the facility.

85. RN Ms F said that, to the best of her knowledge, patients' records were all kept together and not separated. Ms G's recollection was that some information on wounds and dressings was stored in the treatment room away from the main patients' files.

86. UCG responded that "wound care charts are kept in a wound care folder in the treatment room while they are active and the wound is being treated. As soon as the wound is healed the wound care chart is filed in the clinical file in the nurses' station. A short-term care plan is commenced when a wound needs treatment and this cross-references that a wound care chart has been commenced." In response to HDC's provisional report, RN Ms E said that she is sure that she would have filled out the fluid and wound charts.

87. UCG reiterated that no wound assessment chart was completed and no wound management chart was commenced for Mr A. It said that fluid balance charts are normally initiated if a resident is evaluated by the RN or GP as having poor fluid

[24] Issued 20 June 2008.

intake or if abnormal urine is detected. It noted that there was no evidence that RN Ms E checked Mr A's urine as part of the admission process.

88. However, UCG provided a copy of Mr A's prn (as needed) medication signing sheet, which appeared on the reverse of the daily medication sheet. This shows six entries for paracetamol 500mg x2 between Day 4 and Day 8, and one entry stating that Mr A declined paracetamol on Day 5. UCG also provided a food and nutrition sheet, which contains basic information, indicating a normal diet and no additional information.

GP arrangements

89. The district health board's Service Portfolio Manager for Older Persons' Health stated that the 2009 Age Related Residential Care Services Agreement (ARRC) between the DHB and the facility,[25] provides that a medical examination is not required in the first month, where there has been one in the two days before admission.

90. Karadean's Policy[26] provided that the GP should see all new residents within two working days of their admission "in all cases where they had not been seen by a Doctor within 2 days preceding their admission".

91. UCG, RN Ms F and Ms G all stated that there were difficulties with medical cover. In response to HDC's provisional report, RN Ms F commented that she and Ms G had instigated the initial efforts to improve GP cover. Dr H had been the Karadean GP for the previous five years. He provided the service with another doctor at his surgery.

92. Dr H's clinic was about 30 minutes' drive away. He said he visited the facility weekly, which was more frequent GP cover than was usual for rest homes, and that he was available by phone 24 hours a day for advice. He said he would, on occasion, make additional visits to the facility to see acutely unwell patients. He stated that he was not obliged to visit weekly or to provide locum cover. UCG advised that other doctors had been approached at that time but were reluctant to cover the facility.

93. Mr A had been seen by a doctor on Day 2 at the hospital. He received no GP review while he was at Karadean.

94. UCG said that previous signed agreements with Dr H had required him to assess all new residents within 48 hours of admission, so UCG considered that that was accepted practice. However, UCG advised that this was not specified in the 12-month contract with Dr H signed on 28 September 2008. The agreement also did not require

[25] Section D16.5, e. i. states: "1. each Subsidised Resident is examined by a General Practitioner within 2 Working Days of admission, except where the Subsidised Resident has been examined by a Medical Practitioner not more than 2 Working Days prior to admission, and you have a summary of the Medical Practitioner's examination notes. After the initial examination, the Subsidised Resident must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) ***except*** [original emphasis] where the Subsidised Resident's medical condition is stable as assessed by the General Practitioner, in which case the Subsidised Resident may be examined by a General Practitioner less frequently than monthly, but at least every three months. This exception must be noted and signed in the Subsidised Resident's medical records by the General Practitioner;"

[26] Administration of Medication Procedure Policy. Issued 20 June 2008, page 1.

Dr H to arrange locum cover when on leave. However, UCG commented that GPs are expected to provide locum cover as part of their Primary Health Care Contract agreements for enrolled patients. UCG accepted that it was responsible for ensuring that the contractual arrangements between the GP and Karadean were clear.

95. RN Ms F said that Dr H was informed of new admissions by fax, either just before or after the resident's arrival. An undated administrative patient enrolment form for Mr A, signed by RN Ms F, was faxed to Dr H's surgery. The forms are not designed to contain any clinical information.

96. Dr H advised that in the week to Day 3, he was working at his surgery without his other doctor, who was on leave, so he did not go to Karadean on Day 2. He signed Mr A's hospital discharge medications chart[27] and faxed it to Karadean. He said that he would have reviewed Mr A the following week, Day 9. He cannot recall whether Karadean staff contacted his clinic on Day 2, and his clinic message diary contains no note about Mr A.

Arrangements for Mr A's care

97. RN Ms F said that she "made sure staff were aware that [Mr A] would be requiring more care and assistance than would normally be the case with residents in the rest home area and initially there did not appear to be any problems". She said that she saw Mr A each day that she was on duty.

98. RN Ms F stated that she was not working over the weekend. When she returned on Monday, Day 6, staff advised her of the concerns raised by Mr A's family. It was then that she made a verbal arrangement that the enrolled nurse on duty each day was to attend to Mr A's cares.

99. The enrolled nurse on duty on Days 4-6 said that she could recall nothing out of the ordinary about Mr A, and she did not have any input into his care plan. Mr A's records have an entry by the enrolled nurse on Day 5, but it contains no reference to any instructions given regarding Mr A's care. There are no further entries by an enrolled nurse. There are no records of any other steps being taken to arrange more care and assistance for Mr A, in light of his need for hospital-level care.

100. RN Ms F explained that "due to staffing levels in that part of the facility (rest home) there were sometimes delays in attending to [Mr A's] needs". She said she spoke to Mr A on each of the days that she was on duty during his stay, and "his health status appeared to me to be largely unchanged from admission and he presented no immediate cause for concern".

101. UCG stated that "staffing levels were not adjusted to meet [Mr A's] level of care requirement; hence he did not receive the immediate help he required in a timely manner or the ongoing monitoring he required".

[27] Medications listed on this form are doxazosin (blood pressure medication) 2mg once daily, aspirin 100mg (3 months' worth), metoprolol (a betablocker) 95mg once daily, and paracetamol 1gm prn (as required).

102. RN Ms E considered that UCG's criticism of a lack of staffing level adjustment for Mr A was "totally unrealistic", given the staffing problems at Karadean. RN Ms E said that the template rosters were not representative of the staffing and hours delivered, as the rosters were constantly altered by hand as circumstances changed.

103. UCG acknowledged that the inadequacies of the initial care plan and progress notes for Mr A meant that the overview by staff on duty was inadequate, and the monitoring of his condition, urine, bowel habits, and needs was insufficient. None of the staff were proactive in following up on the assessment and recordings that were taken on admission.

Post-admission care

104. On Day 2, Mr A was noted to have walked to the toilet, was cheerful and talkative, and had experienced loose bowel motions. In the evening the caregivers recorded that his urine was dark. The family contact sheet records that RN Ms F spoke to Mr C when he visited, assuring him that his father would "be given excellent care".

105. No progress notes were recorded on Day 3, but regular contact with Mr A's family is recorded in the "Family contact sheet". Mr B called on Day 3, asking to be contacted at any time should his father's condition change. The notes do not indicate any follow-up call.

106. On Day 4, the notes record that Mr A was feeling unwell in the morning and felt like he needed his bowels to open. There is no record of an examination of Mr A or monitoring of his bowel habits. He was given lactulose and experienced further loose bowel motions. It was noted in the late morning that his bowels would be monitored.

107. There is no record of any treatment of the SPC site or of Mr A's leg ulcer.

Family concerns

108. In the evening of Day 4, Mr A was visited by Mrs D and Mr C. Mrs D said that she requested that Mr A's dark urine be investigated, and that she was told by a caregiver and an RN that it would be checked. Mrs D said that staff confirmed the presence of blood in the urine, but then changed the bag used to an opaque bag. The notes record that Mr A's urine was dark, he was encouraged to drink more, and that he was tired and said that paracetamol made him sleepy.

109. Mr A's family stated that on Day 4 they requested that arrangements be made for a doctor to see Mr A, as they were concerned about his health, and were told that this would be arranged on Day 6 (Monday). In response to HDC's provisional report, Mr B stated that "there was an obvious and progressive change in [Mr A's] demeanour which continued over the next 3 days". The notes do not record the family's concerns, any staff acting on the family's request, or any further investigation of Mr A's condition. Mr B stated that he requested that Mr A be reviewed by a doctor on several occasions, the first soon after his father was admitted, but that he was told that the doctor visited only once a week.

110. On Day 5, Mr C spoke with the enrolled nurse about his disappointment in the standard of care. The nurse recorded this conversation in Mr A's notes. The dissatisfaction with Mr A's care included his family members finding him in soiled clothing, and his being unable to reach his call bell for assistance. Further concerns were that Mr A should be enabled to continue his previous regime of rising early, and that his expensive hearing aids were not being cleaned and maintained appropriately.

111. RN Ms F stated that a trial was arranged of the night staff assisting Mr A to rise before they went off duty.

112. On the morning of Day 6, Ms F received a call from Mr C enquiring when Mr A would be able to move into the whānau room — a room in the hospital wing that could be used for either rest-home care or hospital-level care. She advised that it would not be available until the following day.

113. The progress notes for the evening of Day 6 note that Mr A refused tea but took fluids. He was assisted to bed early as requested. Mrs D stated that she called Karadean that evening and spoke to a male staff member, who was unaware of the presence of dark urine or a possible visit by a doctor. The records indicate that no steps were taken in relation to the dark urine, and no doctor's visit was requested.

114. Mr A's family stated that on one occasion Mr A had been unable to reach the call bell and was unable to get assistance when he called out, which resulted in his soiling himself. They stated that Mr A often complained to them that no one responded to him when he required assistance.

Mr A's deterioration

115. On Day 7 at 7am, attempts were made to get Mr A up and dressed, as had been requested by his family. Mr A did not wish to get up and remained on his bed for much of the day, refusing to get up for dinner. Carers checked that the call bell was within reach. Mr A ate a small amount and he would not assist or walk when staff were trying to do his night cares.

116. On the morning of Day 8, staff reported to RN Ms F that there were concerns about Mr A. RN Ms F telephoned Dr H's clinic and, as he was busy, left a message for Dr H to contact her urgently. RN Ms F called Mr A's family twice that morning. She monitored Mr A, waited 15 minutes, and then called an ambulance to transfer Mr A to hospital. The ambulance records indicate that it was despatched at 11.30am and was at Karadean at 11.59am. It departed at 12.08pm and arrived at the hospital ED at 1.04pm.

117. The progress notes (no time recorded) record: "Fell asleep on breakfast this am — later on when checked Pt breathless, T 40°, BP 120/80, P 79 extremely irregular, O_2 82%, GP called, ambulance called, family contacted."

Hospital admission

118. Mr A's hospital ED records for Day 8 state that he had probable sepsis. A suspected diagnosis of urosepsis[28] was made, and treatment commenced with IV hydration and antibiotics. A chest X-ray showed no obvious respiratory source of infection. Mr A was given oxygen and, at 2.20pm, he had an electrocardiogram (ECG). Medical officer notes record at 3.10pm, "Today: unwell + haematuria (blood in urine), + fever … poor oral intake last few days." The SPC site is recorded as being clean, with no erythema (redness).

119. Bloods taken at the time of admission show that Mr A was anaemic but had no neutrophil leucocytosis.[29] Staphylococcus[30] was isolated from a blood culture. A D-dimer test[31] was elevated, but this did not support any specific diagnosis. A medical registrar review was undertaken at 6pm and records the comment: "SPC site purulent …" Mr A's heart rate slowed and he was hypotensive (low blood pressure) during the examination. Sadly, Mr A passed away shortly afterwards. The cause of death was recorded as septic shock.

Complaint handling by Karadean

120. A few days later, Mr B advised Karadean that his family intended to lodge a complaint. A few months later, on 5 May 2009, Mr C met with Karadean staff to discuss the complaint. RN Ms F told HDC that she felt that the meeting was tense, but ended amicably with a request from the family that they be sent a letter of apology.

121. Ms G and RN Ms F drafted a letter, but it was not sent by UCG. On 7 May 2009, Mr C received a letter advising that an investigation would be undertaken by UCG management, and indicating that a report would be ready in June 2009. On 9 September 2009, UCG sent a letter of apology and a copy of its report.

122. The family were dissatisfied with the UCG investigation. UCG's report acknowledged that the family's complaint was not managed to the standard it expected, and that there was "no excuse for this". UCG advised HDC that the documented complaints policy was not followed by staff. It noted that there was a poor response to the family's complaints during Mr A's stay and after his discharge. Three family members had raised concerns but these were not adequately documented in the progress notes, no complaint forms were completed, and the complaints were not actioned.

Subsequent changes made

123. UCG acknowledged that more staff could have been allocated to care for Mr A, the admission documentation was incomplete, the RN overview was inadequate, no

[28] Sepsis is a life-threatening bacterial infection of the blood; urosepsis is sepsis that complicates a urinary tract or prostate infection.
[29] Leucocytosis is a condition characterised by an elevated number of white cells in the blood.
[30] A spherical gram-positive parasitic bacterium of the genus Staphylococcus, usually occurring in clusters and causing boils, septicaemia, and other infections.
[31] D-dimer tests are ordered, along with other laboratory tests and imaging scans, to help rule out the presence of a thrombus. Conditions that the D-dimer test is used to help rule out include deep vein thrombosis, pulmonary embolism, and strokes.

instructions were given for the management of the SPC, there was poor assessment and management of Mr A's bowels, and that Mr A did not receive the care he needed.

124. UCG advised that, by late 2010, key changes had been made to improve their services, namely:

- A restructuring of governance took place in 2009. The roles of Clinical Services Manager and Business Administration Manager were replaced by an RN Facility Manager and an RN Clinical Leader.
- The studio unit was turned into a manager's office and a central nurses' station was created.
- Further education and training on complaints management processes and responsiveness was implemented.
- The number of RNs employed was increased. Staffing is now in accord with Ministry of Health safe staffing indicators.[32] It has an RN rostered on duty 24 hours a day, and a clinical nurse leader working 40 hours a week during business hours. RN hours were adjusted according to resident numbers and work load. Three ENs work at the facility.
- Staff education was reviewed, including study day development to maintain a higher and more comprehensive level of education and training. A separate RN training day on best practice was developed.
- GP services were reviewed and transferred to another provider. The GP is contracted to visit the facility three mornings per week. Other doctors in the practice can respond to urgent matters, and a specialist district nurse practitioner is available for weekend calls.

Responses to provisional opinion

125. UCG, RN Ms F and RN Ms E all provided responses to the provisional opinion, which have been incorporated into the report where relevant.

126. RN Ms F accepted the "findings as being accurate and acknowledge[d] and accept[ed] the mistakes that [she] made". RN Ms F said that she took responsibility for her actions, detailed her reflection on Mr A's care, and said that she had made changes to her practice to ensure a diligent approach to assessment and documentation. RN Ms F stated that she believes her failings were contributed to by the staffing problems at Karadean, which resulted in a lack of support and back-up. She advised that in May 2012 she undertook a course entitled "Assessment in Aged Care".

127. RN Ms E advised that she has not applied to have her annual practising certificate renewed by the Nursing Council of New Zealand. The Council now have her listed as registered but not practising.

128. Mr B responded: "Whilst you are investigating this from a legal and medical perspective, it is also my opinion that the lack of compassionate care and respect for

[32] SNZ 8163:2005 The New Zealand Handbook; indicators for safe aged-care and dementia-care for consumers (Standards New Zealand, 2005).

my father made a significant contribution to his desire to live. He was neglected. I believe he gave up in his humiliation and despair."

Opinion: Breach — RN Ms F

129. RN Ms F commenced the role of Clinical Services Manager a month before Mr A's admission. Her job description and Karadean policies provided that her key responsibilities were to provide clinical leadership and support, monitor care provision, manage admissions, and provide oversight of clinical records.

Care provided in rest-home-level accommodation

130. Before any formal geriatrician review and needs assessment decisions about the level of care required had occurred, RN Ms F liaised with Mr A's family members about a placement for Mr A and she spoke to the hospital social worker.

131. On the afternoon of Day 1, approximately 20 hours before Mr A arrived, the formal needs assessment was faxed to Karadean. The needs assessment clearly indicated that Mr A required hospital-level care (SNL 5). RN Ms F then contacted Mr A's family to explain that the studio unit was not suitable, and to discuss the alternative of utilising a rest-home bed in the interim. There is no record of any communication with Mr A about his preferences, despite him being competent.

132. Ms F stated: "I felt we should allow the family to make the decision." Collaborative decision-making involving consumers and their families is to be applauded. However, it was ill-advised to place the entire onus on the family and take no steps to ascertain Mr A's views or determine whether he had authorised his family to make decisions on his behalf. Additionally, the family were not made aware of the limitations of the room provided and the care able to be provided to Mr A while he was residing in that room.

133. Mr C pointed out that the family members were relying on Karadean staff to liaise with the hospital and determine the suitability of the rest-home bed option. RN Ms F did not contact the public hospital to discuss Karadean's inability to immediately meet Mr A's needs as assessed. I agree with my expert nursing advisor, Ms Grant's comment:

> "Having obtained the information and assessment forms from the Public Hospital, it is my opinion that senior staff should have contacted the Public Hospital and advised that they could not provide hospital level care. The admission should have been put on hold until a hospital bed had become available."

134. Ms Grant advised that she believed the acceptance of Mr A into a rest home level bed, when his needs assessment had indicated a requirement for hospital-level care, would be viewed with mild disapproval by peers.

135. In my view, the issue in this case is more the standard of care Mr A received, rather than where he was placed. If he had received hospital-level care, the designation of the bed would have been of little importance. Once Mr A was admitted to rest home level accommodation, it was essential that steps were taken to ensure that he received appropriate care. Ms Grant advised that "[i]n accepting [Mr A] into a Rest Home bed it was in my opinion senior management's responsibility to ensure that he received the level of care he needed."

136. RN Ms F should have ensured that there was direction and support for the RN on duty. This was particularly so given that Mr A had an SPC, which was likely to require care from an RN, and the RNs spent much of their time in the hospital area caring for hospital-level patients. In addition, Mr A was at risk of being overlooked because of the location of his room.

137. RN Ms F said that she made the staff aware that Mr A would require more assistance than most residents in the rest-home area. RN Ms F also said that once the family expressed concerns about the care provided to Mr A, a verbal arrangement was made that the enrolled nurse on duty each day was to attend to Mr A's cares. However, these instructions were not documented. I agree with Ms Grant, who advised: "It is my opinion that there were not adequate steps taken to ensure that Mr A received a higher level of care despite being in a Rest Home room."

Documentation

138. RN Ms F made no entries in the Karadean records regarding the decision to initially provide Mr A with a rest home-level bed, rather than a hospital-level bed, or arrangements for implementing the follow-up as recommended by the hospital.

139. RN Ms F said that she read through the admission notes the day after admission and did not have any concerns. Despite Mr A requiring hospital-level care, there was no documentation in Mr A's nursing progress notes or his short-term care plan detailing what care he required and how his needs would be met.

140. RN Ms F should have identified the inadequacies in the admission documentation and Mr A's changing condition. Ms Grant advised me:

> "I am of the opinion that direction and supervision would have identified there were omissions in both practical care and documentation. This would have included wound care, catheter care and base line recordings.
>
> …
>
> I am of the opinion that [RN Ms F] failed to identify the omissions, lack of depth in the admission and in the Assessment and Care Plans documentation."

141. Competency 2.3 of the Nursing Council of New Zealand's publication "Competencies for Registered Nurses"[33] provides the indicator that an RN: "[m]aintains clear,

[33] December 2007, p16. See http://www.nursingcouncil.org.nz/index.cfm/1,55,0,0,html/Competencies.

concise, timely, accurate and current client records within a legal and ethical framework".

142. This Office has consistently stressed to all providers the importance of the clinical record, its role in the co-ordination of care, and the need to maintain clear and accurate documentation.[34]

143. In a recent opinion, I stated: "Good residential care requires the clear and accurate documentation of a resident's condition and of the care provided. This ensures that relevant information is shared between those involved, in a timely manner."[35] In my view, Ms F failed to maintain adequate records to assist other staff to provide Mr A with the services he required.

Summary

144. In my view, RN Ms F showed poor judgement and exercised a lack of nursing skill in accepting Mr A to a rest home level bed without making arrangements to ensure that he received hospital-level care, given that she knew the public hospital had assessed him as requiring hospital-level care. She also failed to adequately document the circumstances surrounding Mr A's placement, or sufficiently detail the care he required, which was greater than usual in the rest home area. She failed to oversee the care delivered to Mr A by other staff, as her job description and Karadean policy required her to do.

145. I acknowledge the difficult working environment faced by many aged care facility staff, and that RN Ms F had been in her senior role for only a short time. Ms F said that she was given no orientation to her role, and felt unprepared and lacking in knowledge, although she did not raise her concerns with management at that time. I agree with Ms Grant that, for RN Ms F to be told to read the manuals when she had time, was unprofessional and demonstrated a lack of support for senior staff. However, I do not consider these factors excuse her failures in this case.

146. Accordingly, in my opinion, by failing to ensure that Mr A received services of an appropriate standard, RN Ms F breached Right 4(1) and, by failing to maintain adequate documentation, she breached Right 4(2) of the Code.

Opinion: Breach — RN Ms E

147. At the time of Mr A's admission to Karadean, Ms E had been employed at Karadean as an RN for five years. Her key responsibilities included planning, implementing and evaluating the care of all assigned residents, including the development of care plans and maintenance of progress notes for residents.

[34] Opinion 09HDC01311 (7 December 2010) page 18.
[35] Opinion 09HDC01783 (28 March 2011), page 21.

Documentation and assessment

148. Admission documentation was required to be completed on or before the day of a resident's admission in accordance with the admission checklist. Ms Grant advised that RN Ms E's documentation on the initial assessment form was brief and did not detail or assess important aspects of Mr A's condition.

149. In relation to the SPC, Ms Grant commented that:

> "the site of the catheter should have been assessed. The care issues around the catheter and the site should have been listed and directions for caregivers to follow. The word 'assist' is documented in the space provided to write in. 'Assist' does not demonstrate or provide information as to what assistance would be needed."

150. Ms Grant advised that any patient being admitted with an SPC should have their urine output monitored. She also noted that it would be within an RN's scope of practice to have the knowledge and skills to adequately care for, educate and supervise a patient with an SPC.

151. RN Ms E said that she signed the assessment form without taking the baseline recordings, and that the recordings were done by another staff member. Mr A's blood pressure was 96/70mmHg, his pulse was 48bpm, his oxygen saturation was 96%, and his temperature was 37.3°C. The weight and urine part of the initial assessment form was not completed, and urinalysis was not undertaken.

152. Ms Grant commented that Mr A's pulse rate was low, his blood pressure was low, and his temperature was slightly above normal. I do not consider it was good practice for RN Ms E to sign the form before it had been completed. In any event, she should have reviewed the information once it was recorded, noted the abnormal readings, and ensured that the assessment was repeated. If the results were again abnormal, this should have been reported to the Clinical Manager. This would have been an opportunity to consider whether Mr A should be reviewed by the GP.

153. RN Ms E made an entry in the progress notes on Day 2, but made no further entry until Day 8. The only comment about the SPC was that it was not to be changed. The entry did not refer to Mr A's leg ulcer.

154. Mr A had a pressure ulcer on his left calf, but there is no initial assessment care plan, wound chart, or follow-up documentation in the progress notes, although the ulcer is mentioned in the Health Status and Clinical Risk Assessment Form. There are no entries in the progress notes in relation to wound care.

155. Progress Notes should be sufficiently explicit to allow the resident's progress to be recorded and evaluated. Karadean's documentation policy states the requirement "that all documents relating to service provision are completed accurately in a timely manner that meets legislative and contractual requirements. Documentation provides proof of appropriate care and service provision …"

156. Ms Grant was of the view that:

> "[a]ll of the admission documentation was briefly completed. It was not thorough and its lack of detail and specifics did not give direction to other staff. It is my opinion that the standard of care provided by RN [Ms E] failed to meet the requirement for Competencies for Registered Nurses in two areas.[36]
>
> **Domain One**
> This relates to professional, legal and ethical responsibilities and cultural safety. These include being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises client safety, independence, quality of life and health.
>
> **Domain Two**
> Management of Nursing Care — this relates to clients assessment and managing client care, which is responsive to the client/ client's needs and which is supported by nursing knowledge and evidence based research.
>
> She also failed to meet the documented policy and procedures of Karadean Court.
>
> I believe this departure from policies and procedures would be viewed with moderate disapproval from peers."

157. I am mindful of the heavy workload RN Ms E had during the period of Mr A's admission. She worked long shifts, split shifts, and was the only RN on duty over the weekend. She had worked 56.5 hours over seven days and, in that period, had only one day off. However, although this factor explains the context of the situation, it does not excuse RN Ms E's failure to provide adequate care for Mr A and ensure sufficient supervision of the other staff involved.

158. I acknowledge RN Ms E's claim that the wound and fluid charts she believes she completed were not included in the records Karadean provided to HDC. In addition, RN Ms E said that some documents were stored away from the main file. UCG accepted that active wound care charts were kept in the treatment room, but asserted that no wound charts were ever completed for Mr A, which is why they do not appear on the file. In the circumstances, I am of the view that I do not need to make a finding on this point.

159. I conclude that RN Ms E failed to adequately document Mr A's admission in accordance with her job description, Karadean's admission policy, and professional standards. Importantly, this meant that the records did not give clear direction to other staff regarding Mr A's care needs, and this adversely affected the quality of his care. In my opinion, RN Ms E failed to comply with the relevant standards and breached Right 4(2) of the Code.

[36] December 2007, p4. See http://www.nursingcouncil.org.nz/index.cfm/1,55,0,0,html/Competencies.

160. RN Ms E failed to adequately assess Mr A or evaluate his condition. In my opinion, RN Ms E failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Breach — The Ultimate Care Group Ltd

161. Mr A was elderly and unwell and did not receive the care to which he was entitled. Both he and his family considered he was overlooked and inadequately cared for, in light of his need for hospital-level care. Family members' concerns were not sufficiently listened to and acted on.

162. While I have identified my concerns about the decision-making and actions of key individual staff, in my view, UCG had the responsibility to operate the rest home in a manner that provided Mr A with services of an appropriate standard. This includes responsibility for the actions of its staff.

163. Rest-home owners have an organisational duty of care to provide a safe health-care environment for its residents. This duty of care includes ensuring that staff work and communicate effectively together, ensuring that its policies and procedures are consistent with relevant standards, and ensuring that staff comply with the policies and procedures.[37] The systems within which a team operates must function effectively in order to provide an appropriate standard of care to the residents.

164. In relation to the policies in place at Karadean, Ms Grant advised:

> "It is my opinion that the Policy and Procedures at the time of [Mr A's] admission were thorough and would meet the requirements for certification, DHB contractual arrangements and appropriate sector standards. They are typical of what would be found in any Aged Care Facility."

165. Ms Grant further advised:

> "Through reading all the documentation and statements from staff I am of the opinion that the events that happened to [Mr A] were caused not by one single transgression but rather a collection of individual transgressions that when put together resulted in substandard care which resulted in the poor outcome for [Mr A]."

166. These transgressions included the decision to admit Mr A to a rest home bed without providing hospital-level care, the inadequate admission process, the care subsequently provided to Mr A, and the substandard documentation of Mr A's condition.

167. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and

[37] Opinion 08HDC17309.

assist staff to do what is required of them.[38] In my view, UCG as an organisation must accept responsibility for Mr A's suboptimal care.

168. I have been provided with full job descriptions for staff; however, I note that RN Ms F stated that she was not given a copy of her job description. There was a process for familiarising staff with policies and procedures, and in-service training was provided. However, I am mindful of RN Ms F's and Ms G's comments that they felt out of their depth and were not adequately orientated to their new roles.

169. I am mindful of the staffing difficulties experienced by the facility. Ms Grant commented on RN Ms E's workload. During this period, RN Ms E worked long shifts, split shifts and was the only RN on duty over the weekend. She completed a total of 56.5 hours in 7 days, with only one day off. Ms Grant stated that the job would have been demanding, in that it required RN Ms E to provide care and supervision for patients and staff.

170. I share Ms Grant's concern about the level of professional support provided by UCG to senior staff. HDC has previously highlighted rest-home responsibilities in relation to supporting key staff.[39]

GP review

171. Mr A's family requested that he be reviewed by a doctor, but were told that the doctor visited only weekly. Mr A had last been seen by a doctor on Day 2 at the hospital, and he received no GP review while he was at Karadean.

172. UCG said that previous signed agreements with Dr H had required him to assess all new residents within 48 hours of admission, so UCG considered that that was the accepted practice. However, UCG advised that this was not specified in the 12-month contract signed on 28 September 2008. UCG has accepted responsibility for failing to ensure that the 2008/09 contractual arrangements between Dr H and Karadean were explicit with regard to the GP review of new residents and provision of locum cover. The contract with the new GP service has made the arrangements and expectations clear.

Conclusion

173. I consider that UCG did not did not provide sufficient support for staff or take sufficient steps to ensure that Mr A was provided with appropriate care. Accordingly, in my opinion, UCG breached Right 4(1) of the Code.

[38] Opinion 07HDC16959 (20 May 2008), page 18.
[39] See Opinion 07HDC17647 (5 December 2008) and Opinion 08HDC04291 (19 March 2009).

Other comments

Complaint resolution

174. Following the meeting of 5 May 2009, a letter was drafted acknowledging the gaps in the service and apologising for the inadequate care given to Mr A, but it was not sent. It is unfortunate that UCG failed to appropriately resolve the family's complaint.

Changes made

175. UCG has acknowledged the deficiencies that occurred. I accept the comments of my expert in relation to the subsequent changes made by UCG to address these issues and improve its service since Mr A's admission, namely:

> "Ultimate Care Group have made many changes since 2009 and I am of the opinion that the actions that Ultimate Care Group has taken in relation to restructuring staff, increasing staff, decreasing daily hours worked by Registered Nurses, improved orientation, and increased education and contacting local Doctors to provide services to Karadean Court will only improve the service."

Recommendations

176. In response to recommendations HDC made in its provisional report:

- UCG, RN Ms F and RN Ms E provided formal written apologies to the family, which were duly forwarded on by HDC; and,

- UCG accepted HDC's findings and acknowledged that the care provided was a departure from its organisational best practice. It provided HDC with details of the changes it had made to improve its service delivery at Karadean Lifecare to ensure that the care provided to residents is appropriate. These focussed on:

  a. the restructuring of governance at Karadean Court and the provision of greater availability of senior management to site staff, including weekly visits to the site by the Southern Regional Operations Manager;
  b. the appointment of two senior experienced registered nurse managers;
  c. the establishment of the positions of Registered Nurse Facility Manager (with overall responsibility for the facility) and Clinical Nurse Leader (responsible for quality of care delivery) and the establishment of key performance indicators for these roles;
  d. improvements to the quality management programme including quarterly facility monitoring and auditing;
  e. the initiation of a UCG clinical governance group in 2011 for review of best practice;
  f. the establishment of a managers' education training schedule;
  g. the provision of compulsory staff education and training in complaints management;

h. a review of staff education and development of a training schedule to improve and upskill the workforce;
i. provision of on-site aged care education for caregivers, working toward stage 3 of the Aged Care Education programme;
j. provision of GP services by a local medical practice. The house doctor is the practice's senior doctor, usually on site at least twice per week. A nurse practitioner covers weekends, liaising directly with the GP; and
k. Karadean was audited in November 2011 against Health and Disability Standards and was certified for three years.

177. I recommend that UCG arrange a further external audit of these changes and provide a copy of the audit report to HDC by **1 November 2012.**

178. I recommend that RN Ms F provide evidence to HDC, by **30 July 2012**, of her completion of the course "Assessment in Aged Care".

179. I have recommended to the Nursing Council of New Zealand that before renewing her annual practising certificate in the future, RN Ms E review her practice in light of this report, particularly in relation to documentation.

Follow-up actions

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Karadean Court Lifecare (UCG), will be sent to the Nursing Council of New Zealand, and the Council will be advised of RN Ms F's and RN Ms E's names.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case and Karadean Court Lifecare (UCG), will be sent to the district health board, the Ministry of Health, the College of Nurses Aotearoa Inc, and the New Zealand Aged Care Association, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following preliminary expert nursing advice was obtained from Ms Jan Grant:

"I have been asked to provide an opinion to the Commissioner on Case 10/00308 and that I have read and agree to follow the Commissioners Guidelines for Independent Advisors.

Enclosed is a copy of my qualifications which outline my training and experience relevant to the area of expertise to be called upon in compiling this report.

I have read the supporting information.

Background

[Mr A] was a 93 year old gentleman who was assessed as requiring hospital level care following an admission to [hospital]. His discharge date was [Day 2] 2009. Documentation from [the hospital] states that the social worker faxed to Karadean Court the Needs Assessment information which indicated that [Mr A] required hospital level care. On admission to Karadean Court [Mr A] was placed in the Rest Home bed.

Staff completed admission documentation.

[Mr A's] medical condition deteriorated over subsequent days and he was admitted back to [hospital] on [Day 8] 2009 where he passed away.

Supporting information

- Complaint letter from family
- Response from [the] DHB
- CDHB clinical notes for [Mr A]
- Cover letter from Ultimate Care Group. Includes internal investigation report
- Karadean Court care notes for [Mr A]

Process

I will review each area individually with the supporting information supplied.

Admission

The usual admission procedure commences with the family being advised that their relative needs to go into long term care. It is usual that Social Workers provide a list of available Facilities to families for them to inspect and select one. The procedure is that the Social Worker discusses the placement with the chosen Facility and a date is made to transfer. It is usual for the required documentation to be faxed or sent with the person being admitted.

This process appears to have been followed.

- The Social Worker liaised with Karadean Court on [Day 1] the day before [Mr A] was due to be admitted.
- The paper work was faxed to the Facility.

It is not usual for an assessed hospital level patient to be admitted to the Rest Home part of the Facility.

Hospital level patients require a more intensive input in to activities of daily living and specific Registered Nursing input to ensure an adequate level of care is given. Rest Home beds traditionally do not provide this level of care as residents are usually more independent. Rest Homes do not have a Registered Nurse available 24/7 as hospital beds do. Although there may be Registered Nurses on site, they are allocated to the hospital wing.

The admission process is covered in a number of documents supplied by Karadean Court.

- Initial Assessment Form — this is a three page document. The top of the first page covers administration details such as the patient's name, next of kin etc. Following this there is a brief description of the patient's functional ability and assistance required. This assessment includes areas where a tick or circle can be made to identify the needs required.

- Under the title 'Continence' it is written '*S P Catheter assist*'. It does not define what 'assist' is. It is also identified that [Mr A] is continent of the bowels.

The Self Care area identifies that assistance is needed with showering and dressing

Diet lists :–

- '*cut up meat*'

Sensory lists:–

- Hearing aids are worn, glasses during the day, assistance will be required to fit and clean aids.
- It is also circled that [Mr A] is able to express discomfort.

Pain was not assessed.

Sleep:–

- '*Needs* help *settling*'

Social and family support:–

- It is listed — '*Sons x 2 + daughter*'
- It is circled Alcohol — '*Yes'* Supervision needed — '*Yes'*

Memory Loss/Confusion

- It is circled that [Mr A] is Alert, able to assist in planning care, no short term memory loss and that he is orientated to time and place, it also lists that he has some anxiety

The lower part of this form notes his Baseline Recordings as

- BP 96/70 Pulse 48, SaO2 96 Temperature 37.3.
  Weight was not taken nor was a urine analysis.

It lists the Referring Agency, with […] as the contact.

There is a signature in the Registered Nurse column and the date is listed as [Day 2]

- Individual Assessment Forms are available.
  The Continence Assessment Form has a number of areas that could be ticked or circled.

The only documentation listed on this sheet apart from name and diagnosis is

- '*No* incontinence — *SPC*'

- Health Status and Clinical Risk Assessment Form is a Yes or No column. On this form it states that it is to be completed by a Care Giver during the first shower.

The other part of the form is completed with a tick in the appropriate column. This would indicate that [Mr A] does have an abrasion.
It is written on this form that:–

- '*pressure ulcer outside of L calf (silver dressing)*'
- 'No' is ticked on the area of skin irritations
- 'No' is ticked in relation to irritations around resident's eyes
- *S P Catheter* is written under the heading of incontinence
- A tick indicates that assistance is required with feeding
- Gutter frame is used for walking

In the question of Pressure Area Devices it states that —

- '*looking for air or spenco mattress'*

It also lists that the resident was last seen by a doctor on [Day 2]. This form is signed by a Registered Nurse and dated [Day 2].

- A Falls Risk and Pressure Area Risk Assessment was completed on the day of admission and subsequently show that [Mr A] was at moderate risk of falls and low risk of pressure areas.
- A Detailed Pain Assessment Form was completed to show that [Mr A] had moderate chronic pain, that Panadol decreases pain. Pain does affect his ability to care for himself, alter his ability to sleep, rest and participate in physical activity, but it does not affect his social activity nor affect his ability eat and drink.
- Property List was completed and signed on [Day 2].
- Advance Directive Form was completed and signed on [Day 2].
- Assessment Form with personal family data was documented.
- Diagnosis List — a list of [Mr A's] medical problems are listed.
- Admission Checklist was ticked and signed and dated [Day 2].
- Allied Health Professionals notes include an entry on [Day 2] from the Physiotherapist and again on the [Day 7].

The documentation used by Karadean Court is a common example of what Aged Care Facilities use.

The Initial Assessment Form has been filled in very briefly and does not convey a lot of information. The area relating to continence highlights this. It is noted that a suprapubic catheter was in situ. The only information on the form is the word 'assist'. There is no indication as to what assist is.

This lack of detail is inadequate for Care Staff to carry out the required daily cares in relation to the suprapubic catheter care.

The Continence Assessment Form does not hold any other information other than stating

- '*No incontinence — SPC*'

It would be an expectation that all care relating to the SPC would be listed and a time frame would indicate what was needed, and when it was to be done. There is no assessment of the state of skin surrounding the SPC.

Progress Notes can be used to further explain or plan care but the only entry on the date of admission states

- *'... he has a suprapubic catheter in situ this is not to be changed. An appointment will come for him to go back to hospital and changed there or in an emergency he will need to be readmitted'*

It is my opinion that there does not appear adequate information for staff to care for the SPC. It is not uncommon for patients in Care Facilities to have SPC. It is not an advanced task and hence would be within every Registered Nurses scope of practice to have knowledge and skills to adequately care, provide education and supervision for a patient with a SPC.

It would also be an expectation that any patient being admitted with a SPC should have their urine output closely monitored and a thorough Nursing Care Plan documented to ensure adequate care.

It is my opinion that there is a large gap in the assessment, care and documentation in relation to [Mr A's] SPC.

There is good documentation from Allied Health in relation to mobility. [Mr A] was issued with a Gutter Frame until being assessed by the Physiotherapist. This was done on [Day 7]. Also at that time the Physiotherapist has noted in her documentation that [Mr A] was in pain and reluctant to mobilise.

Assessments were undertaken in relation to Pressure Area Risk Assessment and Falls Assessment. Both of these were done on the date of admission.

Within the Initial Assessment Form there is an area which identifies Self Cares. This area includes skin abrasions/bruises/breaks/oedema. There is no mention of the leg ulcer in the initial assessment. The only documentation of the leg ulcer is on the Health Status and Clinical Risk Assessment. It states —

- '*Pressure ulcer outside of L Calf (silver dressing)*'

There is no Care Plan or follow up documentation in the Progress Notes.

It would be expected that there would be a Wound Chart and/or a Care Plan outlining the treatment and frequency required. There is no evidence of an assessment of the wound and there is no proof that the wound was ever dressed or examined. There are no entries in the Nursing Progress Notes in relation to the wound care for the time that [Mr A] was at Karadean.

It is my opinion that the assessment, plan and evaluation of [Mr A's] wound is very poor. It does not meet an acceptable standard of care.

On the Initial Assessment and Admission Form there is an area for Base Line recordings.

The recordings that have been taken are listed as

- Sitting BP 96/70 Pulse 48 Sao2 96 Temp 37.3
- The area in which weight and urine are listed do not have any information documented.

These recordings may be within the normal range for [Mr A], but it is my opinion that any patient admitted with a raised temperature, low pulse and low blood pressure would alert a Registered Nurse, and that follow up recordings would be taken. It would be expected that the Registered Nurse would follow up with either the past GP or the GP who would be admitting [Mr A]. There is no evidence of any follow up in any documentation.

Failure to follow up on these recordings shows poor nursing judgement.

Summary of admission

In reviewing the documentation I am of the opinion that the admission process failed [Mr A] in two ways:

- First — in the admission to a Rest Home bed rather than a hospital bed.
- Second — once admitted, staff failed to interpret the minimal amount of data they had gained from the admission as having any significant importance; hence cares were not delivered to [Mr A] in an appropriate and timely manner. *Assessment* and ongoing monitoring was not undertaken.

General Practitioner Care

There is no evidence in any documentation that the GP was contacted to come to the Facility and admit [Mr A].

The only entry in the Progress Notes was on [Day 8] in which it states

- '*GP called — ambulance called family contacted*'

It is common practice that a patient admitted into a long term hospital bed is seen within 48 hours. Each Facility will have a policy and procedure in relation to medical care and the timeframe to be seen.

Family have stated that they requested a Doctor to see [Mr A] on [Day 4] as they were concerned about his health status. It does not appear that staff acted on the family's request.

Had a thorough Assessment and Admission process been undertaken by the Registered Nurses it is my opinion that a GP would have been called sooner, and in doing so the GP would have identified that [Mr A] was unwell and implemented appropriate interventions.

Care Plans, Documentation and Ongoing Monitoring

Karadean Court did not include any Care Plans with the documentation that I viewed.

I have taken it then, that a structured Care Plan was not documented for any Cares that [Mr A] needed.

Although [Mr A] was only with the Facility [Days 2-8] a total of 6 days, it would be usual practice to document a plan that showed what specific care was needed for [Mr A's] health needs.

A Care Plan would have ensured there was consistency and continuity for all of [Mr A's] cares. Evaluations would have also identified a change in condition which would have ensured [Mr A] received appropriate and timely care.

The clinical notes indicate several areas where a Care Plan would have allowed a systematic approach to care.

- Concentrated urine
- Wound care
- Supra-pubic catheter care
- Pain relief
- Mobility
- Baseline recordings
- Care of hearing aids
- Bowel *cares*

This lack of documentation, care planning and monitoring is not good nursing practice and in my opinion it shows a serious lack of professional observation. It also does not meet the standard required in relation to Aged Care Facilities; these would be documented in their Policies and Procedures Manuals and the Facilities Service Specifications.

The lack of care planning, documentation, and monitoring does not meet the expected requirements for individual Registered Nurses in relation to Nursing Council competences.

Communication with Family

There is written evidence that when staff did communicate with [Mr A's] family it was documented.

Documentation was listed in the Family Contact Sheet. The entries are dated

- [Day 2]
- [Day 3]
- [Day 5] two entries
- [Day 6] *three* entries

Staff have also documented in the Nursing Progress Notes when communication took place between family and staff.

It is my opinion that there is adequate evidence that staff communicated with [Mr A's] family and when they had done so they documented it.

It is also my opinion that although staff did document that they had communicated with [Mr A's] family, they failed to action any of [Mr A's] family's concerns.

General Cares

An evaluation of general cares is undertaken using the Care Plan and Progress Notes, as well as any supporting information e.g. wound charts, fluid balance chart etc.

There is a lack of the supporting information in relation to individual charts. The Progress Notes are the only information I am able to form an opinion on.

It is my opinion that the level of nursing care was inadequate to care for a man with high needs levels such as [Mr A].

An accurate assessment on admission would have identified the specific areas in which extra care and specific Registered Nursing skill should have been used.

One example of this would be a Wound Chart.

- No Wound Chart was documented and there is no evidence in the Progress Notes that anyone looked and/or did [Mr A's] dressing while he was at Karadean.
- The same can be said for his SPC.

There is no documented evidence in the Drug Signing Sheet that [Mr A] received any pain relief. He was charted Paracetamol QID prn. His Pain Assessment Chart on admission, shows that he experienced moderate pain in relation to his R knee and L calf ulcer.

There is an entry in the Clinical Notes on [Day 4] that states:

- '*Very tired falling asleep in the chair states the Paracetamol is making him to sleepy.*'

There is an inconsistency between the Drug Signing Sheet and the Progress Notes.

At the start of the entry on [Day 4] it is documented that [Mr A's]

- '*urine in the* bag *brownish colour ? blood Encourage to drink more and [Mr A] has done so*'

There is no other mention of this in [Mr A's] notes. [Mr A's] family have documented that they requested staff to address the issue of what appeared to be blood in the urine bag. There is nothing in the Clinical Notes to state what action, if any the Registered Nurse took. This lack of action indicates in my opinion poor professional assessment, intervention and documentation.

[Mr A's] bowel cares were also inconsistent. The Progress Notes indicate that [Mr A] had loose bowel motions twice on [Day 2]. Nothing is documented in the Progress Notes on [Day 3].

On [Day 4] at 0630am Registered Nurse has documented that:

- '*c/o feeling* unwell, *feels like he needs bowels to open given lactulose 20 mls*'

Later that day at 1100am it is documented that

- '*[Mr A] had very loose bowels this morning washed and changed. Do not feel [Mr A] needs Lactulose as bowels very loose. Will monitor. May need a bulking agent?*'

There is nothing else written in the Progress Notes in relation to [Mr A's] bowels.

[Mr A] was given a laxative without any assessment nor as it would appear, without the Registered Nurse checking recent history of bowel motions.

One would expect to see an accurate assessment and this would include a history of bowel motions.

- What laxatives if any were taken
- And if taken at what frequency.

It is my opinion that [Mr A's] bowel care was not up to a standard expected for a patient requiring hospital level care. The care provided by the Registered Nurses did not meet the competences that would be expected.

Complaint handling

Each Facility should have a documented policy for management and staff on how to deal with verbal and written complaints. Policies will include a timeframe on responding to families and actions required.

It appears that this policy was not followed.

Ultimate Care Group have acknowledged that the complaint process was not handled to their expectations.

Staffing

- The rosters for the time of [Mr A's] admission indicate that one Registered Nurse was on duty from 7am till 7.30pm and another Registered Nurse from 7.15pm till 7.15am 7 days a week.
- An Enrolled Nurse was listed on the roster from 7.00 but it does not indicate what hours the EN works.
- A Clinical Manager is employed 5 days a week Monday till Friday. It is not documented what hours this includes.
- Nine Care Givers are employed on a morning shift and five on an afternoon shift.

Karadean Court has a total of 54 rooms, which comprise of:–

- 8 studio apartments.
- 46 Rest Home hospital rooms.

There obviously is the potential to have 46 hospital level patients.

This would be in my opinion, a heavy work load for one RN on a 12 hour shift.

Summary

In reviewing [Mr A's] care I am of the opinion that he did not receive an adequate standard of care due to

- Karadean Court accepting [Mr A] in a Rest Home bed which was located away from the main part of the Hospital.
- Not requesting a visit from the GP once [Mr A] was admitted.
- Inadequate assessment and lack of professional observation by Registered Nurses.
- Lack of assessment, documentation and planning in relation to basic activities of living and high care needs.
- Failure of nurses to act on the family's concerns once they had indentified them to staff.
- Lack of communication between shifts
- Heavy work loads for Registered Nurses.
- Poor complaint handling by Ultimate Care Group

Jan Grant"

Appendix B — Further nursing advice to Commissioner

"I have been asked to provide an opinion to the Commissioner on Case 10/00308 and that I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Enclosed is a copy of my qualifications which outline my training and experience relevant to the area of expertise to be called upon in compiling this report.

I have read the supporting information.

Background

[Mr A] was assessed as requiring hospital level care. He was admitted on [Day 2] into a Rest Home bed as Karadean Court did not have a hospital bed. [Mr A] become unwell and was readmitted to [hospital] on [Day 8] where he passed away from septic shock.

1. Please comment generally on the overall standard and appropriateness of care provided to [Mr A] at Karadean Court.

As in my earlier advice and having read the extra supplied information I am still of the opinion that [Mr A] did not receive an adequate standard of care as for the reasons listed

- Failure to correctly assess and once assessed, failure to interpret the assessment and implement action to review the findings.
- Lack of orientation and training and support from Ultimate Care Group for Senior Staff including Registered Nurses.
- Lack of Registered Staff / Overworked Registered Staff — expecting staff to work long hours.
- Failure to decline [Mr A] to the facility when the needs assessment was identified.
- Failure to document correctly.
- Failure to ensure that a Doctor visited [Mr A].
- Failure to communicate with the family in a timely manner.

2. Please comment on the appropriateness of the discussion had with family members and the overall decision to admit [Mr A] to a Rest Home level bed given his clinical circumstances and his prior needs assessment.

As stated in my initial opinion, the admission process starts with families viewing a chosen facility. It is usual for the social workers to advise families what level their relative has been assessed at. Information provided confirms that 3 days before [Mr A's] admission his son contacted Karadean Court to enquire about the availability of a bed for his father. The next day he visited and was shown around by [Ms F].

When the Needs Level Assessment was faxed through to Karadean Court [Mr A] was assessed as a Hospital Level patient. [Ms F] in her statement, notes that she discussed the situation of not being able to provide a hospital bed with [Ms G], the Business Administration Manager. [Mr A's] family were given the option of taking a Rest Home bed and waiting for a hospital bed to become available. The statements from both [Ms F] and [Ms G] confirm that [Mr A's] family had viewed one of the units.

Following the discussion that staff had prior to admission and with the knowledge that the unit would not be suitable for [Mr A], [Ms F] contacted his son and he agreed that the Rest Home bed would be suitable until a hospital bed became available.

[Ms F] states that on admission it became apparent that [Mr A] was considerably more unwell than staff had been led to believe.

Having obtained the information and assessment forms from the Public Hospital, it is my opinion that senior staff should have contacted the Public Hospital and advised that they could not provide hospital level care. The admission should have been put on hold until a hospital bed had become available.

In accepting [Mr A] into a Rest Home bed it was in my opinion senior management's responsibility to ensure that he received the level of care he needed.

I believe the acceptance of [Mr A] into a rest home bed when his needs indicated hospital level care would be viewed with mild disapproval from peers.

3 Please comment on the overall standard and appropriateness of Karadean Court's admission process.

Policy and Procedures supplied by Karadean Court outline the admission process.

Three specific policies relate to this

1. Admission Policy and Procedures
2. Health Status and Clinical Risk Assessment Policy
3. Progress Note Writing Guidelines/Documentation and report writing

The Admission Policy, staff would have had available, and used at the time of [Mr A's] admission is a 4 page document which outlines the Objectives, Policy, and Procedures.

Procedures are listed in numerical order and the ones that relate to this case are listed.

1. It lists that the Admission forms are to be completed by the Facility Manager or the Registered Nurse, or the Business Administrator.
2. The Admission documents as noted on the Admission Checklist must be filled in on or before the day of admission. To maximize preparedness it is preferable for as much as possible to be completed prior to admission date.

3. The Registered Nurse must be involved with the initial assessment and forming of the initial Care Plan.
4. Ensure the Consent Forms and Admission documents are signed prior to the resident's next-of-kin leaving the premises.
5. Any questions regarding the information given will be discussed with the resident and family on the day of admission.

…

10. Where possible arrange the time of admission to coincide with the Facility Manager or Business Administrator being able to spend sufficient time with the new resident to complete the admission process.

11. Ensure residents being admitted for long term care have been assessed by the Assessment, Treatment & Rehabilitation Unit as meeting the criteria to enter a Rest Home.

12. Prepare Resident's File with all documents as noted on the Admission Checklist.

The Health Status and Clinical Risk Assessment Policy states in its Aim that

'All residents are cared for in a manner that identifies deficiencies in care provision and encourages optimum health and skin integrity.' This process is designed to identify increased risk factors relating to care provision. To identify any adverse health symptoms, monitor and intervene where necessary by implementing corrective actions and/or treatments

It documents a standard and scope and this is followed by the procedure. The procedure includes statements.

Staff are responsible for ensuring they have read the resident's daily Progress Notes and are aware of all the resident's needs.

It also states that a Clinical Risk Assessment is completed on admission.

It goes on to list adverse health issues and makes the statement that any of the listed signs and symptoms are required to be followed up by a trained nurse and medical staff if necessary.

The Progress Notes Policy states that 'the Aim is to ensure that Progress Notes are written up in such a way that resident's progress is recorded and able to be evaluated.'

Its Aim listed for the documentation policy states 'that all documents relating to service provision are completed accurately in a timely manner that meets legislative and contractual requirements.' Documentation provides proof of appropriate care and service provision …

Included in this policy is the policy that relates to Care Plans. It states

'the Registered Nurse will develop and document initial assessment Care Plans within 24 hours of admission, followed by a full nursing Care Plan within 3 weeks of admission'.

It is my opinion that the Policy and Procedures at the time of [Mr A's] admission were thorough and would meet the requirements for certification, DHB contractual arrangements and appropriate sector standards. They are typical of what would be found in any Aged Care Facility.

4. Please provide your view on the appropriateness and standard of care provided to [Mr A] by the admitting registered nurse RN [Ms E] during the admission period and subsequently.

Nurse [Ms E] was the Registered Nurse on duty when [Mr A] was admitted.

The documentation that was completed included

- Admission checklist
- Residents Diagnosis List
- Advance Directive Form
- Property List on Admission
- Initial Assessment on Admission Form — 3 pages
- Continence Assessment
- Health Status and Clinical Risk Assessment
- Detailed Pain Assessment
- Pressure Area Risk Assessment Tool
- Falls Risk Assessment
- Admission Food and Nutrition Information
- Breakfast Order
- Drug charts

Documentation in relation to the Initial Assessment form was brief and did not fully explain nor assess important key areas of [Mr A's] cares. This is in relation to the Continence section. [Mr A] had a suprapubic catheter. This area of this form should have been more fully completed rather than just documenting that [Mr A] had a suprapubic catheter. The site of the catheter should have been assessed. The care issues around the catheter and the site should have been listed and directions for care givers to follow. The word 'assist' is documented in the space provided to write in. 'Assist' does not demonstrate or provide information as to what assistance would be needed.

Under the area of Self Cares, again the word 'Assist' is listed and in the area of showering and dressing 'needs assistance' is written. Again this does not provide Care Staff, direction in relation to Self-Cares.

This is the area in the assessment that would have identified any skin abrasions/bruises/breaks etc. The pressure ulcer that [Mr A] had was not identified in this section of the initial assessment.

Diet — the only comment in this area is 'cut up meat' it does not state if [Mr A] needs assistance to eat nor does it outline any issues he may have had.

On page three of the Initial Assessment there is a space for baseline recordings.

[Mr A] was assessed as having a Blood pressure of 96/70, a pulse of 48, oxygen sats os 96% and a Temperature of 37.3. The weight and urine part of this initial assessment was not filled in. Nurse [Ms E] in her statement dated 15th October 2011, states that she did not take the baseline recordings. She is unsure who did, but thinks she may have asked someone to do them.

The Health Status and Clinical Risk Assessment form was completed and signed by Nurse [Ms E]. The first area of this form asks if there are any abrasions, skin breaks, bruising, pressure area sores. There is a tick in the 'Yes' column and a comment 'pressure ulcer outside of L) calf (silver dressing)'.

The Progress Notes are written on [Day 2] and the entry by RN [Ms E] on [Day 2] states that

'*[Mr A] has transferred from [hospital]. He has a suprapubic catheter in situ this is not to be changed. An appointment will come for him to go back to hosp — changed there, or in an emergency he will need to be readmitted. [Mr A] can walk to the toilet with gutter frame, one assist and belt. He has 2 hearing aids and partial plates (upper and lower). [Mr A] is cognitively able, but you need to speak up clearly. He can have panadol for pain which he refused at dinner time and his meds will arrive tomorrow.*'

There is no other entry in the Progress Notes written by RN [Ms E].

RN [Ms E] completed all documentation that was required following admission but the standard of documentation did not meet the prescribed Policies or Procedures that Karadean Court had available at the time. The documentation was brief. It did not give enough detail to document the required cares that [Mr A] would have needed. The base line recordings once taken and if observed by Nurse [Ms E] should have alerted her that they were abnormal and that if she was concerned they should have been taken again later in that shift or passed on to the next shift to repeat. [Mr A's] temperature was slightly above normal his pulse rate was low as was his blood pressure. It would be the expected norm for this to be documented and re checked and reported to the Clinical Manager. There was no review of the pressure wound that [Mr A] had. It is common for staff to pass over information if they do not have the time to complete the full assessment and have staff on the next shift assess areas that have not been done.

Hours worked

In reviewing the roster and the time sheets it shows that RN [Ms E] work long shifts, split shifts and was the only Registered Nurse on duty over the weekend. She completed a total of 56.5 hours in 7 days only having one day off. It is not usual for Aged Care staff to work 12 hour shifts, nor work split shifts. The job would have been demanding in itself ensuring care and supervision for patients and staff. This does not take away for the failure to give / supervise adequate care for [Mr A] but can be understood in the context of the situation.

5. Further to your preliminary advice, please provide specific comment (with reference to professional nursing standards, rest home policy and job description where applicable) on the quality of RN [Ms E]'s assessment, care planning, patient monitoring and follow-up, wound management, catheter management, and documentation.

All Registered Nurses that worked at Karadean Court should have been registered with the Nursing Council of New Zealand.

- The Nursing Council of New Zealand is the regulatory authority responsible for the registration of nurses. Its primary function is to protect the health and safety of members of the public by ensuring that nurses are competent and fit to practice. (Nursing Council of New Zealand)

Nursing Council fulfils this function by several means. Two of these are

- Registering nurses
- Setting on going competence requirements and issuing practicing certificates.

Job description for a Registered Nurse was provided. One was dated October 2004 and the other June 2008. They are similar in nature. The job descriptions provided are typical of job descriptions in an Aged Care environment. It lists primary objectives, Key Tasks and Performance Standards.

Policies and Procedures provided in the information pack include

- Admission Policy and Procedures
- Administration of Medication Policy
- Continence Management Policy
- Adverse Health Policy
- Catheter Management Policy
- Wound and Skin Care Management Policy
- Documentation and Report Writing Policy
- Complaints Policy
- Health Status and Clinical Risk Assessment Policy
- Staff Training Policy
- Staff Orientation Policy
- Food Services Staff Responsibilities
- Progress Note Writing Guidelines

- Policy and Procedure Familiarisation Policy

Nurse [Ms E] was on duty when [Mr A] was admitted; the initial information documented in the Nursing Progress Notes was from Nurse [Ms E]. It states that he was transferred from [the public hospital]. He has a suprapubic catheter in situ and this was not to be changed. It goes on to state that he was able to walk to the toilet with a gutter frame and one person to assist, he had 2 hearing aids and partial plates upper and lower. She stated that [Mr A] is cognitively able but that you need to speak up clearly. She states that he could have panadol which he refused at dinner time and his meds would arrive tomorrow.

There is no other evidence of her documenting in the Progress Notes until [Day 8] when she documents that there had been a call from the son to say that [Mr A] has passed away.

The other documentation from Nurse [Ms E] was in the Admission Information.

This includes:

- Admission checklist — completed, signed and dated [Day 2]
- Resident's Diagnosis List — not signed or dated
- Advance Directive Form — signed and dated
- Property List on Admission — signed and dated
- Initial Assessment on Admission Form — This is a 3 page form which allows staff to plan a brief assessment and allows staff to identify patient's needs for the short term. There are several headings which relate to activity of daily living.
  The first is mobility — this area is completed.

  Continence. SP Catheter assist is the only documentation in this area.

All of the admission documentation was briefly completed. It was not thorough and its lack of detail and specifics did not give direction to other staff.

It is my opinion that the standard of care provided by RN [Ms E] failed to meet the requirement for Competencies for Registered Nurses in two areas.

Domain One

This relates to professional, legal and ethical responsibilities and cultural safety. These include being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises client safety, independence, quality of life and health.

Domain Two

Management of Nursing Care — this relates to client's assessment and managing client care, which is responsive to the client/client's needs and which is supported by nursing knowledge and evidence based research.

She also failed to meet the documented policy and procedures of Karadean Court.

I believe this departure from policies and procedures would be viewed with moderate disapproval from peers.

6. Please comment on the appropriateness and standard of care provided to [Mr A] by Clinical Services Manager, [Ms F].

[Ms F] was the clinical manager of Karadean Court Life Care. Her previous employment was as an Enrolled Nurse and a Registered Nurse. She commenced work as the Clinical Services Manager [in] December 2008. She states in her statement on the 28th October 2011 that she was not given a job description nor did she have any orientation.

She also states that her role was to liaise with the referrer, resident/patients and their families. The Admission Policies and Procedures are clearly outlined in the information send by Karadean Court.

It would be expected that [Ms F] would have been closely involved in [Mr A's] cares as it was her decision to admit [Mr A] into a Rest Home room when there was documented assessment that [Mr A] was a hospital level patient. This is supported in her statements. There does not appear to be any evidence of any documentation by [Ms F] in the nursing Progress Notes, or the Care Plan. There are two entries in the Family Communication sheet to show that [Ms F] spoke with the family on [Days 2 and 3] 2009. Although the admission documents (policy) state that the Admission Forms can be undertaken by the RN, Clinical Manager or the Business Manager. The only documentation was from the Registered Nurse.

It would be expected that as [Mr A] was located in a Rest Home room that he would have been somewhat isolated, then I believe that [Ms F] should have ensured that there was support and direction for the registered nurse on duty. Their (RN) tasks and time would have been busy and most of this would have been in the hospital, caring for hospital level patients. I am of the opinion that direction and supervision would have identified there were omissions in both practical care and documentation. This would have included wound care, catheter care and base line recordings.

[Ms F] in her statement on the 26/10/11 paragraph 8, states that she did read through his admission documentation the day after admission and she states she did not have any concerns that needed her urgent attention.

I am of the opinion that [Ms F] failed to identify the omissions, lack of depth in the admission and in the Assessment and Care Plans documentation. I believe this departure from policies and procedures would be viewed with mild disapproval from peers.

It is also noted that she had been at her job for a short period of time and that at the time of her employment she was given no orientation. The comment 'to just read the manuals when you have time' is unprofessional and does not support senior staff. The role of Clinical Manager is vital and in my opinion it is her role to ensure all staff are supported in their roles. Ultimate Care Group in my opinion failed to support senior staff, they failed to orientate staff and expected staff to work long shifts and split shifts without clinical professional support.

7. Please comment on the appropriateness of the steps taken by staff to arrange and provide care to [Mr A] in the interim until a hospital level bed became available.

There does not appear to have been a proactive approach to ensuring that [Mr A] received a higher level of care once he was in a Rest Home bed despite senior staff being aware of the need for a higher level of care. No extra staff were made available nor was there any documentation from senior staff to alert staff of the high needs level of this man.

Although Nurse [Ms E] failed to provide a thorough assessment it must also be stated that no other Registered Nurses assessed [Mr A]. It does not appear that other qualified staff took the initiative and followed up on the assessment and recordings that were taken on admission.

It is my opinion that there were not adequate steps taken to ensure that [Mr A] received a higher level of care despite being in a Rest Home room.

8. Please comment on the overall standard and appropriateness of Karadean Court's policies and procedures in place at the time of [Mr A's] admission.

Policies and Procedures provided by Karadean Court would be in my opinion similar to what is seen in most Aged Care facilities. They would meet the requirements for certification.

It is my opinion that the policies were appropriate.

9. Please comment on the appropriateness of the rest home policy in relation to it allowing a 3 week period to complete longer term care planning.

It is appropriate to wait for a length of time before completing the long term Care Plan. Three weeks would be the industry norm. This period of time allows staff to assess the patient and gather information. It does not mean that the plan could not be started and assessment made when carrying out activities of daily living. The time frame also gives other members of the multidisciplinary team time to include their assessments and goals for the patient.

It is my opinion that this is appropriate.

10. Please comment on the appropriateness of the remedial actions taken by the Ultimate Care Group and as a result of this complaint. Please outline any recommendations you may have to address issues raised by this case.

Following the family complaint and the meeting with the family on the 5th May 2009 by the Business Manager and the Clinical Manager a letter was written by both. This was going to be posted to the family until it was stopped [by the Southern Manager].

This letter in my opinion acknowledges there were gaps in the service and apologises for the inadequate care given to [Mr A]. This letter was timely and as discussed with the family they were going to read this as they scattered their father's ashes.

Obviously the family became concerned when Ultimate Care Group failed to respond. It appears that it has now been a long and involved exercise, stressful for all parties concerned.

Ultimate Care Group have made many changes since 2009 and I am of the opinion that the actions that Ultimate Care Group has taken in relation to restructuring staff, increasing staff, decreasing daily hours worked by Registered Nurses, improved orientation, and increased education and contacting local Doctors to provide services to Karadean Court will only improve the service.

11. If in answering any of the above questions, you believe that any of the providers concerned did not provide an appropriate standard of care, please indicate the severity of the departure from that standard.

In summary there was:

- Lack of orientation and training and support from Ultimate Care Group for Senior Staff including Registered Nurses.
- Lack of Registered Staff / Overworked Registered Staff — expecting staff to work long hours.
- Failure to decline [Mr A] to the facility when the needs assessment was identified.
- Failure to correctly assess and once assessed, failure to interpret the results.
- Failure to document correctly.
- Failure to ensure that a Doctor visited [Mr A].
- Failure to communicate with the family in a timely manner.

Through reading all the documentation and statements from staff I am of the opinion that the events that happened to [Mr A] were caused not by one single transgression but rather a collection of individual transgressions that when put together resulted in substandard care which resulted in the poor outcome for [Mr A].

Jan Grant"